This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0168 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/31/2022 Time: 11:00 am use only ] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN MUSCULOSKELETAL CENTER (15-0168) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADM	MI NI STRATOR CHECKBOX	ELECTRONI C SI GNATURE STATEMENT	
1		2	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			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	3, 500	7, 715	0	0	1. 00
2.00	Subprovi der – 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, 500	7, 715	0	0	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	e element of t	he above comple	ex indicated.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168 Peri od: Worksheet S-2 From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7952 W. JEFFERSON BLVD 1.00 PO Box: 1.00 State: IN 2.00 City: FORT WAYNE Zip Code: 46804 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Number Number Certi fi ed Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 LUTHERAN 150168 23060 03/07/2008 N 3.00 MUSCULOSKELETAL CENTER Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2. 00 3.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to N Ν 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 0 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	1.00	2. 00	3. 00	4. 00	5. 00		5. 00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state	0	С	0	0		0		24. 00
Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in colu	ımn							
4, Medicaid HMO paid and eligible but unpaid days								
column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state	0			0		o		25. 00
Medicaid paid days in column 1, the in-state								
Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-sta	ate							
Medicaid eligible unpaid days in column 4, Medicai	d							
HMO paid and eligible but unpaid days in column 5.				Urban/Rı	ıral S	Date of	Geogr	
2/ 00 [5-1		-4 46- 6		1. 0	0	2.	00	24 00
26.00 Enter your standard geographic classification (no cost reporting period. Enter "1" for urban or "2"		at the beg	ginning of t	ne	1			26. 00
27.00 Enter your standard geographic classification (not	wage) status	at the end	d of the cos	it	1			27. 00
reporting period. Enter in column 1, "1" for urbar enter the effective date of the geographic reclass			оргі сарге,					
35.00 If this is a sole community hospital (SCH), enter			CH status ir	ı	0			35. 00
effect in the cost reporting period.				Begi nn	i ng:	Endi	ng:	
			0.4	1. 0		2.		0.4.00
36.00 Enter applicable beginning and ending dates of SCI of periods in excess of one and enter subsequent of		cript line	36 for numb	er				36. 00
37.00 If this is a Medicare dependent hospital (MDH), er		r of period	ds MDH statu	IS	0			37. 00
is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for	the MDH tran	sitional pa	avment in					37. 01
accordance with FY 2016 OPPS final rule? Enter "Y'								
instructions) 38.00 If line 37 is 1, enter the beginning and ending da	ates of MDH st	atus. If li	ne 37 is					38. 00
greater than 1, subscript this line for the number								
enter subsequent dates.				1/Y	V	Υ/	'N	
				1.0	0	2.		
39.00 Does this facility qualify for the inpatient hospi hospitals in accordance with 42 CFR §412.101(b)(2)						N	l	39. 00
1 "Y" for yes or "N" for no. Does the facility mee	et the mileage	requi remer	nts in					
accordance with 42 CFR 412.101(b)(2)(i), (ii), or or "N" for no. (see instructions)	(III)? Enter	in column 2	2 "Y" for ye	es				
40.00 Is this hospital subject to the HAC program reduct						N	I	40. 00
"N" for no in column 1, for discharges prior to 00 no in column 2, for discharges on or after October			yes or "N" t	or				
				<u>.</u>	V	XVIII	XIX	
Prospective Payment System (PPS)-Capital					1. 00	2. 00	3.00	
45.00 Does this facility qualify and receive Capital pay	ment for disp	roporti ona	te share in	accordance	N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment 6	exception for	extraordi na	arv circumst	ances	l N	N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete N					''	"	''	10.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) Pf	PS capital? F	nter "Y fo	r ves or "N"	for no	N	N	N	47. 00
48.00 Is the facility electing full federal capital payr	•		,		N	N	N	48. 00
Teaching Hospitals  56.00 Is this a hospital involved in training residents	in approved G	ME programs	2 Enter "V"	for yes or	l N	T	T	56. 00
"N" for no in column 1. For column 2, if the respo	onse to column	1 is "Y",	or if this $\\$	hospi tal	I IN			30.00
was involved in training residents in approved GMF year, and are you are impacted by CR 11642 (or app								
Enter "Y" for yes; otherwise, enter "N" for no in	column 2.		. 3					
57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y"								57. 00
is "Y" did residents start training in the first r	nonth of this	cost report	ting period?	' Enter "Y"				
for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt.			t E-4. If co	olumn 2 is				
58.00 If line 56 is yes, did this facility elect cost re	eimbursement f	or physicia	ans' service	s as				58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If you specified and seems of the seem			D† I		N			59.00
37. 00 pare costs charmed on Title 100 of Worksheet A? II	yos, comprete	WNSL. D-Z,	, , , , , , , , , , , , , , , , , , , ,		IN	1	I	J 57. UU

	Financial Systems LUTHERAN M FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		ELETAL CENTER Provi der CO		Peri od:	u of Form CMS-2 Worksheet S-2	
				F	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/31/2022 11:	pared
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2.00	3.00	
O. 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 colis "Y", are you impacted by CR 11642 (or subsequent C	85? (s∈ umn 1. R) NAHE	ee If column 1	N			60.
	adjustement? Enter "Y" for yes or "N" for no in colu	mn 2. Y/N	I ME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports				0.00		61.
. 02	ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61.
. 03	and primary care FTEs added under section 5503 of ACA). (see instructions) 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						61.
. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61.
. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61
. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	Drog	gram Name	Program Code	Unweighted IME	Unweighted	61.
		FIO	gi aiii ivaiiie	Frogram code		Direct GME FTE Count	
10	06 the FTFe in Line (1 0F energies and new energy)		1. 00	2. 00	3.00	4.00	/1
. 10	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		01.
. 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.
						1.00	
. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital	trai ned			iod for which	0.00	62.
. 01	your hospital received HRSA PCRE funding (see instruction the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progreaching Hospitals that Claim Residents in Nonprovide	Teachir ram. (se	<u>ee instruction</u>		your hospital	0.00	62.
00		ttings o	during this co	67. (see instr	uctions)	N	63
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No						
. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	y traine -primary all nonp non-pri	ed residents y care provider mary care	0.00	0.00	0. 000000	64

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/31/2022 11:00 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S Part I Date/Time P 5/31/2022 1	repare
		1. 00	
Long Term Care Hospital PPS  .00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.
100 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.  TEFRA Providers	ng period? Enter	N	81.
100 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for you bid this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	85. 86.
.00 Is this hospital an extended neoplastic disease care hospital classified under section	on	N	87.
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	V	XIX	
	1. 00	2. 00	
Title V and XIX Services			
.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	^ N	Y	90
.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Υ	91
full or in part? Enter "Y" for yes or "N" for no in the applicable column.  ON Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92
instructions) Enter "Y" for yes or "N" for no in the applicable column.			'2
.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	~ N	N	93
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94
.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	95
OD Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96
00 If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	97
OD Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	N	Y	98
column 1 for title V, and in column 2 for title XIX.  Ol Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wks	st. N	Y	98
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			
.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98
O3 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAI reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.		N	98
Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, ar in column 2 for title XIX.	N nd	N	98
O5 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance of Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and column 2 for title XIX.		Y	98
O6 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98
Rural Providers			
5.00 Does this hospital qualify as a CAH?	. N		105
6.00  f this facility qualifies as a CAH, has it elected the all-inclusive method of payme for outpatient services? (see instructions)			106
7.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?			107
Enter "Y" for yes or "N" for no in column 2. (see instructions)  8.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 4  CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	42 N		108
Physi cal Occupation		Respirator	У
9.00 If this hospital qualifies as a CAH or a cost provider, are N	3.00	4.00	109
A DOLLE THIS DOSDITAL DUALITIES AS A CAH OF A COST DEDVIDED AND IN IN IN I			

	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

ealth Financial Systems LUTHERAN MUSCULOSKE OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	LETAL CENTER Provider CC		In Lie Period:		
USPITAL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	.N. 13-0100	From 01/01/2021 To 12/31/2021	Worksheet S Part I Date/Time F 5/31/2022 1	Prepare
			1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	reporting p mn 1 is Y, e cipating in	period? Enter enter the column 2.	. N		111.
		1. 00	2. 00	3.00	
12.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting pe Enter "Y" for yes or "N" for no in column 1. If column 1 is " in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	riod? Y", enter	N N	2.00	3.00	112.
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 "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) percent cludes	N			0115.
6.00 s this facility classified as a referral center? Enter "Y" fo	r yes or	N			116
7.00 s this facility legally-required to carry malpractice insuran	ce? Enter	N			117.
"Y" for yes or "N" for no.  8.00 Is the malpractice insurance a claims-made or occurrence polic if the policy is claim-made. Enter 2 if the policy is occurren			1		118
		Premi ums	Losses	Insurance	!
		1. 00	2.00	3.00	
8.01 List amounts of malpractice premiums and paid losses:		16, 2	20, 297		0 118
0.00			1.00	2.00	110
8. 02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 9. 00 D0 NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold H	e listing co	st centers	N N	N	118 119 120
§3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y" ifies for th ? (see instr	for yes or ne Outpatient ructions)			
1.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	able devices	charged to	Y		121
2.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.					122
Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125
yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 f this is a Medicare certified kidney transplant center, ente	-				126
in column 1 and termination date, if applicable, in column 2. 7.00  f this is a Medicare certified heart transplant center, enter					127
in column 1 and termination date, if applicable, in column 2.					
8.00  f this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.					128
9.00  f this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.			n		129
0.00 If this is a Medicare certified pancreas transplant center, endate in column 1 and termination date, if applicable, in column		ification			130
1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum	enter the ce	erti fi cati on			131
2.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.		cation date			132
3.00 Removed and reserved 4.00 If this is an organ procurement organization (0P0), enter the	OPO number i	n column 1			133 134
				1	1
and termination date, if applicable, in column 2.  All Providers  40.00 Are there any related organization or home office costs as def			Y	HB1848	140

From 01/01/2021 Part I Date/Time Prepared: To 12/31/2021 5/31/2022 11:00 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: COMMUNITY HEALTH SYSTEMS | Contractor's Name: WISCONSIN PHYSICIA 141 00 Name: Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 52280 141 00 SERVI CES 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 City: FRANKLIN State: Zip Code: 37067 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 Υ 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157. 00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν N N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161.00 161. 10 CORF N 161. 10 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. CBSA FTE/Campus State Zip Code Name County 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00|If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168. 01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99 169. 00 transition factor. (see instructions) Endi ng Begi nni ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170.00 period respectively (mm/dd/yyyy) 1.00 2.00 0171.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in Ν section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

OSPI T	Financial Systems LUTHERAN MUSCULO: AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0168	Peri od: From 01/01/2021 To 12/31/2021		epared:
				Y/N	Date	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ent	1.00 er all dates in	2.00 the	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	corumn 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.0
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provice officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
	Financial Data and Darents		1. 00	2. 00	3. 00	
00	Financial Data and Reports 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,	N			4.0
00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column	2. If you is	the provide	r N	I	6. 0
.00	is the legal operator of the program?	2. IT yes, is	s the provide	I IN		0.0
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during th	e N		7. ( 8. (
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	is.		N N		9. (
	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		11.
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N N	12. 13.
1. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I1	fyes, see in	structions.	N N	14.
5. 00	Did total beds available change from the prior cost reporti				N	15. (
		Y/N	rt A Date	Y/N	t B Date	
		1.00	2. 00	3. 00	4. 00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	05/17/2022	Y Y	05/17/2022	16. (
'. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17.
3. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.

HOSPI T	Financial Systems LUTHERAN MUSCULOS AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Peri od: From 01/01/2021	Worksheet S-: Part II		
				To 12/31/2021	Date/Time Pro		
		Descri	ption	Y/N	5/31/2022 11 Y/N	: 00 alli	
			)	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 0	
	report data for other. Beserve the other day astments.	Y/N	Date	Y/N	Date		
	I	1. 00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)		1. 00		
2 00	Capi tal Related Cost	1					
2. 00 2. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		als made du	ring the cost		22. 0	
0.00	reporting period? If yes, see instructions.	ade to apprais	ar 5 made ad	Trig the cost		20.0	
4. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost r	eporting period?		24.0	
5. 00	Have there been new capitalized leases entered into during	the cost repor	ting period	? If yes, see		25. 0	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period?	If yes, see		26. 0	
	instructions.	•	0 .				
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g perioa? i	r yes, submit		27. 0	
8. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	itered into dur	t reporting		28.0		
9. 00	period? If yes, see instructions.  Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)					29.0	
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions		30.0			
	instructions.						
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? IT yes	s, see		31. 0	
2. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through c	ontractual		32.0	
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to compet	itive bidding? If		33. 0	
	Provi der-Based Physi ci ans						
4. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-b	ased physicians?		34. 0	
5. 00			ts with the	provi der-based		35. 0	
	phrysicians during the cost reporting period? If yes, see th	ISTI UCTI OIIS.		Y/N	Date		
	To the second se			1. 00	2. 00		
26 OO	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.0	
	If line 36 is yes, has a home office cost statement been pr	epared by the	home office			37. 0	
88. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	ice different	from that o	f Y	12/31/2020	38.0	
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			s, N		39. 0	
10.00	see instructions.  If line 36 is yes, did the provider render services to the	home office?	If ves see	N		40. 0	
	instructions.						
		00					
		CODY		OWENS		41. 0	
1. 00	held by the cost report preparer in columns 1, 2, and 3, respectively.						
		COMMUNITY HEALTH SYSTEMS				42. C	
41. 00 42. 00 43. 00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEAL 615-465-2727	TH SYSTEMS				

Heal th	Financial Systems LUTHE	RAN MUSCULOS	SKELETAL	CENTER		In Li	eu of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	ONNAI RE	Provi	der CCN:		Peri od:	Worksheet S	-2
						From 01/01/202° To 12/31/202°		epared.
							5/31/2022 1	: 00 am
				3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/po		MANAGER,	REVENUE	MANAGEMENT			41. 00
	held by the cost report preparer in columns 1, 2	2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost repo	ort						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	y.						

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: 
 Heal th Financial
 Systems
 LUTHERAN M

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

S/31/2022 11:00   I/P Days / 0/P   Visits / Trips   CAH Hours   Title V	1. 00
Component Worksheet A Line Number No. of Beds Bed Days Available CAH Hours Title V  1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 39 14,235 0.00 0	1.00
Component   Worksheet A   No. of Beds   Bed Days   Available   Title V	1. 00
Line Number         Available           1.00         2.00         3.00         4.00         5.00           1.00         Hospital Adults & Peds. (columns 5, 6, 7 and 30.00)         39         14,235         0.00         0	1. 00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 39 14,235 0.00 0	1. 00
	1. 00
8 exclude Swing Bed. Observation Bed and	
Hospi ce days) (see instructions for col. 2	
for the portion of LDP room available beds)	
	2. 00
	3.00
	4. 00
	5. 00
	6. 00
	7. 00
beds) (see instructions)	0.00
	8. 00
	9. 00
	0.00
	1.00
	2.00
	3.00
	4. 00
	5. 00
	6. 00 7. 00
	8. 00
	9. 00
	0.00
	1.00
	2. 00
	3. 00
	4. 00
	4. 10
	5. 00
	5. 10
	6. 00
	6. 25
	7. 00
	8. 00
	9.00
	0.00
	1. 00
	2.00
	2. 01
outpatient days (see instructions)	
33.00 LTCH non-covered days	3.00
33.01 LTCH site neutral days and discharges 33.01 LTCH site neutral days and discharges 3	3. 01

				•		5/31/2022 11:	00 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	785	281				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, 170	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	1			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0				6. 00
7. 00	Total Adults and Peds. (exclude observation	785	281	3, 696			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0	0			8. 00
9.00	CORONARY CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		0				12.00
13.00	NURSERY	785	0 281		0.00	20/ 00	13.00
14.00	Total (see instructions)	/85			0.00	286. 98	
15. 00 16. 00	CAH visits   SUBPROVIDER - IPF	0	0		0.00	0.00	15. 00 16. 00
17. 00	SUBPROVIDER - I PF	0	0	1			
18. 00	SUBPROVI DER	U	U	١	0.00	0.00	18.00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20. 00	NURSING FACILITY	U	0		0.00		
21. 00	OTHER LONG TERM CARE		0		0.00		
22. 00	HOME HEALTH AGENCY	0	0	٥		l .	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )		0		0.00		1
24. 00	HOSPI CE	0	0	0	0.00	l .	
24. 10	HOSPICE (non-distinct part)		, , , , , , , , , , , , , , , , , , ,		0.00		24. 10
25. 00	CMHC - CMHC	0	0	0	0.00	0.00	
25. 10	CMHC - CORF	o	0	Ö	0. 00	l .	
26. 00	RURAL HEALTH CLINIC	o	0	l o	0.00		1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				0.00		1
28. 00	Observation Bed Days		0	1, 627			28. 00
29.00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

				To	12/31/2021	Date/Time Pre 5/31/2022 11:	
		Full Time		Di scha	arges	070172022 111	
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	320	110	1, 591	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			205			0.00
2.00	HMO and other (see instructions)			395	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4. 00 5. 00	HMO IRF Subprovider				U		4. 00 5. 00
6.00	Hospital Adults & Peds. Swing Bed SNF						6.00
7. 00	Hospital Adults & Peds. Swing Bed NF						7.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	320	110	1, 591	
15. 00	CAH visits	0.00	J	020	110	1,071	15. 00
16. 00	SUBPROVIDER - IPF	0. 00	0	0	o	0	
17. 00	SUBPROVIDER - IRF	0. 00	0	0	o	0	17. 00
18. 00	SUBPROVI DER		-				18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY	0. 00					20. 00
21.00	OTHER LONG TERM CARE	0. 00				0	21. 00
22.00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days			0			33.00
33. U I	LTCH site neutral days and discharges			0			33. 01

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | From 14/2022 | Part II | Part |

					11	0 12/31/2021	Date/lime Pre   5/31/2022 11:	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4.00	col . 4 5.00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3. 00	0.00	
1 00	SALARI ES	200 00	21 207 (05		24 207 (05	F0/ 021 00	) of F2	1 1 00
1. 00 2. 00	Total salaries (see instructions) Non-physician anesthetist Part	200. 00	21, 207, 605			596, 921. 00 0. 00		
3. 00	A		0		0	0.00		
	Non-physician anesthetist Part B Physician-Part A -		0	0				
4.00	Admi ni strati ve		_	_				
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0	0	0	0. 00 0. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0.00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related		0	0	0	0. 00	0.00	8. 00
9. 00 10. 00	organization personnel SNF Excluded area salaries (see	44. 00	0 2, 645, 956	0	_	0. 00 101, 644. 00		
10.00	instructions)  OTHER WAGES & RELATED COSTS		2, 045, 950		2, 043, 930	101, 644. 00	20.03	10.00
11. 00	Contract labor: Direct Patient Care		441, 816	0	441, 816	6, 440. 00	68. 60	11. 00
12. 00	Contract labor: Top level management and other management and administrative		107, 429	0	107, 429	224. 00	479. 59	12. 00
13. 00	servi ces Contract labor: Physician-Part		0	0	0	0. 00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		0	0	0	0. 00	0.00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A		2, 548, 221 0 0	0 0	0	96, 594. 00 0. 00 0. 00	0. 00	1
16. 00	- Administrative Home office and Contract		0	0	0	0. 00		
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		4, 071, 849	0	4, 071, 849			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19.00	(see instructions) Excluded areas		762, 030	0	762, 030			19.00
20. 00	Non-physician anesthetist Part A Non-physician anesthetist Part		0	0				20.00
21.00	B Physician Part A -		0	_				22.00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 00
23. 00	Physician Part B		0	Ö	ő			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	1	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		636, 157	0	636, 157			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	О	0			25. 52
	wage-related (core)			I	I		I	I

Period: Worksheet S-3
From 01/01/2021 Part II
To 1/21/21/2021 Part/II me Propagad:

					Т	o 12/31/2021	Date/Time Prep 5/31/2022 11:0	
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
27 00	OVERHEAD COSTS - DIRECT SALARIE					0.00	0.00	27.00
26. 00	Employee Benefits Department	4. 00	0 744 000	000 400	4 500 0/0	0.00		
27. 00	Administrative & General	5. 00	4, 744, 368	-223, 408	4, 520, 960	· ·		
28. 00	Administrative & General under		0	0	0	0. 00	0. 00	28. 00
29. 00	contract (see inst.)	6. 00	0	_	_	0.00	0.00	29. 00
30.00	Maintenance & Repairs Operation of Plant	7.00	(2, (01	0	62, 601	1, 889. 00		
31.00	•	7. 00 8. 00	62, 601	0	02, 001	1, 889.00		
32.00	Laundry & Linen Service Housekeeping	9. 00	5, 107	0	5, 107	115.00		
32.00		9.00	444, 134	0	·			
33.00	Housekeeping under contract (see instructions)		444, 134	U	444, 134	29, 609. 00		
34.00	Di etary	10. 00	0	0	0	0.00	0.00	34.00
35. 00	Di etary under contract (see instructions)		72, 629	0	72, 629	3, 480. 00	20. 87	35. 00
36.00	Cafeteri a	11. 00	0	0	0	0.00	0.00	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	626, 796	223, 408	850, 204	17, 216. 00	49. 38	38. 00
39.00	Central Services and Supply	14. 00	554, 747	0	554, 747	25, 717. 00	21. 57	39. 00
40.00	Pharmacy	15. 00	266, 949	0	266, 949	6, 923. 00	38. 56	40. 00
41.00	Medical Records & Medical	16. 00	28, 952	0	28, 952	595.00	48. 66	41. 00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00		42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

LUTHERAN MUSCULOSKELETAL CENTER

In Lieu of Form CMS-2552-10
| Worksheet S-3
| Part III |
| Bate/Time Prepared: | 5/31/2022 | 11: 00 am |
| Hours | Average Hourly | Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Peri od: From 01/01/2021 To 12/31/2021 Provider CCN: 15-0168

		Worksheet A	Amount	Recl assi fi cati	Adjusted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4	·	
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		21, 724, 368	0	21, 724, 368	630, 010. 00	34. 48	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 645, 956	0	2, 645, 956	101, 644. 00	26. 03	2.00
	instructions)							
3.00	Subtotal salaries (line 1		19, 078, 412	0	19, 078, 412	528, 366. 00	36. 11	3.00
	minus line 2)							
4.00	Subtotal other wages & related		3, 097, 466	0	3, 097, 466	103, 258. 00	30.00	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		4, 708, 006	0	4, 708, 006	0.00	24. 68	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		26, 883, 884	0	26, 883, 884	631, 624. 00	42. 56	6.00
7.00	Total overhead cost (see		6, 806, 283	0	6, 806, 283	202, 986. 00	33. 53	7.00
	instructions)					·		
7.00	,		6, 806, 283	0	6, 806, 283	202, 986. UC	33.53	7.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0168	From 01/01/2021	Worksheet S-3 Part IV Date/Time Prepared:

	10 12/31/2021	Date/lime Prep 5/31/2022 11:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	417, 659	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2, 772, 333	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	8, 453	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	16, 919	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	27	12.00
13.00		5, 752	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	138, 502	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	1, 163, 667	
18. 00	Medicare Taxes - Employers Portion Only	272, 148	
19. 00	1 1 3	0	19. 00
20. 00	State or Federal Unemployment Taxes	38, 420	20. 00
	OTHER		
21. 00		0	21. 00
	instructions))	_	
22. 00	19 11 11 11 11 11 11 11 11 11 11 11 11 1	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	4, 833, 880	24. 00
05.00	Part B - Other than Core Related Cost		05.00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	1	25. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-25	552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0168	Peri od: Worksheet S-3 From 01/01/2021 Part V	

	i	o 12/31/2021	Date/Time Prep 5/31/2022 11:0	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	441, 816	4, 833, 880	1. 00
2.00	Hospi tal	441, 816	4, 833, 880	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF	0	0	9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	11. 00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14. 00
15.00	Hospital-Based Health Clinic FQHC	0	0	15. 00
16.00	Hospi tal -Based-CMHC	0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
17. 00	Renal Di al ysi s	0	0	17. 00
18. 00	Other	0	0	18. 00

SPI TA	Financial Systems LUTHERAN MUSCULOSKELETAL AL UNCOMPENSATED AND INDIGENT CARE DATA Provi	ider CCN: 15-C		eri od:	worksheet S-1	
			F	rom 01/01/2021		
			T	12/31/2021	Date/Time Pre 5/31/2022 11:	
					1.00	
	Uncompensated and indigent care cost computation					
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202	col umn	3)	0. 090992	1
	Medicaid (see instructions for each line) Net revenue from Medicaid				6, 817, 282	2
- 1	Did you receive DSH or supplemental payments from Medicaid?				γ	3
	If line 3 is yes, does line 2 include all DSH and/or supplemental p	payments from	Medi cai o	1?	l y	4
	If line 4 is no, then enter DSH and/or supplemental payments from M				0	
0	Medi cai di charges				55, 596, 929	6
0	Medicaid cost (line 1 times line 6)				5, 058, 876	7
0	Difference between net revenue and costs for Medicaid program (line	e 7 minus sum	of lines	s 2 and 5; if	0	8
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for ea</pre>	ıch line)				
	Net revenue from stand-alone CHIP	,			0	9
00	Stand-alone CHIP charges				0	10
00	Stand-alone CHIP cost (line 1 times line 10)				0	11
	Difference between net revenue and costs for stand-alone CHIP (line	e 11 minus lir	ne 9; if	< zero then	0	12
- 1	enter zero) Other state or local government indigent care program (see instruct	ions for each	n line)			
	Net revenue from state or local indigent care program (Not included				0	13
00	Charges for patients covered under state or local indigent care pro	ogram (Not inc	cluded i	n lines 6 or	0	14
00	10) State or local indigent care program cost (line 1 times line 14)				0	15
	Difference between net revenue and costs for state or local indigen	+	(1:	1E minus lino		16
~~ I			am (IIne			
	13: if < zero then enter zero)	it care progra	am (iine	15 IIITIUS TTHE		'
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	nd state/Local	i ndi ger		ms (see	
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin	nd state/local	i ndi ger		ms (see	17
00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi	nd state/local ng charity car tal operation	i ndi ger re ns	nt care progran	ms (see	17
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin	nd state/local ng charity car tal operation	i ndi ger re ns	nt care progran	ms (see	17
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind	nd state/local ng charity car tal operation digent care pr	i ndi ger re ns rograms	nt care program	0 0 0 Total (col. 1	17
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind	nd state/local ng charity car tal operation digent care pr	indiger re ns rograms usured i ents	(sum of lines	Total (col. 1 + col. 2)	17
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)	nd state/local ng charity car tal operation digent care pr	i ndi ger re ns rograms	nt care program	0 0 0 Total (col. 1	17
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility	nd state/local ng charity car tal operation ligent care pr Unin pati 1.	indiger re ns rograms usured i ents	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17 18 19
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)	nd state/local ng charity car tal operation digent care pr  Unin pati 1.	i ndi ger re ns rograms sured i ents . 00	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts	nd state/local ng charity car tal operation digent care pr  Unin pati 1.	i ndi ger re ns rograms nsured i ents	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off	d state/local ng charity car tal operation ligent care pr  Unin pati 1.  ry 3, (see	i ndi ger re ns rograms sured i ents . 00	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00	177 18 19 20 21
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care	d state/local ng charity car tal operation ligent care pr  Unin pati 1.  ry 3, (see	i ndi ger re ns rograms isured i ents . 00 , 931, 518 357, 737	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00  3,931,518 357,737	177 188 199 200 211 222
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off	d state/local ng charity car tal operation ligent care pr  Unin pati 1.  ry 3, (see	i ndi ger re ns rograms sured i ents .00 , 931, 518	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00  3,931,518 357,737	177 188 199 200 211 222
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care	d state/local ng charity car tal operation ligent care pr  Unin pati 1.  ry 3, (see	i ndi ger re ns rograms isured i ents . 00 , 931, 518 357, 737	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00  3,931,518 357,737	177 188 199 200 211 222
000 000 000 000 000 000 000 000	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care	d state/local ng charity car tal operation digent care pr  Unin pati 1. Ty 3, (see as	i ndi ger re ns rograms sured i ents . 00 , 931, 518 357, 737 0	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00  3,931,518 357,737	177 188 199 200 211 222
000 000	Grants, donations and total unreimbursed cost for Medicaid, CHIP aninstructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient da imposed on patients covered by Medicaid or other indigent care prog	d state/local ng charity car tal operation ligent care pr  Unin pati 1.  Ty 3, (see as	i ndi ger re ns rograms i ents . 00 , 931, 518 357, 737 0 357, 737	(sum of lines Insured patients 2.00 0 0 f stay limit	Total (col. 1 + col. 2) 3.00 3,931,518 357,737 0 357,737	200 211 222 23
000 000	Grants, donations and total unreimbursed cost for Medicaid, CHIP aninstructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)	d state/local ng charity car tal operation ligent care pr  Unin pati 1.  Ty 3, (see as	i ndi ger re ns rograms i ents . 00 , 931, 518 357, 737 0 357, 737	(sum of lines Insured patients 2.00 0 0 f stay limit	Total (col. 1 + col. 2) 3.00 3,931,518 357,737 0 357,737	200 211 222 23
00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in	d state/local ng charity car tal operation digent care pr  Unin pati 1.  Ty 3, (see as  as  Tys beyond a I gram? digent care pr	i ndi ger re ns rograms i ents . 00 , 931, 518 357, 737 0 357, 737	(sum of lines Insured patients 2.00 0 0 f stay limit	Total (col. 1 + col. 2) 3.00 3,931,518 357,737 0 357,737	20 21 22 23 24 25
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP aninstructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient da imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in stay limit	d state/local ng charity car tal operation digent care pr  Unin pati 1.  y 3, (see as  as  usy beyond a l gram? digent care pr	i ndi ger re ns rograms sured i ents . 00 , 931, 518 357, 737 0 357, 737	(sum of lines Insured patients 2.00 0 0 f stay limit	Total (col. 1 + col. 2) 3.00  3,931,518 357,737 0 357,737	200 211 222 233 244 255 260
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP aninstructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient da imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in stay limit  Total bad debt expense for the entire hospital complex (see instruc	d state/local ng charity car tal operation digent care pr  Unin pati 1.  y 3, (see as  as  ups beyond a l pram? ndigent care pr  ctions) ee instruction	i ndi ger re ns rograms sured i ents . 00 , 931, 518 357, 737 0 357, 737	(sum of lines Insured patients 2.00 0 0 f stay limit	Total (col. 1 + col. 2) 3.00  3,931,518 357,737 0 357,737 1.00 N 0 2,085,308	200 211 222 232 242 252 2627
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP aninstructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient da imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in stay limit  Total bad debt expense for the entire hospital complex (see instruc Medicare reimbursable bad debts for the entire hospital complex (see	d state/local ng charity car tal operation digent care pr  Unin pati 1.  y 3, (see as  as  ups beyond a l pram? ndigent care pr  ctions) ee instruction	i ndi ger re ns rograms sured i ents . 00 , 931, 518 357, 737 0 357, 737	(sum of lines Insured patients 2.00 0 0 f stay limit	Total (col. 1 + col. 2) 3.00  3,931,518 357,737 0 357,737 0 2,085,308 11,451	200 21 22 23 24 25 26 27 27
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP aninstructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient da imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in stay limit  Total bad debt expense for the entire hospital complex (see instruc Medicare reimbursable bad debts for the entire hospital complex (see	d state/local ng charity car tal operation ligent care pr  Unin pati  1.  Ty 3, (see as  as  as  eight care pr  ctions) ee instructions)	i ndi ger re ns rograms isured i ents . 00 , 931, 518 357, 737 0 357, 737 length or orogram's	(sum of lines Insured patients 2.00 0 0 f stay limit	Total (col. 1 + col. 2) 3.00  3,931,518  357,737  1.00  N  2,085,308  11,451 17,618 2,067,690 194,310	20 21 22 23 24 25 26 27 27 28 29
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP aninstructions for each line)  Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilit (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in stay limit  Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see instructions)	d state/local ng charity car tal operation digent care pr  Unin pati 1.  Ty 3, (see as  Tys beyond a I gram? Indigent care pr  ctions) se instructions se (see instructions)	i ndi ger re ns rograms isured i ents . 00 , 931, 518 357, 737 0 357, 737 length or orogram's	(sum of lines Insured patients 2.00 0 0 f stay limit	Total (col. 1 + col. 2) 3.00 3,931,518 357,737 0 357,737 1.00 N 0 2,085,308 11,451 17,618 2,067,690	200 211 222 233 244 25 266 277 288 299 300

	Financial Systems L SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	UTHERAN MUSCULOSK	Provider CO		In Lie Period:	u of Form CMS- Worksheet A	2552-10
REGERE	STITUTE OF THE BALLINGE	or Extended	Trovider ex	1	From 01/01/2021 Fo 12/31/2021	Date/Time Pre 5/31/2022 11:	
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		962, 398			4, 117, 356	1
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		6, 513, 465 0	6, 513, 46!	5 188, 830 0 0	6, 702, 295 0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	184, 725	184, 72!	3, 505, 726	3, 690, 451	1
5.00	00500 ADMI NI STRATI VE & GENERAL	4, 744, 368	44, 742, 619			42, 928, 487	1
7. 00 8. 00	OO700   OPERATION OF PLANT   OO800   LAUNDRY & LINEN SERVICE	62, 601	1, 621, 942 59, 202			2, 227, 510 59, 202	1
9. 00	00900 HOUSEKEEPI NG	5, 107	526, 054			526, 393	1
10.00	01000 DI ETARY	0	220, 743	220, 74	0	220, 743	
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	626, 796	62, 383	689, 179	9 223, 285	912, 464	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	554, 747	1, 638, 112		-713, 692	1, 479, 167	•
15.00	01500 PHARMACY	266, 949	980, 150			389, 451	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	28, 952	587, 201 0	616, 153	-5, 405 0	610, 748 0	1
18. 00	01850 OTHER GENERAL SERVICES	Ö	0	(	0	0	18. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(	0	0	19.00
20. 00 21. 00	02000   NURSING PROGRAM   02100   I&R SERVICES-SALARY & FRINGES APPRV		0			0	20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	Ö	0	· ·	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0		0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 475, 716	603, 574	3, 079, 290	-426	3, 078, 864	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	32. 00 33. 00
34.00	03400 SURGI CAL INTENSI VE CARE UNIT		0			0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0		0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0		0	0	1
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY		0			0	
45.00	04500 NURSING FACILITY	0	0		0	0	45. 00
46. 00	O4600 OTHER LONG TERM CARE   ANCI LLARY SERVI CE COST CENTERS	0	0		0	0	46. 00
50. 00	05000 OPERATING ROOM	4, 810, 885	27, 629, 274	32, 440, 159	9 -17, 117, 067	15, 323, 092	50.00
51.00	05100 RECOVERY ROOM	1, 865, 367	609, 007			2, 474, 387	•
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	0	0 62, 120		0	0 62, 120	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	299, 927	332, 675			526, 373	1
54. 01	03630 ULTRA SOUND	0	3, 302	1		3, 302	
	O5500   RADI OLOGY-THERAPEUTI C   O5600   RADI OI SOTOPE	0	0		0	0	1
	05700 CT SCAN	0	0		o o	0	
58. 00	05800 MRI	0	0	(	0	0	
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	4, 068	0 382, 358	386, 420	0 6 -261	0 386, 165	
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	(	0	0	
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.		0			0	
64. 00	06400 I NTRAVENOUS THERAPY	Ö	0		0	0	64. 00
	06500 RESPIRATORY THERAPY	13, 829	42, 438			56, 267	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 210, 397 519, 136	480, 991 49, 676	2, 691, 388 568, 812		3, 192, 503 0	1
68. 00	06800 SPEECH PATHOLOGY	65, 467	4, 398	69, 86!		0	1
69.00	l l	7, 337	29, 933			37, 259	
70. 00 71. 00	1 · · · · · · · · · · · · · · · · · · ·	0	0		0 851, 163	0 851, 163	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		16, 252, 775	16, 252, 775	72. 00
73.00	l l	0	0		812, 629	812, 629	
	07400   RENAL DIALYSIS   07500   ASC (NON-DISTINCT PART)	0	0		0 0	0	1
	OUTPATIENT SERVICE COST CENTERS						1
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90.00	1		0			0	1
91. 00	09100 EMERGENCY	0	0		0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0	0	94. 00
	09500 AMBULANCE SERVICES	0	0		0 0	0	•

Health Financial Systems	LUTHERAN MUSCULOSKE	LETAL CEN	ITER	In	Lieu of Form CMS-2552-10
				T	

Health Financial Systems LU	JTHERAN MUSCULOSK	ELETAL CENTER		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der CC	N: 15-0168	Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narad.
				To 12/31/2021	5/31/2022 11:	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cati	Reclassi fi ed	00 4
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	, , , , , ,
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	0	97. 00
98. 00   09850   OTHER REI MBURSABLE COSTS	0	0		0	0	98. 00
99. 00 09900 CMHC	0	0		0	0	99. 00
99. 10   09910   CORF	0	0		0	0	99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	] 0	U		0 0	0	101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON		٥		0 0		105. 00
106. 00 10600 HEART ACQUISITION	0	0		0		106. 00
107. 00 10700 LIVER ACQUISITION		0		0		107. 00
108. 00 10800  LUNG ACQUISITION		0		0		107. 00
109. 00 10900 PANCREAS ACQUISITION		0		0		109.00
110. 00 11000   NTESTINAL ACQUISITION		0		0		110, 00
111. 00 11100   SLET ACQUISITION	0	0		0 0		111.00
113. 00 11300 I NTEREST EXPENSE		0				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0 0		115. 00
116. 00 11600 HOSPI CE	0	o		0 0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 561, 649	88, 328, 740	106, 890, 38	30, 777	106, 921, 166	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
191. 00 19100 RESEARCH	0	0		0 0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 051	18, 632	19, 68	-6, 238	13, 445	192. 00
193.00 19300 NONPALD WORKERS	0	0		0 0		193. 00
194. 00 07950 SPORTS MEDICINE	2, 644, 905	613, 651	3, 258, 55	-24, 539		
194. 01 07951 SENI OR CI RCLE	0	0		0		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	21, 207, 605	88, 961, 023	110, 168, 62	28 0	110, 168, 628	200. 00

Peri od: Worksheet A From 01/01/2021 Date/Time Prepared: 5/21/2022 11:00 am

				5/31/2021   bate/11ille Pre	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	92, 430	4, 209, 786		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	148, 996	6, 851, 291		2. 00
3.00	00300 OTHER CAP REL COSTS	0		1	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 690, 451		4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-28, 785, 738	14, 142, 749 2, 227, 510		5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	59, 202		8.00
9. 00	00900 HOUSEKEEPI NG	0	526, 393		9. 00
10.00	01000 DI ETARY	0	220, 743		10.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
13.00	01300 NURSI NG ADMINI STRATI ON	0	912, 464		13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 0	1, 479, 167 389, 451		14. 00 15. 00
16. 00	1 1	-18	l		16.00
17. 00	1 1	0	010,700		17. 00
18. 00	1 1	0	0		18. 00
19. 00	+ I	0	0		19. 00
20.00	i i	0	0		20.00
21. 00 22. 00	+ +	0 0			21. 00
23. 00	1 1		1	·	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS				20.00
30.00		0	3, 078, 864		30.00
31. 00		0	0		31. 00
32. 00		0	0		32. 00
33.00	+ I	0	0		33.00
34. 00 40. 00	1		0		34. 00 40. 00
41. 00	04100 SUBPROVI DER – I RF		٥		41.00
43.00		0	O		43.00
44.00		0	0		44. 00
45. 00	1	0	0	l .	45. 00
46. 00		0	0	)	46. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	15, 323, 092		50.00
51. 00		0		l e e e e e e e e e e e e e e e e e e e	51.00
52.00	1 1	0	1		52. 00
53. 00	05300 ANESTHESI OLOGY	-22, 647	39, 473		53. 00
54.00	I I	0	526, 373		54.00
54. 01	03630 ULTRA SOUND	0	3, 302		54. 01
55. 00 56. 00	+ I	0	0		55. 00 56. 00
57. 00	+ I	0	0		57.00
58.00	1 1	0	O		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60.00	1 1	0			60.00
60. 01	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		60. 01
62. 00	+ I	0	0		61. 00 62. 00
63. 00	I I	0	0		63.00
64. 00		0	Ō		64. 00
65.00	I I	0	56, 267		65. 00
66. 00	1	-3, 103	3, 189, 400		66. 00
67. 00		0	0		67. 00
68. 00 69. 00	I I	0	37, 259		68. 00 69. 00
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0	37, 239		70.00
71. 00	1 1	0	851, 163		71. 00
72.00		0	16, 252, 775		72. 00
73. 00		0	812, 629	l .	73. 00
74.00		0	0		74.00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	75. 00
88. 00		0	0		88. 00
89. 00		0			89. 00
90. 00	I I	0	o		90.00
91. 00	09100 EMERGENCY	0	0		91. 00
92. 00	`				92. 00
04.00	OTHER REIMBURSABLE COST CENTERS				04.00
94. 00 95. 00	· ·	0 0	1		94. 00 95. 00
96.00	+ I	0	ł		96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	· -		97. 00

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

 
 Health Financial
 Systems
 LUTHERAN MUSC

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-0168 

			10   12/31/2021   Date/lime Prepared:     5/31/2022 11:00 am
Cost Center Description	Adjustments	Net Expenses	
·	(See A-8)	For Allocation	
	6. 00	7. 00	
98.00 09850 OTHER REIMBURSABLE COSTS	0	0	98.00
99. 00 09900 CMHC	0	0	99.00
99. 10   09910   CORF	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	101. 00
SPECIAL PURPOSE COST CENTERS			
105. 00 10500 KIDNEY ACQUISITION	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	110.00
111.00   11100   I SLET ACQUI SI TI ON	0	0	111.00
113. 00 11300 I NTEREST 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 H0SPI CE	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-28, 570, 080	78, 351, 086	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
191. 00 19100 RESEARCH	0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	13, 445	· · · · · · · · · · · · · · · · · · ·
193. 00 19300 NONPALD WORKERS	0	0	193. 00
194. 00 07950 SPORTS MEDICINE	0	3, 234, 017	
194. 01 07951 SENI OR CI RCLE	0	0	194. 01
200.00   TOTAL (SUM OF LINES 118 through 199)	-28, 570, 080	81, 598, 548	200.00

					5/31/2021   5/31/2021	022 11:00 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT		•	<u>3, 505, 7</u> 26		1. 00
	0		0	3, 505, 726		
	B - RENTAL AND LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	2, 507, 266		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	182, 015		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0. 00 0. 00	0	0		6. 00
7. 00 9. 00		0.00	0	0		7. 00 9. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12.00
13. 00		0.00	0	0		13. 00
13.00						13.00
	C - OTHER CAPITAL COST		<u> </u>	2,007,201		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	131, 025		1, 00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	o	516, 667		2. 00
3.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	6, 815		3. 00
				654, 507		
	D - REPAIRS & MAINTENANCE					
1.00	OPERATION OF PLANT	7. 00	0	542, 967		1. 00
2.00	RECOVERY ROOM	51.00	0	13		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
10.00				542, 980		10.00
	E - CHIEF NURSING OFFICER		<u> </u>	342, 700		
1.00	NURSI NG ADMI NI STRATI ON	13. 00	223, 408	0		1.00
	0		223, 408	— — <u> </u>		
	F - MEDICAL SUPPLIES			'		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	851, 163		1. 00
	PATI ENT					
2.00	IMPL. DEV. CHARGED TO	72. 00	0	16, 252, 775		2. 00
	PATI ENTS					
3.00		0.00	•	0		3. 00
	0		0	17, 103, 938		
1 00	G - DRUGS/IV SOLUTIONS	70.00	al	040 (00		1.00
1. 00	DRUGS CHARGED TO PATIENTS		•	812, 629		1. 00
	U MICC DEDTC		0	812, 629		
1. 00	H - MISC DEPTS PHYSICAL THERAPY	66.00	584, 603	53, 749		1. 00
2.00	PRISICAL IMERAPY	0.00	584, 603	53, 749		2.00
2.00		— — <del>0.</del> 00	584, 603	53, 749		2.00
500 00	Grand Total: Increases		808, 011	25, 362, 810		500.00
300.00	Jordina Total. Thereases	l	000, 011	23, 302, 610		1 300. 00

					10		Prepared: 2 11:00 am
		Decreases				07 017 2022	11.00 am
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9. 00	10.00		
	A - EMPLOYEE BENEFITS	•					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 505, 726	0		1. 00
				3, 505, 726			
	B - RENTAL AND LEASE	•					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 918, 345	10		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	55, 409	10		2. 00
3.00	NURSING ADMINISTRATION	13.00	o	119	0		3. 00
4.00	MEDICAL RECORDS & LIBRARY	16.00	o	5, 405	0		4. 00
5.00	PHARMACY	15.00	o	23, 879	o		5. 00
6.00	OPERATING ROOM	50.00	o	446, 122	0		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	O	97, 865	0		7. 00
9.00	PHYSI CAL THERAPY	66.00	O	117, 575	o o		9. 00
11.00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	33			11. 00
12.00	SPORTS MEDICINE	194.00	o	24, 524	o		12. 00
13.00	ELECTROCARDI OLOGY	69.00	o	. 5	0		13. 00
				2, 689, 281	1		
	C - OTHER CAPITAL COST	<u> </u>	-	, , , , ,			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	654, 507	12		1.00
2.00		0.00	0	C	1		2, 00
3. 00		0.00	Ö	Ċ			3. 00
0.00		— — <del></del>	<del> </del>	654, 507			0.00
	D - REPAIRS & MAINTENANCE		<u> </u>	331, 331			
1.00	ADMINISTRATIVE & GENERAL	5. 00	O	256, 514	0		1.00
2. 00	HOUSEKEEPI NG	9. 00	o	4, 768			2. 00
3.00	NURSING ADMINISTRATION	13. 00	o	1, 700			3.00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	0	62, 120			4. 00
5.00	PHARMACY	15. 00		21, 140			5. 00
6. 00	ADULTS & PEDIATRICS	30.00	o o	426	1		6. 00
7. 00	OPERATING ROOM	50.00	0	163, 978			7. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00		8, 364			9. 00
10.00	LABORATORY	60.00		261	1		10.00
11. 00	PHYSI CAL THERAPY	66.00		18, 854			11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00		6, 205	1		12.00
13. 00	SPORTS MEDICINE	192.00		0, 203	1		13. 00
15. 00	OCCUPATI ONAL THERAPY	67. 00		325			15. 00
16. 00	ELECTROCARDI OLOGY	69. 00		320			16. 00
10.00	O CONTROL OF THE PROPERTY OF T			542, 980			10.00
	E - CHIEF NURSING OFFICER		U_	342, 900	,		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	223, 408		0		1. 00
1.00	ADWI NI 31 KATI VE & GENERAL	— — <u>-3.</u> 00	223, 408	<u> </u>	<del> </del> 4		1.00
	F - MEDICAL SUPPLIES		223, 400		,		
1. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	596, 163	0		1.00
	•	50.00	0				
2.00	OPERATING ROOM		-	16, 506, 967			2.00
3.00	PHYSICAL THERAPY	6600		808			3. 00
	C DDUCC (LV COLUTIONS		UU	17, 103, 938	5		
1 00	G - DRUGS/IV SOLUTIONS	15 00	ما	012 (20			1 00
1.00	PHARMACY	15. 00	0	81 <u>2, 6</u> 29			1. 00
	U U CO PERTO		0	812, 629	<u>'</u>		
	H - MISC DEPTS						
1.00	OCCUPATI ONAL THERAPY	67.00	519, 136	49, 351			1. 00
2.00	SPEECH PATHOLOGY		<u>65, 4</u> 67	4, 398			2. 00
	0		584, 603	53, 749			
500.00	Grand Total: Decreases		808, 011	25, 362, 810	ן		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0168

Peri od: Worksheet A-7 From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/31/2022 11:00 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 26, 765 570, 012 0 2.00 Land Improvements 0 0 2.00 0 3.00 165, 806 165, 806 3.00 Buildings and Fixtures 0 9, 091, 995 0 4.00 Building Improvements 54, 141 54, 141 810, 805 4.00 5.00 Fixed Equipment 710, 106 1, 226, 866 0 1, 226, 866 5.00 0 6.00 Movable Equipment 21, 209, 217 1, 413, 470 1, 413, 470 1, 126, 131 6.00 0 7.00 HIT designated Assets 202, 081 188, 715 7.00 0 8.00 Subtotal (sum of lines 1-7) 31, 810, 176 2, 860, 283 2, 860, 283 2, 125, 651 8.00 9.00 Reconciling Items 0 9.00 2<u>, 125, 651</u> Total (line 8 minus line 9) 31, 810, 176 2, 860, 283 10.00 0 2, 860, 283 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 1.00 2.00 Land Improvements 26, 765 0 2.00 3.00 Buildings and Fixtures 735, 818 0 3.00 0 4.00 Building Improvements 8, 335, 331 4.00 5.00 Fi xed Equipment 1, 936, 972 0 5.00 Movable Equipment 21, 496, 556 0 6.00 6.00 7.00 HIT designated Assets 13, 366 0 7.00 Subtotal (sum of lines 1-7) 8.00 32, 544, 808 0 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 32, 544, 808 0 10.00

Health Financial Systems	LUTHERAN MUSCULO	SKELETAL CENTER	₹	In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part II Date/Time Pre 5/31/2022 11:	pared:
		SUMMARY OF CAPITAL				
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 WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00 CAP REL COSTS-BLDG & FLXT	962, 398	0	)	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	6, 513, 465	0	)	0 0	0	2.00
3.00 Total (sum of lines 1-2)	7, 475, 863	0		0 0	0	3. 00
	SUMMARY (	OF CAPITAL				
Cost Center Description	0ther	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				

0 0 0

962, 398 6, 513, 465 7, 475, 863

1. 00 2. 00 3. 00

1. 00 2. 00

3.00 Total (sum of lines 1-2)

Provider CCN: 15-0168	Heal th	Financial Systems LU	THERAN MUSCULO	SKELETAL CENTEI	₹	In Lie	eu of Form CMS-2	2552-10
Cost Center Description	RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		From 01/01/2021	Part III Date/Time Prep	
Leases			COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Death Interest   Cost Center Description   Cost Center Description   Death Interest   Cost Center Description   Cost Center Description   Death Interest   Cost Center Description   Cost Center Description   Des		Cost Center Description	Gross Assets				Insurance	
DART   111 - RECONCILIATION OF CAPITAL COSTS CENTERS   1.00   2.00   3.00   4.00   5.00   5.00				Leases	(col. 1 - col			
PART       - RECONCILIATION OF CAPITAL COSTS CENTERS			1. 00	2.00		4. 00	5. 00	
CAP REL COSTS-MVBLE EQUIP   23,446,894   0   23,446,894   0   32,544,808   1.000000   0   3.00		PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	0.00	1.00	0.00	
Total (sum of lines 1-2)   32,544,808   0   32,544,808   1.000000   0   3.00	1.00	CAP REL COSTS-BLDG & FIXT	9, 097, 914	C	9, 097, 91	4 0. 279550	0	1.00
ALLOCATION OF OTHER CAPITAL   SUMMARY OF CAPITAL	2.00	CAP REL COSTS-MVBLE EQUIP	23, 446, 894	C	23, 446, 89	0. 720450	0	2.00
Cost Center Description	3.00	Total (sum of lines 1-2)	32, 544, 808	C	32, 544, 80			3. 00
Capital -Relate   Cols. 5   through 7)   6.00   7.00   8.00   9.00   10.00	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
A Costs   Cost		Cost Center Description				Depreciation	Lease	
CAP REL COSTS-BLDG & FIXT   O   O   O   O   O   O   O   O   O								
PART       - RECONCILIATION OF CAPITAL COSTS CENTERS						0.00	10.00	
1.00   CAP REL COSTS-BLDG & FIXT   0   0   0   1,054,828   2,507,266   1.00   2.00   3.00   Total (sum of lines 1-2)   0   0   0   0   6,662,461   182,015   2.00   3.00   Total (sum of lines 1-2)   0   0   0   7,717,289   2,689,281   3.00   SUMMARY OF CAPITAL		DADT III DECONCILIATION OF CARLTAL COCTO OF		7.00	8.00	9.00	10.00	
2. 00   CAP REL COSTS-MVBLE EQUIP   0   0   0   6, 662, 461   182, 015   2. 00   0   7, 717, 289   2, 689, 281   3. 00      SUMMARY OF CAPITAL  Cost Center Description   Interest   Insurance (see instructions)   Instructions   Inst	1 00				\	0 1 054 000	2 507 244	1 00
Total (sum of lines 1-2)			-	1	ł			
SUMMARY OF CAPITAL   Cost Center Description   Interest   Insurance (see instructions)   Instructions   Instr			-	1				
Cost Center Description	3.00	Total (Suil of Titles 1-2)	0		IMMADY OF CADI		2,007,201	3.00
instructions   instructions   Capital -Relate   of cols. 9   through 14)				31	SIMINARY OF CALL	IAL		
Costs (see instructions)   11.00   12.00   13.00   14.00   15.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
Instructions		·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
11.00 12.00 13.00 14.00 15.00    PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						d Costs (see	through 14)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS  1. 00								
1. 00     CAP REL COSTS-BLDG & FIXT     0     131, 025     516, 667     0     4, 209, 786     1. 00       2. 00     CAP REL COSTS-MVBLE EQUIP     0     6, 815     0     0     6, 851, 291     2. 00				12.00	13.00	14. 00	15. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP 0 6, 815 0 0 6, 851, 291 2. 00						_		
			1					
3.00     137,840   516,667   0   11,061,077   3.00			1		•			
	3.00	Iotal (sum of lines 1-2)	0	137, 840	ار 516, 66	/  0	] 11, 061, 077	3.00

| Period: | Worksheet A-8 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0168

					To 12/31/2021	Date/Time Prep 5/31/2022 11:0	
				Expense Classification or			oo alii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		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 0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAD DEL COSTS MADLE FOLLID	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL COSTS-MVBLE EQUIP	2.00		
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	o	5. 00
4 00	expenses (chapter 8)		0		0.00		<i>(</i> 00
6. 00	Rental of provider space by suppliers (chapter 8)		U		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay stations excluded) (chapter	A	-4, 521	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)	A	-16, 759	ADMINISTRATIVE & GENERAL	5. 00	0	8. 00
9.00	Parking Lot (chapter 21)	4.0.2	0		0.00		9. 00
10. 00	Provider-based physician adjustment	A-8-2	-52, 759			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	-1, 126, 210			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests	1	0		0.00		14.00
15. 00	Rental of quarters to employee and others		Ü		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
47.00	pati ents						
17.00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-18	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00		20.00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		0		0.00		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT	А	-8, 955	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
27. 00	Depreciation - CAP REL	А	-66, 036	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant	4.0.2	0		0.00		29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32 NN	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest		_				
33. 00	RENTAL INCOME	В	-14, 906	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 00

					o 12/31/2021	Date/Time Pre 5/31/2022 11:	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	,	1.00	2. 00	3. 00	4. 00	5. 00	
33. 01	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 01
	(3)						
33. 02	TELEVISION DEPRECIATION	Α	·	PHYSI CAL THERAPY	66.00	l e	33. 02
33. 03	FI TNESS REVENUE	В	·	ADMINISTRATIVE & GENERAL	5. 00		33. 03
34.00	OTHER MISC REVENUE	В		ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MARKETING EXPENSES	A	-739, 381	ADMINISTRATIVE & GENERAL	5. 00	0	35. 00
36.00	LOBBYING EXPENSES	A	-73	ADMINISTRATIVE & GENERAL	5. 00	0	36. 00
37.00	CHARITABLE CONTRIBUTIONS	A	-195, 145	ADMINISTRATIVE & GENERAL	5. 00	0	37. 00
38.00	PHYSICIAN RECRUITING	A	-514, 703	ADMINISTRATIVE & GENERAL	5. 00	0	38. 00
39.00	MI NORI TY I NTEREST	A	-25, 399, 778	ADMINISTRATIVE & GENERAL	5. 00	0	39. 00
40.00	PENALTI ES	A	-4, 698	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41.00	LEGAL FEES	A	-13, 317	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-28, 570, 080				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0168

Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/21/2023 11:00 am

Line No. Cost Center Expense I tems Amount of	5/31/2022 11:00 am Amount
Enterior   Cost contor   Expense I tells   Allount of	
Al I owable Cos	Included in
	Wks. A, column
	5
1.00 2.00 3.00 4.00	5. 00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OF	CLAIMED
HOME OFFICE COSTS:	1 00
1. 00   0. 00   0. 00   0. 00   0. 00	1 -1
2. 00   0. 00	0 2.00 0 3.00
3.00	0 3.00
3.02	0 3.01
3. 03	0 3.02
3. 04	0 3.03
3. 05	0 3.05
3.06	0 3.06
3. 07	0 3.07
3.08	0 3.08
3.09	0 3.09
3. 10	0 3.10
3. 11 0. 00	0 3.11
3. 12 0. 00	0 3.12
3. 13 0. 00	0 3.13
3. 14 0. 00	0 3.14
3. 15 0. 00	0 3.15
3. 16 0. 00	0 3.16
4.00   1.00 CAP REL COSTS-BLDG & FIXT PASI Capital Costs - Bldg & 2,67	
4.01 2.00 CAP REL COSTS-MVBLE EQUIP PASI Capital Costs - Moveabl 32	
4.02 5.00 ADMINISTRATIVE & GENERAL PASI Operating Costs 227,04	
4. 03 5. 00 ADMINISTRATIVE & GENERAL Shared Service Center Alloca 2, 079, 92	1
4.04 1.00 CAP REL COSTS-BLDG & FIXT New Capital - Building & Fix 98,71 4.05 2.00 CAP REL COSTS-MVBLE EQUIP New Capital - Movable Equipm 229,61	
4.05   2.00 CAP REL COSTS-MVBLE EQUIP   New Capital - Movable Equipm   229,61   4.06   5.00 ADMINISTRATIVE & GENERAL   Non-Capital Home Office Cost   2,472,61	
4. 07 S. OO ADMINISTRATIVE & GENERAL MAI practice Costs 36, 51	
4. 07 S. 00 ADMINISTRATIVE & GENERAL Management Fees 30, 51	
4.09 5. OOIADMINISTRATIVE & GENERAL 401K Fees	4,400 4.09
4.10 5. OOIADMINI STRATIVE & GENERAL Audit Fees	74, 945 4. 10
4.11 5.00 ADMINISTRATIVE & GENERAL   Corporate Overhead Allocatio	1, 553, 330 4. 11
4.12 5. OOIADMINISTRATIVE & GENERAL HIIM Allocation	194, 943 4. 12
4.13 5.00 ADMINISTRATIVE & GENERAL PASI Lien Unit Collection Fe	8, 785 4. 13
5.00 TOTALS (sum of lines 1-4). 5,147,42	1
Transfer column 6, line 5 to	
Worksheet A-8, column 2,	
line 12.	

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

	to both pooted to not to to the time of and of 2, the amount arronage of the octourn to the parti								
				Related Organization(s) and/	Related Organization(s) and/or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1. 00	2. 00	3.00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

i ci ilibai	Schieffe dider ti tre XVIII.					
6.00	В	COMMUNITY HEALT	60.00	COMMUNITY HEALT	60. 00	6. 00
7.00	В	LUTHERAN HEALTH	40.00	LUTHERAN HEALTH	40. 00	7. 00
8.00	В	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:					

Health Fi	nancial Systems	LUTHERAN MUSCULO	SKELETAL CENTE	ER	In Lieu of Form CMS-2552-10		
		RELATED ORGANIZATIONS AND HOM	ME Provider (	CCN: 15-0168	Peri od: From 01/01/2021	Worksheet A-8	3-1
OFFICE CO	DSTS				To 12/31/2021	Date/Time Pre 5/31/2022 11:	
				Related Orga	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of Ownership	1	Name	Percentage of Ownership	

3.00

4. 00

5. 00

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

1. 00

- 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.

2.00

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.

002	000.0				To 12/31/2021	Date/Time Pre 5/31/2022 11:	epared:
	Net	Wkst. A-7 Ref.				373172022 11.	00 4111
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:					
1.00	0	0					1.00
2.00	0	0					2. 00
3.00	0	0					3. 00
3. 01	0	0					3. 01
3.02	0	0					3. 02
3.03	0	0					3. 03
3.04	0	0					3. 04
3.05	0	0					3. 05
3.06	0	0					3. 06
3.07	0	0					3. 07
3.08	0	0					3. 08
3.09	0	0					3. 09
3. 10	0	0					3. 10
3. 11	0	0					3. 11
3. 12	0	9					3. 12
3. 13	0	9					3. 13
3. 14	0	9					3. 14
3. 15	0	9					3. 15
3. 16	0	-					3. 16
4.00	2, 675						4. 00
4.01	328						4. 01
4.02	-1, 715						4. 02
4.03	1, 084, 407						4. 03
4.04	98, 710						4. 04
4.05	229, 610						4. 05
4.06	2, 472, 617						4. 06
4 07	-198 762	0					4 07

\* 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.

4.08

4.09

4.10

4.11

4.12

4. 13

5.00

		Related Organization(s) and/or Home Office		
Type of Business		Type of Business		
6.00		6. 00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	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.

-2, 977, 677

-1, 553, 330

-1, 126, 210

-194.943

-8, 785

-4, 400

-74, 945

0

0

0

0

4.08

4.09

4.10

4.11

4.12

4.13

5.00

| Period: | Worksheet A-8-2 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0168

West. A Line #   Cost Center/Physician Identifier   Renuneration   Provider Component						-	Γο 12/31/2021	Date/Time Pre 5/31/2022 11:	
Table   Tabl		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		00 4111
1.00				Remuneration		Component			
1.00					·	·		Hours	
2,000									
3.00							179, 000	76	
4, 00	2.00	53. 00	ANESTHESI OLOGY	22, 647	22, 647	0	0	0	
S				0	0	0	0	0	1
6.00	4.00			0	0	0	0	0	4. 00
1.00				0	0	0	0	_	4
8.00   0.00				0	0	0	0	1	
0				0	0	0	0	1	
10.00				0	0	0	0	1	4
New Year   Cost Center/Physician   Identifier   Cost Center/Physician   Identifier				0	0	0	0	Ĭ	
Wkst. A Line #   Cost Center/Physician Identifier   Limit   Limit   Cost of Limit   Cost of Limit   Cost of Component Share of col.   Cost of Share of Cost of Share o		0. 00		0	0	0	0	_	1
Identifier									
1.00		Wkst. A Line #							
1.00			Identitier	Limit					
1.00					LIMIT			Insurance	
1.00		1 00	2 00	9 00	0.00			14.00	
2. 00	1 00								1 00
3. 00				1		_	1	_	
4.00			ANEST TEST DEDOT	_			0	1	1
5. 00         0. 00         0. 00         <				0	1	0	0		1
6.00				0	0	0	0	1	
7. 00				l o	l o	0	l o		1
9.00				0	0	0	0	0	1
10.00	8.00	0.00		0	0	0	0	0	8. 00
Next	9.00	0.00		0	0	0	0	0	9. 00
Wkst. A Line #   Cost Center/Physician   Identifier   Component   Share of col.   14   1.00   15.00   16.00   17.00   18.00   1.00   2.00   15.00   16.00   17.00   18.00   1.00   2.00   15.00   16.00   17.00   18.00   1.00   2.00   16.00   17.00   18.00   1.0	10.00	0.00		0	0	0	0	0	10.00
Identifier   Component Share of col.   Li mi t   Di sal I owance	200.00			6, 540	327		0	0	200.00
Share of col .   14		Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
1.00   2.00   15.00   16.00   17.00   18.00     1.00   1.00     1.00   1.00     1.00   1.			ldentifier		Limit	Di sal I owance			
1. 00         2. 00         15. 00         16. 00         17. 00         18. 00           1. 00         5. 00 ADMI NI STRATI VE & GENERAL         0         6, 540         6, 237         30, 112         1. 00           2. 00         53. 00 ANESTHESI OLOGY         0         0         0         22, 647         2. 00           3. 00         0. 00         0         0         0         0         0         3. 00           4. 00         0. 00         0         0         0         0         0         4. 00           5. 00         0. 00         0         0         0         0         0         5. 00           6. 00         0. 00         0         0         0         0         0         6. 00           7. 00         0. 00         0         0         0         0         0         6. 00           7. 00         0. 00         0         0         0         0         0         7. 00         0         0         0         8. 00           9. 00         0         0         0         0         0         0         0         9. 00         10. 00         10. 00         10. 00         10. 00         10. 00									
1. 00         5. 00 ADMI NI STRATI VE & GENERAL         0         6, 540         6, 237         30, 112         1. 00           2. 00         53. 00 ANESTHESI OLOGY         0         0         0         22, 647         2. 00           3. 00         0. 00         0         0         0         0         0         3. 00           4. 00         0. 00         0         0         0         0         0         4. 00           5. 00         0. 00         0         0         0         0         0         5. 00           6. 00         0. 00         0         0         0         0         0         6. 00           7. 00         0. 00         0         0         0         0         0         6. 00           7. 00         0. 00         0         0         0         0         0         6. 00           7. 00         0. 00         0         0         0         0         0         7. 00         8. 00           9. 00         0. 00         0         0         0         0         0         9. 00         9. 00           10. 00         0         0         0         0         0 <td< td=""><td></td><td>1.00</td><td></td><td>14</td><td>1/ 00</td><td>17.00</td><td>10.00</td><td></td><td></td></td<>		1.00		14	1/ 00	17.00	10.00		
2. 00     53. 00 ANESTHESI OLOGY     0     0     0     22, 647     2. 00       3. 00     0. 00     0     0     0     0     3. 00       4. 00     0. 00     0     0     0     0     0     4. 00       5. 00     0. 00     0     0     0     0     0     5. 00       6. 00     0. 00     0     0     0     0     0     6. 00       7. 00     0. 00     0     0     0     0     0     7. 00       8. 00     0. 00     0     0     0     0     0     0     7. 00       9. 00     0. 00     0     0     0     0     0     9. 00       10. 00     0     0     0     0     0     0     0	4 00								1 00
3.00     0.00       4.00     0.00       5.00     0.00       6.00     0.00       7.00     0.00       8.00     0.00       9.00     0.00       10.00     0.00       0     0									
4.00     0.00       5.00     0.00       6.00     0.00       7.00     0.00       8.00     0.00       9.00     0.00       10.00     0.00       0     0       0		1	ANESTHESTULUGY	_		_		1	4
5.00         0.00         0         0         0         0         5.00           6.00         0.00         0         0         0         0         6.00           7.00         0.00         0         0         0         0         0         7.00           8.00         0.00         0         0         0         0         0         8.00           9.00         0.00         0         0         0         0         9.00           10.00         0         0         0         0         0         10.00				0	· ·	-	0		
6.00         0.00           7.00         0.00           8.00         0.00           9.00         0.00           10.00         0.00           0         0           <									4
7.00         0.00           8.00         0.00           9.00         0.00           10.00         0.00									
8.00     0.00       9.00     0.00       10.00     0.00									
9.00 0.00 0 0 0 9.00 10.00 0 0 0 10.00									1
10.00 0.00 0 0 0 10.00									1
	200.00	3.00		1 0	6, 540	6, 237	52, 759		200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/31/2022 11:00 am CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP EMPLOYEE Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 4, 209, 786 4, 209, 786 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 6, 851, 291 6, 851, 291 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 690, 451 3, 943, 484 4.00 96, 303 156, 730 14, 983, 408 5 00 00500 ADMINISTRATIVE & GENERAL 840 659 5 00 14, 142, 749 7.00 00700 OPERATION OF PLANT 2, 227, 510 713, 089 1, 160, 529 11,640 4, 112, 768 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 59, 202 59, 202 8.00 00900 HOUSEKEEPI NG 526, 393 0 950 527, 343 9.00 9.00 01000 DI ETARY 0 10 00 10 00 220, 743 Ω 0 220, 743 12.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 01300 NURSING ADMINISTRATION 912, 464 1, 070, 557 13.00 158.093 13.00 293, 682 01400 CENTRAL SERVICES & SUPPLY 1, 479, 167 180, 453 2, 056, 456 14.00 103.154 14.00 15.00 01500 PHARMACY 389, 451 0 49,638 439, 089 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 610, 730 0 5, 384 616, 114 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 0 01850 OTHER GENERAL SERVICES 0 18.00 0 0 0 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 Ω 19 00 02000 NURSING PROGRAM 0 20.00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 22, 00 0 02300 PARAMED ED PRGM 0 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 078, 864 438, 840 714, 197 460, 352 4, 692, 253 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 33.00 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 40.00 04000 SUBPROVI DER - I PF C 0 Ω 40.00 04100 SUBPROVIDER - IRF 0 41.00 41.00 0 0 43.00 04300 NURSERY 0 43.00 0 04400 SKILLED NURSING FACILITY 0 0 44 00 Λ 44 00 45.00 04500 NURSING FACILITY 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 15, 323, 092 964.465 1, 569, 637 894.564 18, 751, 758 50.00 51.00 05100 RECOVERY ROOM 2, 474, 387 269, 823 439, 128 346, 859 3, 530, 197 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 39, 473 39, 473 53 00 0 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 526, 373 84,048 136, 785 55, 771 802, 977 54.00 54.01 03630 ULTRA SOUND 3, 302 3, 302 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0 05600 RADI OI SOTOPE 0 56 00 0 0 56 00 0 57.00 05700 CT SCAN 0 0 0 57.00 05800 MRI 0 0 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 0 756 60.00 06000 LABORATORY 386, 165 0 386, 921 60 00 60.01 06001 BLOOD LABORATORY 0 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62.00 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS 0 63.00 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 65.00 56, 267 2,571 58,838 65.00 06600 PHYSI CAL THERAPY 3, 189, 400 538.316 876, 091 519, 722 66.00 5, 123, 529 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 69.00 37, 259 0 0 1, 364 38, 623 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 851, 163 0 851, 163 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 16, 252, 775 0 16, 252, 775 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 812,629 0 812, 629 73.00 0 74.00 07400 RENAL DIALYSIS r 0 Ω 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0 C 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 0 91.00 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168 Peri od: Worksheet B From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94 00 0 94 00 0 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 97 00 0 09850 OTHER REIMBURSABLE COSTS 0 98.00 98.00 0 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 Ω 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0000 00000 106.00 10600 HEART ACQUISITION 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 113. 00 11300 | INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 78, 351, 086 3, 285, 337 75, 430, 118 118. 00 118.00 5, 346, 779 3, 451, 477 NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 13, 445 924, 449 1, 504, 512 195 2, 442, 601 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193. 00 194.00 07950 SPORTS MEDICINE 3, 234, 017 491, 812 3, 725, 829 194. 00 0 194. 01 07951 SENI OR CIRCLE 0 0 194. 01 200.00 Cross Foot Adjustments 0 200, 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 81, 598, 548 4, 209, 786 6, 851, 291 3, 943, 484 81, 598, 548 202. 00

Provider CCN: 15-0168

In Lieu of Form CMS-2552-10
Worksheet B
01/2021 Part I
01/2021 Date/Time Prepared:
05/31/2022 11:00 am Peri od: From 01/01/2021 To 12/31/2021

	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/31/2022 11: DI ETARY	00 am
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	14, 983, 408					5. 00
7. 00	00700 OPERATION OF PLANT	925, 064	5, 037, 832				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	13, 316	0	72, 518			8. 00
9.00	00900 HOUSEKEEPI NG	118, 613	0	0	645, 956	l	9. 00
10.00	01000 DI ETARY	49, 651	0	0	0	270, 394	10.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMINI STRATI ON	240 705	0	0	0	0	12.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	240, 795 462, 548	267, 350	0	34, 280		13. 00 14. 00
15. 00	01500 PHARMACY	98, 762	207, 330	0	0 34, 200	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	138, 579	0	Ō	0	Ō	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 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	02000   NURSI NG PROGRAM   02100   L&R SERVI CES-SALARY & FRI NGES APPRV	0	0	0	0		20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	o o	0	Ö	0	Ö	22. 00
23. 00	1 I	O	0	Ō	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00	03000 ADULTS & PEDI ATRI CS	1, 055, 405	650, 160	58, 033	83, 364	l	30. 00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT		0	0	0		32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	O	0	Ō	0	Ō	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
44. 00	04400 SKI LLED NURSI NG FACILI TY	0	0	0	0	0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
40.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	0	0	0		40.00
50.00	05000 OPERATING ROOM	4, 217, 737	1, 428, 896	14, 485	183, 215	0	50. 00
51. 00	05100 RECOVERY ROOM	794, 030	399, 755	0	51, 257	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY	8, 878	124 521	0	15.044	0	53. 00 54. 00
54. 00	05400   RADI OLOGY-DI AGNOSTI C   03630   ULTRA SOUND	180, 610 743	124, 521 0	0	15, 966 0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	Ö	0	ő	55. 00
56.00	05600 RADI OI SOTOPE	O	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	87, 028	0	0	0	0	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	07,020	0	0	0	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		3		G		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	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	13, 234 1, 152, 410	797, 538	0	102, 261	0	65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY	1, 132, 410	141, 556	0	102, 201	0	67. 00
68. 00	1	o	0	Ö	0	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	8, 687	0	0	0	0	69. 00
70. 00		0	0	0	0	0	70. 00
71. 00		191, 448	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	3, 655, 655 182, 781	0	0	0	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	182, 781	0	0	0	0	74.00
	07500 ASC (NON-DISTINCT PART)	o	0	Ö	0	o o	75. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	1	0	0	0	0	0	88. 00
89. 00		0	0	0	0	0	89.00
90.00		0	0	0	0	0	90. 00 91. 00
91. 00 92. 00	09100   EMERGENCY   09200   OBSERVATION   BEDS (NON-DISTINCT PART		0		0		91.00
72.00	OTHER REIMBURSABLE COST CENTERS			1		1	72.00
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	1	0	0	0	0	0	96. 00
97. 00 98. 00	1	0	0	0	0	0	97. 00 98. 00
70.00	O 2000 O THEIR INCHWIDDINGABLE COSTS	<u>ı</u>	0	1 0	0	1 0	70.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0168

Period: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/31/2022 11:00 am ADMINISTRATIVE OPERATION OF Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 99. 00 09900 CMHC 99. 00 0 n 0 0 99. 10 99. 10 09910 CORF 0 C 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 106. 00 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 0 0 0 0 0 108. 00 10800 LUNG ACQUISITION 0 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111. 00 0 113.00 11300 I NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 595, 974 3, 668, 220 72, 518 470, 343 270, 394 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH 0 190. 00 0 0 0 0 0 0 191.00 O 192.00 19200 PHYSICIANS' PRIVATE OFFICES 549, 402 1, 369, 612 0 175, 613 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194.00 194.00 07950 SPORTS MEDICINE 838, 032 C 0 0 0 194. 01 194. 01 07951 SENI OR CIRCLE C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 270, 394 202. 00 14, 983, 408 5, 037, 832 72, 518 645, 956

Provider CCN: 15-0168

| Peri od: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Da

				To	12/31/2021	Date/Time Pre 5/31/2022 11:	
Cost Center Description	MAI NTENANCE		NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	PERSONNEL		ADMI NI STRATI ON	SERVI CES & SUPPLY		RECORDS & LI BRARY	
	12. 00		13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FLXT		_					1 00
1.00   00100   CAP REL COSTS-BLDG & FLXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP							1. 00 2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT							4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL							5. 00
7.00 00700 OPERATION OF PLANT							7. 00
8.00   00800   LAUNDRY & LINEN SERVICE							8. 00
9. 00   00900   HOUSEKEEPI NG							9. 00
10. 00   01000   DI ETARY 12. 00   01200   MAI NTENANCE OF PERSONNEL		۸					10. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON		0	1, 311, 352				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY		0	0	2, 820, 634			14. 00
15. 00   01500   PHARMACY		0	3	3, 020	540, 874		15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY		0	0	0	0	754, 693	16. 00
17. 00 01700 SOCIAL SERVICE		0	0	0	0	0	17. 00
18. 00 O1850 OTHER GENERAL SERVICES 19. 00 O1900 NONPHYSICIAN ANESTHETISTS		0	0	0	0	0	18. 00 19. 00
20. 00   02000   NURSI NG   PROGRAM		o	ő	0	Ö	0	20. 00
21.00 02100 I &R SERVI CES-SALARY & FRINGES APPRV		0	O	0	ō	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0	O	0	o	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			424 005	22.01/	ol	11 000	20.00
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T		0	426, 895 0	22, 016 0	ol Ol	11, 999 0	30. 00 31. 00
32. 00   03200   CORONARY CARE UNIT		0	0	0	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	O	0	ō	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	O	0	34.00
40. 00   04000   SUBPROVI DER - I PF		0	0	0	0	0	40. 00
41. 00   04100   SUBPROVI DER -   RF		0	0	0	0	0	41.00
43.00   04300   NURSERY 44.00   04400   SKILLED   NURSING FACILITY		0	0	0	0	0	43. 00 44. 00
45. 00   04400  SKI ELED NORSING FACILITY		0	0	0	0	0	45. 00
46. 00   04600   OTHER LONG TERM CARE		0	o	0	o	0	46. 00
ANCILLARY SERVICE COST CENTERS							
50.00   05000   OPERATING ROOM		0	536, 405	963, 928	0	251, 716	50.00
51. 00   05100   RECOVERY ROOM		0	344, 311	0	0	49, 660	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY		0	0	0 3, 978	0	0 22, 130	52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0	2, 637	3, 770	0	16, 381	54. 00
54. 01   03630   ULTRA SOUND		0	0	0	ō	14	54. 01
55. 00   05500 RADI OLOGY-THERAPEUTI C		0	О	0	О	0	55. 00
56. 00   05600   RADI OI SOTOPE		0	0	0	0	0	56. 00
57. 00   05700   CT   SCAN		0	0	0	0	0	57. 00
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON		0	0	0	0	0	58. 00 59. 00
60. 00   06000 LABORATORY		0	612	8, 927	0	10, 935	60.00
60. 01 06001 BLOOD LABORATORY		0	0	0	Ö	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   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY		0	0	0	0	0 717	64. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY		o	ő	12, 601	Ö	34, 858	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0	0	0	o	0	67. 00
68.00 06800 SPEECH PATHOLOGY		0	О	0	О	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0	489	0	0	1, 840	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	0	(0.505	0	42.020	70.00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00   07200   MPL. DEV. CHARGED TO PATIENTS		0	0	69, 585 1, 654, 676	0	43, 830 274, 658	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS		0	0	81, 891	540, 874	35, 905	73.00
74. 00 07400 RENAL DIALYSIS		0	o	0.,0,1	0	50	74. 00
75.00 07500 ASC (NON-DISTINCT PART)		0	0	0	О	0	75. 00
OUTPATIENT SERVICE COST CENTERS							
88. 00 08800 RURAL HEALTH CLINIC		0	0	0	0	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC		0	0	0	0	0	89. 00 90. 00
91. 00   09100   EMERGENCY		0	n	0	Ol Ol	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		٧			٩	O	92.00
OTHER REIMBURSABLE COST CENTERS		'					
94. 00 09400 HOME PROGRAM DI ALYSI S		0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		0	0	0	0	0	95. 00
96. 00   09600   DURABLE   MEDI CAL   EQUI P-RENTED 97. 00   09700   DURABLE   MEDI CAL   EQUI P-SOLD		0	0	0	0	0	96. 00 97. 00
11. 00  07100  DUNADLE WILDI CAL LUUI P-30LD	1	U	પ	U	Ч	0	77.00

Provider CCN: 15-0168

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared:

			10	12/31/2021	Date/IIMe Pre   5/31/2022 11:	
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	PERSONNEL	ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	12.00	13.00	14.00	15. 00	16. 00	
98.00 09850 OTHER REIMBURSABLE COSTS		0	0	0	0	70.00
99. 00   09900   CMHC		0	0	0	0	99. 00
99. 10   09910   CORF		0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM		0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	(	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	(	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	(	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	(	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	(	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	(	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	(	0	0	0		110. 00
111.00   11100   I SLET ACQUI SI TI ON	(	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	(	0	0	0		115. 00
116. 00 11600 H0SPI CE	(	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	(	1, 311, 352	2, 820, 622	540, 874	754, 693	118. 00
NONREI MBURSABLE COST CENTERS	1	_				
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	(	0	12	0		192. 00
193. 00 19300 NONPALD WORKERS	(	0	0	0		193. 00
194. 00 07950 SPORTS MEDICINE	(	0	0	0		194. 00
194. 01 07951 SENI OR CI RCLE	(	) O	0	O	0	194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0 000 (04	540.074		201. 00
202.00   TOTAL (sum lines 118 through 201)		1, 311, 352	2, 820, 634	540, 874	754, 693	J202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: | From 14/2022 | Part | | Part | | Prepared: | Part | | Prepared: | Part | | Prepared: | Part | Part | Prepared: | Part | Part | Prepared: | Part | Par Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168

				11	o 12/31/2021	Date/lime Pre 5/31/2022 11:	
			OTHER GENERAL			INTERNS &	
		COOLAL CEDVICE	SERVI CE	NONDUNCI OLAN	NUDCINO	RESI DENTS	
	Cost Center Description	SOCI AL SERVI CE	S	NONPHYSICIAN ANESTHETISTS	NURSI NG PROGRAM	SERVICES-SALAR Y & FRINGES	
				ANESTHETISTS	1 KOOKAW	APPRV	
		17. 00	18. 00	19. 00	20.00	21.00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG					-	8. 00 9. 00
10. 00	01000 DI ETARY						10.00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	0					17. 00
18. 00	01850 OTHER GENERAL SERVICES	0	0				18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19. 00
20.00	02000 NURSI NG PROGRAM	0	0		0		20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	O	0			0	21. 00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22. 00
23.00	02300 PARAMED ED PRGM	0	0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00	04300 NURSERY	0	0	0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50. 00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	o o	0		0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	Ö	0	l ő	0	ő	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	Ö	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	l o	0	o o	54.00
54. 01	03630 ULTRA SOUND	0	0	l o	0	o o	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	O	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 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68. 00	O6800   SPEECH PATHOLOGY   O6900   ELECTROCARDI OLOGY	0	0	0	0	0	68.00
69. 00 70. 00	07000 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		70.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0		71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	Ö	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	1 0	0		75. 00
. 5. 66	OUTPATIENT SERVICE COST CENTERS	<u> </u>					. 5. 55
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	l ol	0	l o	0	Ö	89. 00
90. 00	09000 CLINIC		0	0	0	Ō	90.00
91.00	09100 EMERGENCY	ol	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0			94. 00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00

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

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared:

			10	12/31/2021	5/31/2022 11:	pared: OO am
		OTHER GENERAL			INTERNS &	00 4
		SERVI CE			RESI DENTS	
Cost Center Description	SOCIAL SERVICE	S	NONPHYSI CI AN	NURSI NG	SERVI CES-SALAR	
			ANESTHETI STS	PROGRAM	Y & FRINGES	
					APPRV	
	17. 00	18. 00	19. 00	20. 00	21. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0	0	0	0	98. 00
99. 00  09900  CMHC	0	0	0	0	0	99. 00
99. 10  09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 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 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	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	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 SPORTS MEDICINE	0	0	0	0		194. 00
194. 01 07951 SENI OR CI RCLE	0	0	0	0		194. 01
200.00 Cross Foot Adjustments			0	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

Cust Center Rescription		Financial Systems LU LLOCATION - GENERAL SERVICE COSTS	JTHERAN MUSCULOS		CN: 15-0168	Period: From 01/01/2021	worksheet B Part I	2552-10
INLERES   SECULO   SUBJECT   Subtotal   Interest   Subtotal   Interest   Subtotal   Interest   Subtotal   Interest   Subtotal   Septiments   Subtotal   Interest   Subtotal   Septiments   Septiments   Subtotal   Septiments   Septiments   Subtotal   Septiments   Septimen						To 12/31/2021	Date/Time Pre	pared:
BITWINEST STRINGT COST CENTERS		Cost Center Description	RESI DENTS SERVI CES-OTHER PRGM COSTS		Subtotal	Residents Cost & Post Stepdown		oo aiii
1.00		CENEDAL CEDIUCE COCT CENTEDO	22.00	23. 00	24. 00	25. 00	26. 00	
2.00	1.00				1			1.00
30.00   03000   ADULTS & PEDI ATRI CS   0   0   7,270,519   0   7,270,519   3   32.00   03200   OSPONARY CARE UNIT   0   0   0   0   0   0   0   0   3   3	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 PARAMED ED PRGM	0	C				2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00
31.00   03100   INTERSIVE CARE UNIT	30.00			0	7 270 5	19 0	7 270 519	30.00
33.00   03300   BURR I NITENSI VE CARE UNIT					7, 270, 3			1
34. 00   03400   SURRO   CHE NITENSIVE CARE UNIT   0   0   0   0   0   0   3   4   41. 00   04100   SUBPROVI DER - I PF   0   0   0   0   0   0   0   0   4   4			0	0			_	
40.00   04000   SUBPROVI DER - I PF				0			_	
A3. 00   O4300   NURSERY	40.00	04000 SUBPROVI DER - I PF	0	0		0 0	0	1
44 0.0   04400   SKILLED NURSING FACILITY   0   0   0   0   0   0   0   445.00   04500 NURSING FACILITY   0   0   0   0   0   0   0   0   0			0	0		0 0	-	1
45. 00 04500 NURSI NG FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		0 0	_	
ANCILLARY SERVICE COST CENTERS				Ö		-	_	
SOLO   05000   05000   05000   05100	46. 00		0	0		0 0	0	46. 00
51-00   05-100   RECOVERY ROOM & LABOR ROOM	50.00			0	26 348 1	10 0	26 348 140	50.00
53.00   05300   AMESTHESI OLOGY   0   0   74, 459   5   5   5   5   5   5   5   5   5			-	Ö				
54.01 03630   ULTRA SOUND			0	0		-	-	
54.01   03630   ULTRA SOUND   0   0   0   4,059   0   4,059   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0			0	0	•			
55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   5   5   5   5			0	0				
57. 00   05700   CT SCAN   0   0   0   0   0   0   0   58. 00   05800   MRI   0   0   0   0   0   0   0   0   0	55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0		55. 00
58. 00   05800   MRI			0	0		0	0	56. 00 57. 00
60. 00   06000   LABORATORY   0   0   494, 423   0   494, 423   6   60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0				0		0 0	0	1
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   6   6   6   6			0	0		0 0		
61. 00			0	0	494, 42	23 0		1
63. 00				Ö	Ί	0	-	1
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   72,789   0   72,789   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   72,23,197   0   7,223,197   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   0   0   0			0	0		0 0	_	
65. 00 06500 RESPIRATORY THERAPY 0 0 72, 789 0 72, 789 6 66. 00 06600 PHYSI CAL THERAPY 0 0 0 7, 223, 197 0 7, 223, 197 6 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 6 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 6 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 49, 639 0 49, 639 0 49, 639 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0 0	_	
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 49, 639 0 49, 639 6 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 71. 156, 026 7 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 1, 156, 026 0 1, 156, 026 7 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 1, 654, 080 0 1, 654, 080 7 7 7 7 3. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 1, 654, 080 0 1, 654, 080 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7			O	Ö	72, 78	89 0	_	
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 49, 639 0 49, 639 6 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 7. 156, 026 7 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 1, 156, 026 0 1, 156, 026 0 1, 156, 026 7 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 1, 654, 080 0 1, 654, 080 7 7 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1, 654, 080 0 1, 654, 080 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7			0	0	7, 223, 19	97 0		
69. 00   06900   ELECTROCARDI OLOGY   0 0 49, 639   0 49, 639   670. 00 07000   ELECTROENCEPHALOGRAPHY   0 0 0 0 0 0 0 0 7 7 7 1. 00 07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   0 0 1, 156, 026   0 1, 156, 026   7 1, 1			0	0		0 0	-	
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   7 71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   1, 156, 026   7 72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   21, 837, 764   0   21, 837, 764   7 73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   1, 654, 080   0   1, 654, 080   7 74. 00   07400   RENAL DI ALYSI S   0   0   50   0   50   7 75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   0  TO OUTPATI ENT SERVI CE COST CENTERS  88. 00   08800   RURAL HEALTH CLINI C   0   0   0   0   0   0  89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   0   0  91. 00   09100   EMERGENCY   0   0   0   0   0   0   0   0   0			0	0	49, 63	39 0		1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   21, 837, 764   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   1, 654, 080   0   1, 654, 080   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   0   70. 00   0. 00   0   0   0   0   0   0			0	0		0 0		
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   1,654,080   74.00   07400   RENAL DI ALYSIS   0   0   0   50   0   50   75.00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   70   00   0			0	0				1
74. 00   07400   RENAL DI ALYSI S   0   0   50   0   50   75   75   00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   0   7   75   75				0				
OUTPATIENT SERVICE COST CENTERS           88. 00         08800 RURAL HEALTH CLINIC         0         0         0         0         0         89.00         9         9         91.00         0			0	0		50 0		74. 00
88. 00   08800   RURAL   HEALTH   CLINI C   0   0   0   0   89. 00   08900   FEDERALLY   QUALI FI ED   HEALTH   CENTER   0   0   0   0   0   0   89. 00   09900   CLINI C   0   0   0   0   0   0   99. 00   09100   EMERGENCY   0   0   0   0   0   0   99. 00   0   0   0   0   0   99. 00   0   0   0   0   0   0   0   0   0	75. 00		] 0	0	01	0 0	0	75. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	88. 00		O	C		0 0	0	88. 00
91. 00   09100  EMERGENCY   0   0   0   0   9   9   9   9   9   9	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O		0 0	-	89. 00
			0	0		0	-	
				O	1	0		92.00
			•		•	•	-	-

NITERIS & RESIDENTS   PROM	Health Financial Systems LU	JTHERAN MUSCULOS	KELETAL CENTER	3	In Lie	eu of Form CMS-	2552-10
To 12/31/2021   Date/Time Prepared:   To 12/31/2021   Date/Time Prepared:   SRESIDENTS   SERVICES-OTHER PROM COSTS   APPRV   PROM   PROGRAM DI ALYSI S	COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0168			
INTERNS & RESIDENTS   SERVICES-OTHER   PARAMED ED   PRGM   Residents Cost & Post   Residents Cost   R						Date/Time Pre	epared:
RESIDENTS   SERVICES-OTHER   PARAMED ED   Residents Cost & Post   Residents Cost & Post   Seport   Parameter   P		I NITEDNIS 8.				5/31/2022 11:	00 am
PRGM COSTS   APPRV   Residents Cost   & Post   Stepdown   Adjustments		RESI DENTS					
APPRV	Cost Center Description			Subtotal		Total	
OTHER REIMBURSABLE COST CENTERS   22.00   23.00   24.00   25.00   26.00			PRGM				
OTHER REI MBURSABLE COST CENTERS		741111					
OTHER REI MBURSABLE COST CENTERS   O   O   O   O   O   O   O   O   O		00.00	00.00	24.00		07.00	
94. 00   09400   HOME PROGRAM DI ALYSIS   0   0   0   0   0   0   0   0   94. 00   95. 00   09500   O9500   AMBULANCE SERVI CES   0   0   0   0   0   0   0   0   0   96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   0   0   0   0   97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0   0   0   0   0   0   0   98. 00   09800   OTHER REI MBURSABLE COSTS   0   0   0   0   0   0   0   0   99. 00   09900   CMHC   0   0   0   0   0   0   0   0   0   99. 10   09910   OORF   0   0   0   0   0   0   0   0   0   99. 10   09910   OORF   0   0   0   0   0   0   0   0   101. 00   100000   1&R SERVI CES-NOT APPRVD PRGM   0   0   0   0   0   0   0   101. 00   101000   100000   1&R SERVI CES-NOT APPRVD PRGM   0   0   0   0   0   0   0   101. 00   10100   HOME   HEALTH AGENCY   0   0   0   0   0   0   0   0   105. 00   10500   KI DINEY ACQUI SITI ON   0   0   0   0   0   0   0   106. 00   10500   KI DINEY ACQUI SITI ON   0   0   0   0   0   0   0   0   107. 00   10700   1	OTHER RELIMBURSARIE COST CENTERS	22.00	23.00	24.00	25.00	26.00	
96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   0   0   96.00   97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0   0   0   0   0   97. 00   09850   OTHER REI MBURSABLE COSTS   0   0   0   0   0   0   99. 00   09900   CUHIC   0   0   0   0   0   0   0   99. 10   09970   CORF   0   0   0   0   0   0   100. 00   10000   1&R SERVI CES-NOT APPRVD PRGM   0   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0    SPECIAL PURPOSE COST CENTERS		O	0	1	0 0	C	94.00
97. 00   09700   DURABLE MEDICAL EQUI P-SOLD   0   0   0   0   0   97. 00   98. 00   09850   OTHER REIMBURSABLE COSTS   0   0   0   0   0   0   98. 00   99. 00   09900   CMHC   0   0   0   0   0   0   0   99. 00   99. 10   09910   CORF   0   0   0   0   0   0   0   0   99. 00   99. 10   09910   CORF   0   0   0   0   0   0   0   0   0	95. 00 09500 AMBULANCE SERVICES	o	0		0 0	C	95.00
98. 00   09850   OTHER REIMBURSABLE COSTS   0   0   0   0   0   98. 00   99. 00   09900   CMHC   0   0   0   0   0   0   0   99. 10   09910   CORF   0   0   0   0   0   101. 00   10000   1&R SERVICES-NOT APPRVD PRGM   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   101. 00   10500   KI DNEY ACQUI SI TI ON   0   0   0   0   0   106. 00   10600   HEART ACQUI SI TI ON   0   0   0   0   0   107. 00   10700   LI VER ACQUI SI TI ON   0   0   0   0   0   108. 00   10800   LUNG ACQUI SI TI ON   0   0   0   0   0   109. 00   10900   PANCREAS ACQUI SI TI ON   0   0   0   0   101. 00   11000   INTESTI NAL ACQUI SI TI ON   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   111. 00   11100   INTEREST EXPENSE   114. 00   114. 00   11400   UTI LI ZATI ON REVIEW-SNF   114. 00   115. 00   11500   AMBURSABLE COST CENTERS   0   0   0   0   0   116. 00   10600   HEART SUMBURSABLE COST CENTERS   0   0   0   0   0   119. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   191. 00   191. 00   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   4, 537, 240   0   4, 537, 240   192. 00   194. 01   107951   SENI OR CI RCLE   0   0   0   0   0   0   194. 01   107951   SENI OR CI RCLE   0   0   0   0   0   194. 01   107951   SENI OR CI RCLE   0   0   0   0   0   190. 00   10000   1		0	0		0 0	1	
99. 00   09900   CMHC   09910   CORF   0 0 0 0 0 0 0 0 0 99. 00   99. 10   09910   CORF   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0 0		
99. 10   09910   CORF   0   0   0   0   0   0   0   0   99. 10   100. 00   10000   18R SERVI CES-NOT APPRVD PRGM   0   0   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0   0    SPECIAL PURPOSE COST CENTERS  105. 00   10500   KI DNEY ACQUI SI TI ON   0   0   0   0   0   0   0   106. 00   10600   KI DNEY ACQUI SI TI ON   0   0   0   0   0   0   0   107. 00   10700   LI VER ACQUI SI TI ON   0   0   0   0   0   0   0   108. 00   10800   LUNG ACQUI SI TI ON   0   0   0   0   0   0   0   109. 00   10900   LUNG ACQUI SI TI ON   0   0   0   0   0   0   0   110. 00   11000   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   111. 00   11100   ISLET ACQUI SI TI ON   0   0   0   0   0   0   111. 00   11100   ISLET ACQUI SI TI ON   0   0   0   0   0   0   111. 00   11100   UTI LI ZATI ON REVI EW-SNF   113. 00   115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   0   0   0   0   0   0   115. 00   116. 00   15000   AMBULATORY SURGI CAL CENTER (D. P. )   0   0   0   0   0   0   0   110. 00   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   190. 00   191. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   0   0   0   0   0   0   193. 00   194. 00   07950   SPORTS MEDI CI NE   0   0   0   0   0   0   194. 01   194. 00   07950   SPORTS MEDI CI NE   0   0   0   0   0   0   0   0   0   200. 00   Nopadi ve Cost Centers   0   0   0   0   0   0   0   0   0		0	0		0	1	
100. 00   10000   18R SERVI CES-NOT APPRVD PRGM   0   0   0   0   0   0   0   0   0			0		0 0		
SPECIAL PURPOSE COST CENTERS   105.00   10500   KI DNEY ACQUI SI TI ON   0   0   0   0   0   0   105.00   10500   KI DNEY ACQUI SI TI ON   0   0   0   0   0   0   105.00   10500   10500   KI DNEY ACQUI SI TI ON   0   0   0   0   0   0   0   107.00   107.00   107.00   107.00   107.00   107.00   107.00   107.00   108.00   10800   LUNG ACQUI SI TI ON   0   0   0   0   0   0   0   108.00   109.00   109.00   109.00   107.00		o	0		0 0	d	
105. 00   10500   KI DNEY ACQUI SI TI ON   0   0   0   0   0   105. 00		0	0		0 0	C	101. 00
106. 00   10600   HEART ACQUI SI TI ON   0   0   0   0   0   0   106. 00   107. 00   10700   LI VER ACQUI SI TI ON   0   0   0   0   0   0   107. 00   108.00   10800   LUNG ACQUI SI TI ON   0   0   0   0   0   0   0   0   108.00   109. 00   109				ı			1105 00
107. 00 10700 LI VER ACQUI SITION 0 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SITION 0 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SITION 0 0 0 0 0 0 108. 00 110. 00 11000 INTESTI NAL ACQUI SITION 0 0 0 0 0 0 110. 00 111. 00 11100 ISLET ACQUI SITION 0 0 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P. ) 0 0 0 0 0 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 72, 497, 447 0 72, 497, 447 118. 00 190. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 4, 537, 240 0 4, 537, 240 192. 00 194. 00 17950 SOROTS MEDI CI NE 0 0 0 0 0 0 0 194. 01 194. 01 07951 SENIOR CIRCLE 0 0 0 0 0 0 0 0 0 194. 01 194. 01 07955 SOROTS MEDI CI NE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 -1	0		-		
108. 00			0		0 0	<b>l</b>	
110.00   11000   INTESTINAL ACQUISITION   0   0   0   0   0   110.00		o	0		0 0		
111.00   11100   1   SLET ACQUI SI TI ON   113.00   1   1100   1   1100   1   1100   1   1		0	0		0 0		
113. 00   11300   1   1   1   1   1   1   1   1   1		0	0		0 0		
114. 00		٩	U	1	0		
116. 00							
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   0   0   72, 497, 447   0   72, 497, 447   118.00	115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0		0 0	C	115. 00
NONRE   MBURSABLE   COST   CENTERS   190. 00   19000   GIFT,   FLOWER,   COFFEE   SHOP & CANTEEN   0   0   0   0   0   190. 00   191. 00   191. 00   191. 00   192. 00   192. 00   192. 00   192. 00   192. 00   192. 00   193.			0		0 0		
190. 00     19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN     0     0     0     0     190. 00       191. 00     19100 RESEARCH     0     0     0     0     0     191. 00       192. 00     19200 PHYSI CI ANS' PRI VATE OFFI CES     0     0     4, 537, 240     0     4, 537, 240     192. 00       193. 00     19300 NONDAI D WORKERS     0     0     0     0     0     193. 00       194. 00     07950 SPORTS MEDI CI NE     0     0     4, 563, 861     0     4, 563, 861     194. 00       194. 01     107951 SENI OR CI RCLE     0     0     0     0     0     194. 01       200. 00     Cross Foot Adjustments     0     0     0     0     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     0     0     0     0     0     201. 00		0	0	72, 497, 4	47  O	72, 497, 447	7 118. 00
191. 00   19100   RESEARCH   0 0 0 0 0 0 0 191. 00   192. 00   1			0	1	0 0	(	190 00
193. 00 19300 NONPAID WORKERS 0 0 0 0 0 193. 00 194. 00 194. 00 1950 SPORTS MEDICINE 0 0 0 0 0 0 194. 00 194. 01 07951 SENIOR CIRCLE 0 0 0 0 0 0 194. 01 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00		1	0		0 0	l .	
194. 00     07950     SPORTS MEDICINE     0     4, 563, 861     0     4, 563, 861     194. 00       194. 01     07951     SENI OR CIRCLE     0     0     0     0     0     194. 01       200. 00     Cross Foot Adjustments     0     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     201. 00		0	0	4, 537, 2	40 0		
194. 01 07951     SENI OR CI RCLE     0     0     0     0     194. 01       200. 00     Cross Foot Adjustments     0     0     0     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     0     0     0     0     201. 00		0	0		0 0		
200.00         Cross Foot Adjustments         0         0         0         0         0         200.00           201.00         Negative Cost Centers         0         0         0         0         0         0         201.00		0	0	4, 563, 8	0		
201.00   Negative Cost Centers   0   0   0   0   201.00			0		0 0		
202.00   TOTAL (sum lines 118 through 201)   0   81,598,548   0   81,598,548   202.00			0		0 0	<b>l</b>	
	202.00   TOTAL (sum lines 118 through 201)	0	0	81, 598, 5	48 0	81, 598, 548	3 202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

				То	12/31/2021	Date/Time Pre 5/31/2022 11:	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	oost conton boost per on	Assigned New	5250 a 11%1		oub to tu.	BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	96, 303	156, 730	253, 033	253, 033	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	0	0	0	53, 940	5. 00
7.00	00700 OPERATION OF PLANT	0	713, 089	1, 160, 529	1, 873, 618	747	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	0		0	61	9. 00 10. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	Ö		0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	10, 144	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	180, 453	293, 682	474, 135	6, 619	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0		0	3, 185 345	15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	o o	Ö	o o	Ö	0	17. 00
18. 00	01850 OTHER GENERAL SERVICES	0	0	0	0	0	18. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	02000   NURSING PROGRAM   02100   L&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	Ö		0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		400.040	744 407	4 450 007	00 500	1 00 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	438, 840 0	714, 197	1, 153, 037	29, 538 0	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	Ö		0	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0		0	0	40. 00 41. 00
43. 00	04300 NURSERY	0	Ö		0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0		ij U	U	0	46. 00
50. 00	05000 OPERATING ROOM	0	964, 465	1, 569, 637	2, 534, 102	57, 402	50.00
51.00	05100 RECOVERY ROOM	0	269, 823	439, 128	708, 951	22, 256	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	84, 048	136, 785	220, 833	0 3, 578	53. 00 54. 00
54. 01	03630 ULTRA SOUND	o o	01,010	0	0	0, 3, 5	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 58. 00	05700   CT   SCAN     05800   MRI	0	0		0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö		0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	49	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö		0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	520, 217	0	0	165	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	538, 316	876, 091	1, 414, 407	33, 347 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	88	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
73. 00		0	0		0	0	73.00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
99 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	J ol	0	0	00 00
88. 00 89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	88. 00 89. 00
90. 00	09000 CLI NI C	0	Ö	ol ol	Ö	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				0		92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	<u>,                                     </u>	·	. 9	<u> </u>		

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2021 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

			To	12/31/2021	Date/Time Pre 5/31/2022 11:	
		CAPI TAL REL	ATED COSTS		3/31/2022 11.	OO alli
		OALL TAL INCL	LATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	o	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	o	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	O	0	0	o	0	98. 00
99. 00 09900 CMHC	O	0	0	o	0	99. 00
99. 10   09910   CORF	O	0	0	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O	0	0	o	0	100. 00
101.00 10100 HOME HEALTH AGENCY	O	0	0	o	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	o	0	106. 00
107.00 10700 LIVER ACQUISITION	O	0	0	o	0	107. 00
108.00 10800 LUNG ACQUISITION	O	0	0	o	0	108. 00
109.00 10900 PANCREAS ACQUISITION	O	0	0	o	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0	o	0	110. 00
111.00 11100 ISLET ACQUISITION	o	0	0	o	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0	0	o	0	115. 00
116. 00 11600 HOSPI CE	o	0	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 285, 337	5, 346, 779	8, 632, 116	221, 464	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	924, 449	1, 504, 512	2, 428, 961	13	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194. 00 07950 SPORTS MEDICINE	0	0	0	0	31, 556	194. 00
194. 01 07951 SENI OR CI RCLE	0	0	0	0	0	194. 01
200.00 Cross Foot Adjustments				O		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	4, 209, 786	6, 851, 291	11, 061, 077	253, 033	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	OO am
	I	5. 00	7. 00	8. 00	9. 00	10.00	
4 00	GENERAL SERVICE COST CENTERS	T			T		4 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	53, 940					5. 00
7. 00	00700 OPERATION OF PLANT	3, 331	1, 877, 696				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	48	0	48			8. 00
9.00	00900 HOUSEKEEPI NG	427	0	0	488		9. 00
10.00	01000 DI ETARY	179	0	0	0	179	10. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13. 00	01300 NURSING ADMINISTRATION	867	0	0	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 666	99, 646	0	26	0	14. 00
15. 00	01500 PHARMACY	356	0	0	0	0	
	01600 MEDICAL RECORDS & LIBRARY	499	0	0	0	0	
	01700 SOCIAL SERVICE	0	0	0	U O	0	
	01850 OTHER GENERAL SERVICES   01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
	02000 NURSI NG PROGRAM		0	0	0	0	1
	02100 I &R SERVI CES-SALARY & FRINGES APPRV		0	0	Ö	0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o	Ö	0	ol	0	22. 00
	02300 PARAMED ED PRGM	o	0	0	ō	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 801	242, 327	38	63	179	30. 00
	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
	03200 CORONARY CARE UNIT	0	0	0	0	0	
	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	
41. 00 43. 00	04100 SUBPROVI DER - I RF	0	0	0	U O	0	
44. 00	04300   NURSERY   04400   SKILLED   NURSING   FACILITY		0	0	0	0	
45. 00	04500 NURSING FACILITY		0	0	0	0	1
46. 00	04600 OTHER LONG TERM CARE		0	0	ő	0	
	ANCI LLARY SERVI CE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		10.00
50.00	05000 OPERATING ROOM	15, 171	532, 577	10	138	0	50. 00
51.00	05100 RECOVERY ROOM	2, 859	148, 996	0	39	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	32	0	0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	650	46, 411	0	12	0	
54. 01	03630 ULTRA SOUND	3	0	0	0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
56. 00 57. 00	05600	0	0	0	0	0	
58. 00	05800 MRI		0	0	0	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	59.00
60. 00	06000 LABORATORY	313	0	0	Ö	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	ō	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	0	o	0	62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	48	0	0	0	0	65. 00
	06600 PHYSI CAL THERAPY	4, 150	297, 258	0	77	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY	31	0	0	U O	0	
	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	31	0	0	0	0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	689	0	0	0	0	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	13, 165	0	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	658	0	0	Ö	0	1
74. 00	07400 RENAL DIALYSIS	0	0	0	ol	0	74. 00
	07500 ASC (NON-DISTINCT PART)	o	0	0	ol	0	1
	OUTPATIENT SERVICE COST CENTERS	-1	-,		-,		1
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o	0	89. 00
	09000 CLI NI C	0	0	0	o	0	
91. 00	09100 EMERGENCY	0	0	0	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	1 51	51		- I		04.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 96. 00	09500  AMBULANCE SERVI CES   09600  DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	
96. 00 97. 00	09700 DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	1
98. 00	09850 OTHER REIMBURSABLE COSTS		0	0	ol Ol	0	
	, , ,	, 9	<u> </u>	<u> </u>	<u> </u>		

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

					5/31/2022 11:00 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10. 00
99. 00  09900  CMHC	0	0	0	0	0 99.00
99. 10  09910  CORF	0	0	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	48, 943	1, 367, 215	48	355	179 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 979	510, 481	0	133	0 192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194. 00 07950 SPORTS MEDICINE	3, 018	0	0	0	0 194. 00
194. 01 07951 SENI OR CIRCLE	0	0	0	0	0 194. 01
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	53, 940	1, 877, 696	48	488	179 202. 00
	•	•	•		•

Provider CCN: 15-0168

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/31/2022 | 11:00 am

				10	12/31/2021	5/31/2022 11:	
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL	ADMI NI STRATI ON			RECORDS &	
		12. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS	12.00	13.00	14.00	15.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0					12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	11, 011				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	582, 092			14. 00
15. 00	01500 PHARMACY	0	0	623	4, 164		15. 00
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	844	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	01850 OTHER GENERAL SERVICES	0	0	0	0	0	18.00
19. 00	01900   NONPHYSICIAN ANESTHETISTS   02000   NURSING PROGRAM	0	0	0	U O	0	19.00
20. 00 21. 00		0	0	0	O O	0	20. 00 21. 00
22. 00	02100   I &R SERVICES-SALARY & FRINGES APPRV   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	23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		O O	<u> </u>	<u> </u>	0	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	0	3, 584	4, 543	ol	13	30. 00
31. 00	03100   NTENSI VE CARE UNIT	0	0,001	1, 510	o	0	31. 00
32. 00	03200 CORONARY CARE UNIT	0	Ö	Ö	Ö	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	o	Ö	o	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43.00	04300 NURSERY	0	0	О	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	4, 505	198, 921	0	266	50. 00
51. 00	05100 RECOVERY ROOM	0	2, 891	0	0	52	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	821	0	23	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	22	0	0	17	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	O O	0	55.00
56. 00 57. 00	05600	0	0	0	O O	0	56. 00 57. 00
58. 00	05800 MRI	0	0	0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60.00	06000 LABORATORY	0	5	1, 842	0	12	60.00
	06001 BLOOD LABORATORY	0	O.	1, 012	0	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				Ĭ	Ü	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	o	o	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	O	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	0	О	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	2, 600	O	37	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	4	0	0	2	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	. 0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14, 360	O -	46	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	341, 481	0	337	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	16, 899	4, 164	38	73.00
74. 00	07400 RENAL DI ALYSI S	0	0	0	U O	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	U <sub>I</sub>	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	٥	ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89. 00
90.00	09000 CLINIC		0		0	0	90.00
91. 00	09100 EMERGENCY		n		ol Ol	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				٩	O	92. 00
00	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	ol	0	94. 00
95.00	09500 AMBULANCE SERVICES	0	0	o	o	0	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	О	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	o	0	97. 00
-					·		

| Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

			То	12/31/2021	Date/Time Prepare   5/31/2022 11:00 a	
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	PERSONNEL	ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	12.00	13.00	14. 00	15. 00	16.00	
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0	0	0	0 98	3. 00
99. 00 09900 CMHC	0	0	O	o	0 99	9. 00
99. 10   09910   CORF	0	0	0	0	0 99	9. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100	). 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101	. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105	
106.00 10600 HEART ACQUISITION	0	0	0	0	0 106	
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107	
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108	
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110	
111.00 11100 SLET ACQUISITION	0	0	0	0	0 111	
113.00 11300 I NTEREST EXPENSE						3. 00
114.00 11400 UTILIZATION REVIEW-SNF					114	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115	
116. 00 11600 HOSPI CE	0	0	0	0	0 116	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	11, 011	582, 090	4, 164	844 118	ł. 00
NONREI MBURSABLE COST CENTERS	_	T		_1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190	
191. 00 19100 RESEARCH	0	0	0	0	0 191	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	2	0	0 192	
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0 193	
194. 00 07950 SPORTS MEDICINE	0	0	0	0	0 194	
194. 01 07951 SENI OR CI RCLE	0	0	0	O	0 194	
200.00 Cross Foot Adjustments						0.00
201.00 Negative Cost Centers		11 011	E02 002	4 4 4	0 201	
202.00   TOTAL (sum lines 118 through 201)	1	11, 011	582, 092	4, 164	844   202	00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Prepa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

COST CENTER   DESCRIPTION							10 12/31/202	1   Date/lime Pre   5/31/2022 11:	
Case   Center   Description					OTHER GENERAL				
						-			
CAMPRION   19.00   19.00   20.00   21.00   2		Cost Center Description	SOCI AL	SERVI CE	S				
17.00   18.00   19.00   20.00   21.00   20.00   21.00   20.0						ANLSTILLITSTS	FROGRAM		
1.00			17.	00	18. 00	19.00	20.00		
2 00 00000 CAR PEL DOSTS-WARLE EQUIP   2 00 00000 CAR PEL DOSTS-WARLE EQUIP   4 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HAVE START HE & GENERAL   5 00 00000 CARD HAVE START HAVE STAR			T						
4.00   00-000   PARLY ONE SERENT IS DEPARTMENT		+ I							1
0,000   0,000   ADMIN INTERATIVE & CEREBAL		+ I							1
7.00   DOTORD (DIFFACTION OF PLANTS)   7.00   9.00		1 1							ı
9.00 10.000   10.000   10.000   10.000   11.000   10.000   11.000   10.000   11.000   10.000   11.000   10.000   11.000   10.000   11.000									ı
10.00   10000   ETARY	8.00	00800 LAUNDRY & LINEN SERVICE							8. 00
12.00   12.00   MAINTENINGE OF PERSONNEL   12.00   13.00   1		1 1							1
13.00   01300   NURSING ADMINISTRATION     14.00   1									1
14.00   01400  CHITARA SERVICES & SURPLY   15.00   10500  PARAMEY   16.00   10500  PARAMEY   17.00   10700  PARAMEY   17.00   17									1
15.00   01500   PHASMACY   15.00   16.00   17.									1
17.00   1700   SCYLAL SERVICE   0   17.00   19.00		1							
18.00     18.00     18.00       18.00	16.00	01600 MEDICAL RECORDS & LIBRARY							16. 00
19.00   01900   NOMPHYSICI AN AMESTHEIT ISTS   0   0   0   20.00   20.				0					1
20.00   2000   MURSIND PROGRAM   0   0   0   22.00   27.00				0		0			1
21.00   2020   IAS SERVICES-SALARY & FRINGES APPRV   0   0   22.00   22.00   22.00   22.00   1AS SERVICES-OTHER PRICE OSTS APPRV   0   0   22.00   22.00   23.00   IAS SERVICES-OTHER PRICE OSTS APPRV   0   0   0   22.00   IAS SERVICES COST CENTERS				0			-		1
22.00   0200   IAR SERVICES-OTHER PROM COSTS APPRV   0   0   22.00   23.00   230.0				0			'	-	1
0   02300   PARAMED ED PRICAI   0   0   0   0   0   0   0   0   0		1		0		~			1
30.00   3000   ADULTS & PEDIATRICS   0   0   33.00   30.00   30.00   31.00		1		0		0			1
31.00		INPATIENT ROUTINE SERVICE COST CENTERS							
32.00   33200 CORROMARY CARE UNIT   0 0 0   33.00		+ I		0		-			1
33.00     33.00   33.00   33.00   33.00   33.00   33.00   33.00   33.00   33.00   33.00   34.00   33.00   34				0		1			1
34. 00   03400 SURGICAL INTENSIVE CARE UNIT   0   0   40. 00   40. 00   40. 00   40. 00   40. 00   40. 00   40. 00   40. 00   40. 00   41. 00   4		1		0		~			1
40.00   04000 SUBPROVIDER - IPF   0 0 0		†		0					ı
1.1 0.0   0.410.0 SUBPROVIDER - I IRF		1 1		0					1
44. 0.0   0.4400   SKI LLED NURSI NG FACI LITY		+ I		0		o			1
45.00 (04500   OHSPI NOR TERM CARE	43.00	04300 NURSERY		0		0			43. 00
A6. 00				0		0			1
ANCI LLARY SERVICE COST CENTERS		1		0					1
50.00     05000     05000     05000     0   0	46. 00			U		0			46.00
51.00   05100   RECOVERY ROOM   51.00   52.00   53.00   54.00   54.00   54.00   54.00   54.00   54.00   55.00   54.00   55.00   54.00   55.0	50 00		I	0		ol			50.00
53.00   05300   ANESTHESI OLOGY   0 0 0   54.00				0					1
54. 00   05400   RADI OLOGY-DIAGNOSTI C   0   0   0   0   54. 00   54. 00   54. 00   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0	52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0			52. 00
54. 01   03630   ULTRA SOUND   54. 01   55. 00   55. 00   55. 00   55. 00   55. 00   55. 00   55. 00   55. 00   55. 00   55. 00   55. 00   55. 00   56. 00				0		0			1
55. 00   05500   RADI OLOGY-THERAPEUTI C				0		0			1
56. 00   05600   RADI OI SOTOPE   0 0 0 0 0 0 57. 00 57.00   57. 00 57.00   57. 00 57.00   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   59.0				0					1
57. 00   05700   0T SCAN   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0					1
58. 00   05900   ORP   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0				0					1
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0	58.00	1		0		0			58. 00
60. 01				0		0			59. 00
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY   61. 00   62.00   40.00   60.00   40.00   80.000   80.000   80.000   80.000   50.0000   50.000   50.000   50.000   50.000   50.000   50.000   50.0000   50.000   50.000   50.000   50.000   50.000   50.000   50.0000   50.000   50.000   50.000   50.000   50.000   50.000   50.0000   50.000   50.000   50.000   50.000   50.000   50.000   50.0000   50.000   50.000   50.00000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.0000   50.00000   50.00000   50.00000   50.0000   50.0000   50.00000   50.00000   50.00000   50.000000   50.00000		1		0	'	0			
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   62. 00   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   65. 00   06500   RESPIRATORY THERAPY   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   67. 00   06600   PHYSI CAL THERAPY   0   0   0   68. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   06600   PHYSI CAL THERAPY   0   0   0   69. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   71. 00   07400   RENAL DI ALYSI S   0   0   71. 00   07500   ASC (NON-DI STI NCT PART)   0   0   71. 00   07500   ASC (NON-DI STI NCT PART   0   0   72. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   73. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   74. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   75. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   75. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   75. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   75. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   75. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   76. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   77. 00   07600   DRUGS CHARGED TO PATI ENT   0   0   77. 00   07600   DRUGS CHARGED TO PAT		1		0	'	O			
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0				0					
64. 00   664. 00   664. 00   664. 00   665. 00   665. 00   665. 00   665. 00   666. 00   666. 00   666. 00   666. 00   666. 00   666. 00   666. 00   667. 00   667. 00   667. 00   668. 00   667. 00   668. 00   669. 00		1 1		0		o o			1
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0		О			
67. 00	65.00	1		0		0			
68. 00		1 1		0		0			
69. 00				0	'	D			
70. 00				0					
71. 00				0					
72. 00				0		Ö			1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 74.00 07400 RENAL DIALYSIS 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	1	0		О			
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73. 00	07300 DRUGS CHARGED TO PATIENTS		0		0			73. 00
SERVICE COST CENTERS				0		0			
88. 00	75. 00			0		DI			75.00
89. 00	go 00			0		nl			88 00
90. 00				0					1
91. 00				0		ol			
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   92. 00   0THER REIMBURSABLE COST CENTERS   94. 00   09400   HOME PROGRAM DI ALYSI S   0   0   94. 00			1	Ö		o			
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00		09200 OBSERVATION BEDS (NON-DISTINCT PART							1
95. UU  U950U AMBULANCE SEKVICES   U    95. 00		1		_		1			1
	95.00	IOADOOI WINDOTHINGE DEKALCED	1	U		Ч		I	J 95. UU

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

				10 12/31/2021	5/31/2022 11:	pared: OO am
		OTHER GENERAL			INTERNS &	00 4
		SERVI CE			RESI DENTS	
Cost Center Description	SOCIAL SERVICE		NONPHYSICIAN	NURSI NG	SERVI CES-SALAR	
'			ANESTHETI STS	PROGRAM	Y & FRINGES	
					APPRV	
	17. 00	18. 00	19.00	20.00	21.00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0				98. 00
99. 00 09900 CMHC	0	0				99. 00
99. 10 09910 CORF	0	0				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0				100. 00
101.00 10100 HOME HEALTH AGENCY	0	0				101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0				105. 00
106.00 10600 HEART ACQUISITION	0	0				106. 00
107.00 10700 LIVER ACQUISITION	0	0				107. 00
108.00 10800 LUNG ACQUISITION	0	0				108. 00
109.00 10900 PANCREAS ACQUISITION	0	0				109. 00
110.00 11000 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			l .	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0			l .	192. 00
193.00 19300 NONPALD WORKERS	0	0			1	193. 00
194. 00 07950 SPORTS MEDICINE	0	0				194. 00
194. 01 07951 SENI OR CI RCLE	0	0				194. 01
200.00 Cross Foot Adjustments				0 0		200. 00
201.00 Negative Cost Centers	0	0		0		201. 00
202.00   TOTAL (sum lines 118 through 201)	0	0		0 0	0	202. 00

	n Financial Systems L ATION OF CAPITAL RELATED COSTS	UTHERAN MUSCULOS	Provi der CC	CN: 15-0168	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/31/2022 11:	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	OO alli
		22. 00	23. 00	24. 00	25. 00	26. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 12.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	O	0				1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 12.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	1			1, 437, 12		1, 437, 123	1
31.00					0 0	0	
32. 00 33. 00						0	
34. 00					o o	0	
40.00					0 0	0	
41. 00					0 0	0	
43.00	1				0 0	0	
44. 00	1			•	0 0	0	
45. 00 46. 00	1			•	0 0	0	
.0.00	ANCI LLARY SERVICE COST CENTERS				<u> </u>		1
50.00	1			3, 343, 09		3, 343, 092	1
51.00	1			886, 04		886, 044	1
52.00	1 1				0 0	0	
53. 00 54. 00	1 1			87 271, 52		876 271, 523	
54. 00				1	3 0	271, 323	
55. 00				l	0 0	0	1
56. 00					0 0	0	
57. 00	1				0 0	0	
58. 00 59. 00	1				0	0	
60.00	1			2, 22	1 0	2, 221	
60. 01				_,	0 0	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	1				0 0	0	1
63.00					0 0	0	
64. 00 65. 00				21	0	0 214	
66. 00				1, 751, 87		1, 751, 876	
67. 00				1, ,51, 57	o ol	1, 731, 878	1
68. 00					o o	0	1
69. 00	1			12	5 0	125	
70.00	1				0 0	0	
71. 00 72. 00	1			15, 09 354, 98		15, 095 354, 983	1
73. 00				21, 75		21, 759	1
74. 00	1			ı	o o	0	1
75. 00	07500 ASC (NON-DISTINCT PART)				0 0	0	75. 00
0	OUTPATIENT SERVICE COST CENTERS						
88. 00				•	0 0	0	
89. 00 90. 00	1			•	0 0	0	
91.00	1					0	
		1		I		· ·	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00

Health Financial Systems LL	JTHERAN MUSCULOS	SKELETAL CENTE	R	In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0168	Peri od:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narodi
				10 12/31/2021	5/31/2022 11:	oo am
	INTERNS &				7 07 0 17 2022 111	
	RESI DENTS					
Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
	PRGM COSTS	PRGM		Residents Cost		
	APPRV			& Post		
				Stepdown Adjustments		
	22.00	23. 00	24.00	25. 00	26.00	
OTHER REIMBURSABLE COST CENTERS	22.00	23.00	24.00	25.00	20.00	
94. 00 09400 HOME PROGRAM DIALYSIS				0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES				0 0	Ö	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED				0 0	Ö	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD				0 0	Ö	
98.00 09850 OTHER REIMBURSABLE COSTS				0 0	0	98. 00
99. 00 09900 CMHC				0 0	0	99. 00
99. 10   09910   CORF				0 0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				0 0		100.00
101.00 10100 HOME HEALTH AGENCY				0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON				0 0		105.00
106. 00 10600 HEART ACQUISITION				0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON				0		107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION				0		108. 00 109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON				0		1109.00
111. 00 11100   SLET ACQUISITION				0 0		111.00
113. 00 11300   NTEREST EXPENSE					l	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				0 0	0	115. 00
116. 00 11600 HOSPI CE				0 0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	o	C	8, 084, 9	34 0	8, 084, 934	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0 0		190. 00
191. 00 19100 RESEARCH				0 0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES			2, 941, 5	69 0	2, 941, 569	
193. 00 19300 NONPALD WORKERS				0		193. 00
194. 00 07950 SPORTS MEDICINE			34, 5	74 0		194. 00
194. 01 07951 SENI OR CI RCLE			,	0		194. 01
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	C		0 0		200. 00 201. 00
202.00   TOTAL (sum lines 118 through 201)		C	1	٥		
202. 00   TOTAL (Suil Titles TTO till ough 201)	١		11,001,0	,,,	11,001,077	1202.00

LUTHERAN MUSCULOSKELETAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 164 539 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 164, 539 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3,764 3, 764 21, 207, 605 4.00 66, 615, 140 5 00 00500 ADMINISTRATIVE & GENERAL 4, 520, 960 -14, 983, 408 5 00 7.00 00700 OPERATION OF PLANT 27,871 27,871 62, 601 4, 112, 768 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 59, 202 8.00 00900 HOUSEKEEPI NG 5, 107 527, 343 9.00 9.00 0 0 0 01000 DI ETARY 0 220, 743 10 00 10 00 C C 12.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 01300 NURSING ADMINISTRATION 0 850, 204 1, 070, 557 13.00 0 13.00 01400 CENTRAL SERVICES & SUPPLY 7,053 554, 747 2, 056, 456 14.00 7.053 14.00 266, 949 15.00 01500 PHARMACY 0 439, 089 15 00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 28, 952 616, 114 16.00 C 01700 SOCIAL SERVICE 0 17.00 17.00 0 01850 OTHER GENERAL SERVICES 0 0 18.00 0 0 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 19 00 02000 NURSING PROGRAM 0 0 0 20.00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22, 00 C 0 23.00 02300 PARAMED ED PRGM 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17, 152 17, 152 2, 475, 716 4, 692, 253 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT C 0 34.00 0 0 40.00 04000 SUBPROVI DER - I PF C 0 0 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 41.00 0 0 43.00 04300 NURSERY 0 0 0 43.00 0 04400 SKILLED NURSING FACILITY 0 44 00 C Λ 44 00 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 4, 810, 885 05000 OPERATING ROOM 37.696 37, 696 0 18, 751, 758 50.00 51.00 05100 RECOVERY ROOM 10,546 10, 546 1,865,367 0 3, 530, 197 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 39, 473 53 00 05300 ANESTHESI OLOGY 0 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 285 3, 285 299, 927 802, 977 54.00 54.01 03630 ULTRA SOUND o 3, 302 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 0 05600 RADI OI SOTOPE 0 56 00 0 0 56 00 57.00 05700 CT SCAN 0 0 0 57.00 05800 MRI 0 0 58.00 0 58.00 0 0 59.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 60.00 06000 LABORATORY 4.068 386, 921 60 00 60.01 06001 BLOOD LABORATORY 0 o 60.01 C 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS 0 63.00 0 0 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0 64.00 0 06500 RESPIRATORY THERAPY 65.00 13,829 58,838 65.00 06600 PHYSI CAL THERAPY 21,040 21,040 2, 795, 000 66.00 5, 123, 529 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 C 68.00 0 0 06900 ELECTROCARDI OLOGY 69.00 7, 337 38, 623 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 C 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 851, 163 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0 16, 252, 775 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 812, 629 73.00 0 0 74.00 07400 RENAL DIALYSIS C 0 74.00 Λ 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 C 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 0 0 91.00 91.00 0 92.00 |09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

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

			To	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/31/2022 11:	
	CAPITAL REL	ATED COSTS			070172022 11.	OO diii
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
			SALARI ES)			
OTHER REIMBURSABLE COST CENTERS	1.00	2. 00	4. 00	5A	5. 00	
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	ol	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0	-		0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	0	- 1	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	97.00
98. 00 09850 OTHER REIMBURSABLE COSTS		0	0	0	0	98.00
99. 00   09900   CMHC		0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM		0	0	0	-	100.00
101. 00 10100 HOME HEALTH AGENCY		0	0	-		101.00
SPECIAL PURPOSE COST CENTERS		J	<u> </u>	<u> </u>		101.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	O	0	105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	-		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	Ö	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	O		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. F	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 throu	ıgh 117) 128, 407	128, 407	18, 561, 649	-14, 983, 408	60, 446, 710	118. 00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CAN	ITEEN O	0	-			190. 00
191. 00 19100 RESEARCH	0	0	0	-1		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	36, 132	36, 132	1, 051	0	2, 442, 601	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 SPORTS MEDICINE	0	0	2, 644, 905	0	3, 725, 829	
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	D 4 000 704	( 054 004	0.040.404		4.4.000.400	201. 00
202.00 Cost to be allocated (per Wkst.	B, 4, 209, 786	6, 851, 291	3, 943, 484		14, 983, 408	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B,	Part I) 25. 585338	41. 639313	0. 185947		0. 224925	202 00
204.00 Cost to be allocated (per Wkst. B,		41.039313	253, 033			203.00
Part II)	Ь,		200, 000		33, 940	204.00
205.00 Unit cost multiplier (Wkst. B,	Part		0. 011931		0. 000810	205. 00
206.00 NAHE adjustment amount to be al (per Wkst. B-2)	located					206. 00
207.00 NAHE unit cost multiplier (Wkst	D,					207. 00
Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0168 | Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

				Ť	o 12/31/2021	Date/Time Pre 5/31/2022 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	MAINTENANCE OF	00 4
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	PERSONNEL (NUMBER	
			LAUNDRY)		10.00	HOUSED)	
	GENERAL SERVICE COST CENTERS	7. 00	8.00	9. 00	10. 00	12.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					-	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	132, 904					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	84, 080	1			8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	0	132, 904 0			9. 00 10. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0		0		i .	12. 00
13. 00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	7, 053	0	7, 053 0		0	14.00
16. 00	01600 MEDICAL RECORDS & LIBRARY			0		1	15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	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 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM			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	I	1	22. 00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	) 0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	17, 152	67, 286	17, 152	20, 061	0	30. 00
31.00	03100   NTENSI VE CARE UNI T	0	0	1		1	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 SURGICAL INTENSIVE CARE UNIT	0	Ö	ő	Ö	o o	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0	0	0	0	41. 00 43. 00
44. 00	04400 SKI LLED NURSING FACILITY	0		0	0		44. 00
45. 00	04500 NURSING FACILITY	0	0	0		1	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50. 00	05000 OPERATING ROOM	37, 696	16, 794	37, 696	0	0	50. 00
51.00	05100 RECOVERY ROOM	10, 546	0			1	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0		0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 285	Ö	3, 285	_	1	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	0	0	0	0	0	55. 00 56. 00
57. 00	05700 CT SCAN	0	0	ő	Ö	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00 60. 00
60. 01	06000 LABORATORY  06001 BL00D LABORATORY	0		Ö	0	1	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY			0			64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	21, 040	0	21, 040	0	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY			0			67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS			0			71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	Ō	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0		0	74.00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0			1	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0	89. 00 90. 00
90.00	09100 EMERGENCY	0	0	0	0	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
94 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		l 0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0	0			1	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00

| Peri od: | Worksheet B-1 | To | 12/31/2021 | Date/Time | Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168

			T	o 12/31/2021	Date/Time Pre 5/31/2022 11:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	MAINTENANCE OF	oo aiii
	PLANT	LINEN SERVICE		(MEALS SERVED)		
	(SQUARE FEET)	(POUNDS OF		· ·	(NUMBER	
		LAUNDRY)			HOUSED)	
	7. 00	8. 00	9. 00	10.00	12.00	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	ľ	1	0	0	
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0	0	0	0	
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 SERVI CES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	U	0	101. 00
SPECIAL PURPOSE COST CENTERS  105. 00 10500 KI DNEY ACQUI SI TI ON		0	0	0	0	105 00
106. 00 10600 HEART ACQUISITION	0	0		0	l e	105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		108.00
108. 00 10800 LUNG ACQUISITION		0	0	0		107.00
109. 00 10900 PANCREAS ACQUISITION		0	0	0	<b>l</b>	109.00
110. 00 11000   NTESTI NAL ACQUI SI TI ON		0	0	0		110.00
111. 00 11100   SLET ACQUISITION		0	0	0		111.00
113. 00 11300   NTEREST EXPENSE		Ĭ	Ĭ	J	Ĭ	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)	96, 772	84, 080	96, 772	20, 061	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	36, 132	0	36, 132	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 SPORTS MEDICINE	0	0	0	0		194. 00
194. 01 07951 SENI OR CI RCLE	0	0	0	0	0	194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers					_	201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	5, 037, 832	72, 518	645, 956	270, 394	0	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	37. 905797	0. 862488	4. 860320	13. 478590	0.000000	203. 00
204.00 Cost to be allocated (per Wkst. B,	1, 877, 696	48	488	179	0	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	14. 128213	0. 000571	0. 003672	0. 008923	0. 000000	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	I	I	I		I	

	*	LUTHERAN MUSCULUS				eu of Form CMS	
COST	NLLOCATION - STATISTICAL BASIS		Provi der CC	1	Period: From 01/01/2021 Fo 12/31/2021		pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/31/2022 11: SOCI AL SERVI CE	OU am
	oost conten boscii peron	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	SOUTHE SERVICE	
			SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT NRSI NG	(COSTED		(GROSS CHAR		
		HRS) 13.00	REQUI S. ) 14. 00	15. 00	GES) 16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	6, 708, 667					12. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	0, 708, 007	27, 990, 068				14. 00
15. 00	01500 PHARMACY	17	29, 972	812, 62	9		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(	796, 748, 205	l	16. 00
17. 00		0	0	(	0	0	
18. 00 19. 00	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0	(		0	18. 00 19. 00
20. 00	02000 NURSI NG PROGRAM	o	Ö		o o	ő	20. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	(	0	0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	(	0	0	
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	U <sub>I</sub>		0	0	23. 00
30. 00		2, 183, 929	218, 468	(	12, 670, 761	0	30.00
31. 00		0	0		0	0	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	(	0	0	32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	(		0	33. 00 34. 00
	1 1		0	,		0	1
41. 00	04100 SUBPROVI DER - I RF	o	O	(	0	Ō	1
43. 00	04300 NURSERY	0	0	(	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	(	0	0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0 0	0	
10.00	ANCILLARY SERVICE COST CENTERS		91		<u> </u>		10.00
50. 00		2, 744, 155	9, 565, 344		265, 803, 607	l	
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	1, 761, 444	0		52, 439, 489	0	
53. 00	05300 ANESTHESI OLOGY	0	39, 473		23, 368, 207	ı	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	13, 493	0		17, 297, 972	l	1
54. 01	03630 ULTRA SOUND	0	0	(	14, 885	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(	0 0	0	
57.00	05600	0	0	(	0	0	
58. 00	05800 MRI	O	Ö		o o	Ö	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0	0	
60.00		3, 129	88, 590	(	11, 546, 715	0	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	٩	o <sub>l</sub>	(	J U	0	60. 01
62. 00	l l	0	О	(	o	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	О	(	0	0	63. 00
64. 00		0	0	(	0	0	64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	125, 045	(	756, 930 36, 809, 131	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		123, 043		0 30, 607, 131	0	67. 00
68. 00	l l	0	O	(	0	0	68. 00
69. 00	l l	2, 500	0	(	1, 942, 682	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	690, 510	(	0 46, 282, 915	0	70.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	16, 419, 922	(	289, 847, 116	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	o	812, 629	812, 62		l	73. 00
74. 00	07400 RENAL DIALYSIS	0	0		52, 919	l	
75. 00	O7500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	Ö	·	o o	ő	
90. 00	09000 CLI NI C	0	О	(	0	0	90.00
91.00	l l	0	0	(	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0	(	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	o	O		0		95. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & (COSTED RECORDS & SUPPLY REQUIS.) LI BRARY (TIME SPENT) (DIRECT NRSING (GROSS CHAR (COSTED REQUIS.) HRS) GES) 15.00 17.00 13.00 14.00 16.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 0 0 0 0 98. 00 09850 OTHER REIMBURSABLE COSTS 0 98.00 0 99.00 09900 CMHC 0 0 99.00 0 0 99. 10 09910 CORF 0 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 106, 00 107.00 10700 LIVER ACQUISITION 0 0 107, 00 0 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION O 0 110 00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 708, <u>667</u> 118.00 27, 989, 953 812, 629 796, 748, 205 0 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 115 0 193.00 193. 00 19300 NONPALD WORKERS 0 C 0 194.00 194.00 07950 SPORTS MEDICINE 0 0 0 0 194. 01 07951 SENI OR CIRCLE 0 0 0 0 194. 01 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 1, 311, 352 2, 820, 634 540, 874 754, 693 0 202. 00 0. 000000 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 195471 0.100773 0.665585 0.000947 Cost to be allocated (per Wkst. B, 0 204. 00 204.00 11,011 582, 092 4, 164 844 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001641 0.020796 0.005124 0.000001 0.000000 205.00

206.00

207. 00

II)

(per Wkst. B-2)

Parts III and IV)

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

206.00

207.00

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

					10 12/31/2021	Date/lime Pre 5/31/2022 11:	
		OTHER GENERAL			INTERNS &	RESI DENTS	
	Cost Center Description	SERVI CE S	NONPHYSICIAN	NURSI NG	SEDVICES SALAE	SERVI CES-OTHER	
	cost center bescription	(TIME SPENT)	ANESTHETI STS	PROGRAM	Y & FRINGES	PRGM COSTS	
		(112 01.2.11)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
			TIME)	TIME)	(ASSI GNED	(ASSI GNED	
		10.00	10.00	20.00	TI ME)	TIME)	
	GENERAL SERVICE COST CENTERS	18. 00	19. 00	20. 00	21.00	22. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00	OO5OO   ADMINISTRATIVE & GENERAL   OO7OO   OPERATION OF PLANT						5. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10.00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300   NURSI NG ADMI NI STRATI ON   01400   CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE						17. 00
18.00	01850 OTHER GENERAL SERVICES	0					18.00
19. 00 20. 00	01900   NONPHYSI CI AN ANESTHETI STS   02000   NURSI NG PROGRAM	0	0		0		19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0		·			21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	1
23. 00	02300 PARAMED ED PRGM	0					23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			20.00
30. 00 31. 00	03000   ADULTS & PEDI ATRI CS   03100   I NTENSI VE CARE UNI T	0	0				
32. 00	03200 CORONARY CARE UNIT	0	0			1	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	7	
40.00	04000 SUBPROVI DER - I PF	0	0			0	
41. 00 43. 00	04100   SUBPROVI DER - 1 RF   04300   NURSERY	0	0			0	
44. 00	04400 SKILLED NURSING FACILITY	0	Ö			1	1
45.00	04500 NURSING FACILITY	0	0	•	0	1	
46. 00	04600 OTHER LONG TERM CARE	0	0		O C	) 0	46. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS    05000   OPERATI NG ROOM	0	0			0	50.00
51. 00	05100 RECOVERY ROOM	0	0	•		1	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	i	0	0	
54. 00 54. 01	05400   RADI OLOGY-DI AGNOSTI C   03630   ULTRA SOUND	0	0			0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
	05600 RADI OI SOTOPE	0	0		0	0	1
	05700 CT SCAN	0	0	(	0	1	
58. 00 59. 00	05800 MRI	0	0			0	
60.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0	0				
60. 01	06001 BLOOD LABORATORY	0	0			Ö	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1				]	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	1
63. 00 64. 00	06300   BLOOD STORING, PROCESSING & TRANS.   06400   INTRAVENOUS THERAPY	0	0			0	
65. 00	06500 RESPIRATORY THERAPY	0	0			o o	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		o	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68. 00 69. 00	06800   SPEECH   PATHOLOGY   06900   ELECTROCARDI OLOGY	0	0			0	
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0	0				1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		Ö			Ö	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	O C	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	1		0	
74. 00 75. 00	07400  RENAL DI ALYSI S   07500  ASC (NON-DI STI NCT PART)	0	0	1		1	
75.00	OUTPATIENT SERVICE COST CENTERS			1	<i>σ</i> 1	ή υ	75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		) C	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(	0	1	
	09000 CLINIC	0	0	9		0	
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT   PART		0	1		ή	91. 00 92. 00
55	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	•	1	1	•	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0168

Peri od: Worksheet B-1 From 01/01/2021

12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am OTHER GENERAL INTERNS & RESIDENTS SERVI CE NONPHYSI CI AN Cost Center Description NURSI NG SERVI CES-SALAR SERVI CES-OTHER (TIME SPENT) **ANESTHETI STS** PROGRAM Y & FRINGES PRGM COSTS (ASSI GNED (ASSI GNED **APPRV APPRV** (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) 18.00 19. 00 20.00 21.00 22.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94 00 0 94 00 00000 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 Ω 0 98.00 |09850 OTHER REIMBURSABLE COSTS 0 0 0 98.00 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100 00 Ω 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 105. 00 10500 KIDNEY ACQUISITION 0 0 105. 00 000000 106.00 10600 HEART ACQUISITION 0 Ω 0 106, 00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 C 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM\_OF\_LINES\_1 through 117) 118.00 0 0 118.00 NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 0 0 191. 00 19100 RESEARCH 0 0 191.00 0 0 0 0 0 192.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 193. 00 19300 NONPALD WORKERS 0 0 193. 00 C 194.00 07950 SPORTS MEDICINE 0 0 0 194. 00 0 194. 01 07951 SENI OR CIRCLE 0 0 194. 01 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 0 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 0. 000000 203. 00 Cost to be allocated (per Wkst. B, 0 204. 00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 0.000000 205.00 H) 206.00 NAHE adjustment amount to be allocated 206.00 C (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207. 00

Parts III and IV)

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 FMPLOYEE BENEFLTS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17 00 18.00 01850 OTHER GENERAL SERVICES 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 20.00 20 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0000000 31.00 32 00 03200 CORONARY CARE UNIT 32 00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 40.00 41 00 41 00 04300 NURSERY 43.00 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 0 45.00 04500 NURSING FACILITY 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 000000000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 03630 ULTRA SOUND 54.01 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 57.00 05800 MRI 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 00000000000 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 07400 RENAL DIALYSIS 74.00 74.00 75 00 07500 ASC (NON-DISTINCT PART) 75 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLI NI C 90.00 90 00 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94 00 0 95.00 09500 AMBULANCE SERVICES 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00

Health Financial Systems LUTHERAN		LUTHERAN MUSCULOSKELE	TAL CENTER		In Lieu of Form CMS-2552-10	
	COST ALLOCATION - STATISTICAL BASIS	D	rovider CCN: 15-0168	Peri od:	Worksheet R-1	

near th i manci	ai Systems Lu	THERAIN WOOCULOOK	LLLIAL OLIVILIA	THE LIC	u 01 101111 01113-2332-11
COST ALLOCATI	ON - STATISTICAL BASIS		Provider CCN: 15-016		Worksheet B-1
				From 01/01/2021 To 12/31/2021	Date/Time Prepared:
				10 12/31/2021	5/31/2022 11:00 am
C	Cost Center Description	PARAMED ED			
		PRGM			
		(ASSI GNED			
		TI ME)			
07 00 00700 0	URABLE MEDICAL EQUIP-SOLD	23. 00			97.00
	THER REIMBURSABLE COSTS	0			98.00
99. 00 09900 C		0			99.00
99. 10 09910 C		o o			99. 10
	&R SERVICES-NOT APPRVD PRGM	o			100.00
	IOME HEALTH AGENCY	0			101.00
	PURPOSE COST CENTERS	<u>'</u>			
	IDNEY ACQUISITION	0			105. 00
106. 00 10600 H	IEART ACQUISITION	0			106. 00
1 1	IVER ACQUISITION	0			107. 00
	UNG ACQUISITION	0			108.00
	ANCREAS ACQUISITION	0			109. 00
	NTESTI NAL ACQUI SI TI ON	0			110.00
	SLET ACQUISITION	U			111.00
	NTEREST EXPENSE ITILIZATION REVIEW-SNF				113. 00 114. 00
	MBULATORY SURGICAL CENTER (D.P.)	o			115. 00
116. 00 11600 H		0			116. 00
	SUBTOTALS (SUM OF LINES 1 through 117)	o o			118. 00
	MBURSABLE COST CENTERS	<u> </u>			
190. 00 19000 G	IFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
191. 00 19100 R	ESEARCH	0			191. 00
	'HYSICIANS' PRIVATE OFFICES	0			192.00
	IONPAI D WORKERS	0			193. 00
	PORTS MEDICINE	0			194. 00
194. 01 07951 S		0			194. 01
	cross Foot Adjustments				200. 00
1 1	legative Cost Centers	0			201. 00 202. 00
	cost to be allocated (per Wkst. B, Part I)	U			202.00
	Unit cost multiplier (Wkst. B, Part I)	0. 000000			203. 00
1 1	cost to be allocated (per Wkst. B,	0.000000			204. 00
	Part II)				201.00
	Init cost multiplier (Wkst. B, Part	0. 000000			205. 00
	1)				
	AHE adjustment amount to be allocated	0			206. 00
	per Wkst. B-2)				
	AHE unit cost multiplier (Wkst. D,	0. 000000			207. 00
P	arts III and IV)				

To 12/51/200   Description	COMPUT	ATI ON	OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2021	Worksheet C Part I	
This   Will   Society								Date/Time Pre	pared: 00 am
Cost Center Description					Title	e XVIII			1
Part   1,00			Cost Center Description	Total Cost	Therany limit	Total Costs		Total Costs	
NON-LINE SERVICE COST CENTERS			cost center bescription			Total costs		Total Costs	
I					j				
NAMELIENT SOUTHER SERVICE COST CENTERS   7, 270, 519   7, 270, 519   30, 00   3000 ON SERVICE COST CENTERS   7, 270, 519   0   7, 270, 519   30, 00   31, 300   31,					2 00	3 00	4.00	5 00	
31.00   03100   NTENSIVE CARE UNIT   0   0   0   31.00   32.00   03200   DURNI INTENSIVE CARE UNIT   0   0   0   0   32.00   32.00   03200   DURNI INTENSIVE CARE UNIT   0   0   0   0   0   0   0   32.00   03200   DURNI INTENSIVE CARE UNIT   0   0   0   0   0   0   0   41.00   0400   DURNI INTENSIVE CARE UNIT   0   0   0   0   0   0   0   41.00   04100   DURNISHOW CARE INTENSIVE CARE UNIT   0   0   0   0   0   0   0   0   41.00   04100   DURNISHOW CARE INTENSIVE CARE UNIT   0   0   0   0   0   0   0   0   0		I NPAT	IENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
32.00				7, 270, 519		7, 270, 51		7, 270, 519	•
33.00				0			0 0		1
34 00 0 34000 SURRICCAL INTENSIVE CARE UNIT 0 0 0 0 0 4 4 00 0 4 00 0 4 00 0 4 00 0 4 00 0 4 0 0 0 0 0 4 4 0 0 0 4 0 0 0 0 0 0 4 0 0 0 0 0 0 4 0 0 0 0 0 0 0 4 1 0 0 0 0				0				-	1
11 00   01 00 SUBPROVIDER - I RF				o			0 0	0	1
43.00   0.3300   MURSERY   0   0   0   0.43.00   0   0.44.00   0.40   0.40   0.40   0.40   0.40   0.40   0.44.00   0.40   0.45.00   0.50   0.45.00   0.44.00   0.40   0.45.00				0			0 0	_	1
45.00   014500   DIREN LONG TEARL LITY		1	l .	0			0 0	O O	
0   0   0   0   0   0   0   0   0   0				0			0 0	O O	
ARCILLARY SERVICE COST CENTERS 50.00 (05000) GORARTHOR GROWN 51.00 (05100) RECOVERY ROOM 51.00 (05100) RESOVERY ROOM 51.00 (05100) RECOVERY ROOM 51.00 (05100) RECOVERY RO				0		1		-	
50.00   05000   0FRATING ROOM	40.00			<u> </u>			0  0		40.00
52.00   05.0		05000	OPERATING ROOM						
53.00   05.00   ANESTRESIOLOGY   74, 459   74, 459   74, 459   3.00   74, 459   5.00				1		1			
54.00				1					ı
55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   55.00   56.00   56.00   56.00   05.00   RADI OSTOPE   0   0   0   0   56.00   56.00   57.00   6700   CT SCAN   0   0   0   0   57.00   57.00   58.00   58.00   6	54.00	05400	RADI OLOGY-DI AGNOSTI C	1, 143, 092		1, 143, 09	2 0	1, 143, 092	54.00
56.00				4, 059		4, 05	9 0		
57.00   05700   CT SCAN   0   0   0   0   57.00   58.00   59.00   05900   MRI   0   0   0   0   58.00   05900   MRI   0   0   0   0   0   58.00   05900   MRI   0   0   0   0   0   58.00   05900   05900   CARDIAC CATHETERIZATION   0   0   0   0   59.00   0   0   0   0   0   0   0   0   0		1	l e e e e e e e e e e e e e e e e e e e	0				0	•
59,00   05900   ASPOLAC CATHETERIZATION   0   0   0   0   59,00		05700	CT SCAN	0			o o	0	57. 00
60.00				0			0 0	O O	•
60.01				494.423		494. 42	3 0		
62.00		1	l .	0		1			•
63.00   06300   BLODD STORINS, PROCESSING & TRANS.   0   0   0   0   63.00   64.00   06400   INTRAVENDUS THERAPY   72,789   0   72,789   0   72,789   65.00   65.00   06500   RESPIRATORY THERAPY   72,2789   0   72,2789   0   72,2789   66.00   66.00   06600   PMSICALT HERAPY   7,223,197   0   7,223,197   0   7,223,197   0   7,223,197   0   7,223,197   0   7,223,197   0   0   0   0   0   0   0   0   0				0			0 0	0	1
64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   64.00				0				0	
66. 00   06600   PHYSI CAL THERAPY   7, 223, 197   0   7, 223, 197   0   0   0   0   0   0   0   0   0				0			o o	-	1
67. 00   06700   05070				1	C				1
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   68. 0. 00   09. 00				1	C				ı
70. 00   07000   ELECTROENCEPHALDGRAPHY   0   0   0   70. 00   7		06800	SPEECH PATHOLOGY	0	C		0 0	0	1
1.1   0   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   1.156, 026   1.156, 026   0   1.156, 026   71.00   072.00   07200   IMPL DEV. CHARGED TO PATIENTS   21, 837, 764   21, 837, 764   0.21, 837, 764   72.00   07300   07300   DRUGS CHARGED TO PATIENTS   1.654, 080   1.654, 080   0.1654, 080		1	l .	49, 639		49, 63	9 0		
12. 00   07200   MPL   DEV   CHARGED TO PATIENTS   21,837,764   21,837,764   0   21,837,764   0   73.00   07300   DRUGS CHARGED TO PATIENTS   1,654,080   1,654,080   0   1,654,080   73.00   07400   RENAL DIALYSIS   50   50   0   50   74.00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0				1, 156, 026		1, 156, 02	6 0		ł
74.0   07400   RENAL DI IALYSIS   50   50   0   50   74.00	72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21, 837, 764		21, 837, 76	4 0	21, 837, 764	72. 00
75.00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0				1		1			
Name									
89.00   09900   CLINIC   0   0   0   0   0   0   0   0   0		OUTPA	TIENT SERVICE COST CENTERS						
90. 00   09000   CLINI C   0   0   0   0   0   0   0   90. 00   91. 00   09100   BERGENCY   0   0   0   0   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   2, 222, 270   2, 222, 270    92. 00   O9400   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   OURABLE MEDI CAL EQUI P-SOLD   0   0   0   97. 00   98. 00   09850   OTHER REI MBURSABLE COSTS   0   0   0   0   98. 00   99. 00   09900   CMHC   0   0   0   0   0   99. 100   99. 10   09900   CMHC   0   0   0   0   0   99. 100   99. 10   09900   CMHC   0   0   0   0   0   99. 100   99. 10   09910   CORF   0   0   0   0   0   99. 100   100. 00   10000   1ax SERVI CES-NOT APPRVD PRGM   0   0   0   0   100. 00   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   101. 00   105. 00   10500   KI DIVEY ACQUIL SI TI ON   0   0   0   0   105. 00   107. 00   10700   LI VER ACQUIL SI TI ON   0   0   0   0   100. 00   108. 00   10900   PANCREAS ACQUI SI TI ON   0   0   0   100. 00   110. 00   11000   INTESTI NAL ACQUI SI TI ON   0   0   0   111. 00   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   111. 00   113. 00   11500   AMBULATORY SURGICAL CENTER (D. P. )   0   0   115. 00   116. 00   11500   AMBULATORY SURGICAL CENTER (D. P. )   0   0   0   115. 00   116. 00   11600   HOME HEALTH ACTORY SURGICAL CENTER (D. P. )   0   0   0   115. 00   116. 00   11500   11500   0   0   0   0   0   115. 00   116. 00   11500   11500   11500   0   0   0   0   0   0   0   116. 00   11500   11500   0   0   0   0   0   0   0   117. 00   11500   11500   11500   0   0   0   0   0   0   118. 00   11500   11500   11500   0   0   0   0   0   0   119. 00   11600   11500   0   0   0   0   0   0   0   110. 00   11600   11500   0   0   0   0   0   0   0   0   110. 00   11600   11500   0   0   0   0   0   0   0   0   110. 00   11600   11500   0   0   0   0   0   0   0   0   0				0		1			
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   2, 222, 270   2, 222, 270   92. 00   94. 00   OFF REI MBURSABLE COST CENTERS   0				0			0 0	-	
OTHER REIMBURSABLE COST CENTERS   94. 00   00   00   00   00   00   00   00		1	l e e e e e e e e e e e e e e e e e e e	0			-		1
94. 00	92. 00			2, 222, 270		2, 222, 27	0	2, 222, 270	92.00
96. 00	94. 00			0			0 0	0	94. 00
97. 00				0		1			•
98. 00		1	l .	0		1		_	
99. 10				l o		1		-	•
100. 00   10000   1&R SERVI CES-NOT APPRVD PRGM   0   0   100. 00   101. 00   101. 00   101. 00   101. 00   101. 00   101. 00   105. 00   105. 00   105. 00   105. 00   105. 00   106. 0				0			0	-	
101. 00				0		1			
105. 00				0		•			
106. 00 10600 HEART ACQUISITION 0 10700 LIVER ACQUISITION 0 0 107. 00 10700 LIVER ACQUISITION 0 108. 00 108.00 108.00 LUNG ACQUISITION 0 0 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 INTESTINAL ACQUISITION 0 0 0 111. 00 111. 00 INTEREST EXPENSE 111. 00 11400 UTILIZATION REVIEW-SNF 111. 00 11500 AMBULATORY SURGICAL CENTER (D. P. ) 0 0 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00	405.00								
107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108. 00 10800 LUNG ACQUISITION 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 110. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 111. 00 113. 00 11300 INTERST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. ) 0 0 0 116. 00 116. 00 11600 HOSPICE 0 0 0 116. 00		1	l .	1		•			
109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 110. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 111. 00 113. 00 11300 INTERST EXPENSE 1114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. ) 0 0 0 116. 00 116. 00 11600 HOSPICE 0 0 0 116. 00				0		•		0	107. 00
110.00   11000   INTESTINAL ACQUISITION				0		1			
111. 00   11100   I SLET ACQUI SI TI ON				0		1	~		
114. 00	111.00	11100	ISLET ACQUISITION				o l		111. 00
115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. ) 0 0 115. 00 116. 00   116. 00									
116. 00   11600   HOSPI CE 0   116. 00							0		
200.00   Subtotal (see instructions)   74,719,717  0  74,719,717  0  74,719,717	116.00	11600	HOSPI CE	0			ō	0	116. 00
	200.00	)	Subtotal (see instructions)	74, 719, 717	C	74, 719, 71	7  0	74, 719, 717	200. 00

Health Fin	ancial Systems	LUTHERAN MUSCULOS	LUTHERAN MUSCULOSKELETAL CENTER			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der Co		Peri od:	Worksheet C		
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	nared.	
<u> </u>						5/31/2022 11:	00 am	
			Title	XVIII	Hospi tal	PPS		
					Costs			
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs		
		(from Wkst. B,	Adj .		Di sal I owance			
		Part I, col.						
		26)						
		1.00	2.00	3.00	4. 00	5. 00		
201. 00	Less Observation Beds	2, 222, 270		2, 222, 27	0	2, 222, 270	201. 00	
202. 00	Total (see instructions)	72, 497, 447	0	72, 497, 44	7 0	72, 497, 447	202. 00	
		·	•		·	•		

Health Financial Systems

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

		T' 11	20/11/1	10 12/31/2021	5/31/2022 11:	
		Charges	XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Rati o	Inpati ent	
	6. 00	7. 00	8. 00	9. 00	Rati o 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	7, 439, 771		7, 439, 77	1		30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 03200 CORONARY CARE UNIT	0		9			32. 00 33. 00
33.00   03300   BURN INTENSIVE CARE UNIT 34.00   03400   SURGICAL INTENSIVE CARE UNIT						34.00
40. 00   04000   SUBPROVI DER -   PF	o					40. 00
41. 00   04100   SUBPROVI DER - I RF	o					41. 00
43. 00   04300   NURSERY	0					43. 00
44.00   04400   SKILLED NURSING FACILITY 45.00   04500   NURSING FACILITY	0					44. 00 45. 00
46. 00   04600   OTHER LONG TERM CARE						46.00
ANCILLARY SERVICE COST CENTERS	-1					
50. 00 05000 OPERATING ROOM	57, 802, 138	208, 001, 469	1		0. 000000	50. 00
51. 00 05100 RECOVERY ROOM	6, 722, 072	45, 717, 417	1		0.000000	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	0 6, 488, 209	16, 879, 998	23, 368, 20	0.00000	0. 000000 0. 000000	52. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	2, 630, 844	14, 667, 128			0. 000000	54.00
54. 01   03630   ULTRA SOUND	14, 310	575	1		0. 000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0.00000	0. 000000	55. 00
56. 00   05600   RADI OI SOTOPE	0	0	9	0.00000	0.000000	56.00
57. 00   05700   CT   SCAN 58. 00   05800   MRI		0		0. 000000 0. 000000	0. 000000 0. 000000	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0.000000	0. 000000	59.00
60. 00   06000   LABORATORY	5, 023, 825	6, 522, 890	11, 546, 71		0. 000000	60. 00
60. 01   06001   BLOOD   LABORATORY	0	0	)	0. 000000	0. 000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0.000000	0.000000	61.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL 63.00   06300   BLOOD STORING, PROCESSING & TRANS.		0		0. 000000 0. 000000	0. 000000 0. 000000	62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0		0.000000	0. 000000	64.00
65. 00 06500 RESPIRATORY THERAPY	529, 793	227, 137	756, 930		0. 000000	65. 00
66. 00   06600   PHYSI CAL THERAPY	3, 664, 077	33, 145, 054	36, 809, 13		0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0.000000	0.000000	67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	673, 169	1, 269, 513	1, 942, 68	0. 000000 0. 025552	0. 000000 0. 000000	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1,7,12,00	0. 000000	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15, 618, 205	30, 664, 710			0. 000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	143, 107, 584	146, 739, 532	1		0.000000	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	12, 518, 528 52, 919	25, 396, 348 0			0. 000000 0. 000000	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	32, 71	1	0. 000000	75. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	)	1		88. 00
89. 00   08900   FEDERALLY QUALI FI ED HEALTH CENTER 90. 00   09000   CLI NI C	0 0	0		0. 000000	0. 000000	89. 00 90. 00
91. 00   09100   EMERGENCY		0		0.000000	0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	659, 905	4, 571, 085	1		0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0.000000	0.000000	94.00
95. 00   09500   AMBULANCE SERVI CES 96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED	0 0	0		0.00000	0. 000000 0. 000000	95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD		0			0. 000000	97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	o	0	)	0. 000000	0. 000000	98. 00
99. 00 09900 CMHC	0	0				99. 00
99. 10   09910   CORF	0	0	9			99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0 0	0				100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		1	21		101.00
105.00 10500 KIDNEY ACQUISITION	0	0				105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		1		106. 00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0	0				107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION		0				108.00
110. 00 11000 INTESTINAL ACQUISITION	o	0				110.00
111.00 11100 I SLET ACQUI SI TI ON	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	,			114. 00 115. 00
116. 00 11600 HOSPI CE		0		<u> </u>		116.00
200.00 Subtotal (see instructions)	262, 945, 349	533, 802, 856	796, 748, 20	5		200. 00
201.00 Less Observation Beds						201. 00

Health Financial Systems LU	THERAN MUSCULOS	KELETAL CENTER	₹	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2021	Worksheet C Part I	
				To 12/31/2021	Date/Time Pre 5/31/2022 11:	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7.00	8. 00	9. 00	10.00	
202.00 Total (see instructions)	262, 945, 349	533, 802, 856	796, 748, 20	5		202. 00

PSS   Impact   Impa				Title XVIII	Hospi tal	5/31/2022 11: PPS	00 am
Next   1.00		Cost Center Description	PPS Inpatient	THE XVIII	nospi tui	113	
INVALLED   ROUTES   REDIT RESERVE COST CENTERS   30.00   30.00   30.00   40.		p					
30.00   30.000   ARULTS & PERI ATRICES   30.00   30.00   31.		T	11.00				
31.00 (30100) INTERISTIC CARE UNIT (31.00) (30100) INTERISTIC CARE UNIT (32.00) (30100) CORRANAY CARE UNIT (32.00) CORRANA	20.00						
32.00							1
33.00		1 1					1
34.00 0.04005 SURROLAL INTERSIVE CARE UNIT		1 1					1
0.000   0.000   SUBPROVIDER - I   IPF		1 1					1
11.00   01100   SUPPROVIDER - 1 INF		1 1					1
44.00   04.0							1
45.00	43.00	04300 NURSERY					43.00
46.00   Octool Optimar Lord Treat Caper	44.00	04400 SKILLED NURSING FACILITY					44. 00
ARCHILARY SERVICE COST CRITERS   50.00	45.00	04500 NURSING FACILITY					45.00
50.00	46.00						46. 00
51.00							
1.00   1.00		1 1	1				1
1.53.00   0.500   AMESTHESI OLDOY   0.0003186   53.00		1 1	1				1
94.00   09400  RADIOLOSY-DIAGNOSTIC   0.060682   54.00   55.00   05500  RADIOLOSY-THERAPEUTIC   0.000000   0.00000   0.0000  RADIOLOSY-THERAPEUTIC   0.000000   0.00000   0.0000  RADIOLOSY-THERAPEUTIC   0.000000   0.00000   0.0000  LABORATORY   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		1 1	1				1
54.01   03630   ULTRA SOUND   0.272691   54.01   55.00		1 1	1				
55.00			1				1
56. 00   06000   RADIOLSTOTOPE   0.000000   55. 00   55		I I	1				
57.00   05700   CT SCAN   0.000000   55.00   59.00		1	1 1				
58.00   0.5800 MR   0.000000   59.00   59.00   60.00		1 1	1				
59.00   05900  CARDIAC CATHETER IZATION   0.000000   59.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			1				1
0.00   0.0000   0.000ADRATORY   0.000000   0.001   0.001   0.001   0.001   0.001   0.000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		I I	1				1
1.0	60.00		1				1
62.00   06200   NHOLE BLOOD & PACKED RED BLOOD CELL   0.000000   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   63.00   63.00   63.00   63.00   63.00   65.	60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
63.0   06300   06000 STORI NG, PROCESSI NG & TRANS.   0.000000   64.0   06400   018704 NUST THERAPY   0.000000   64.0   06400   018704 NUST THERAPY   0.000000   65.0   06500   0859F RATORY THERAPY   0.996163   65.0   06600   08600   0949S ICAL THERAPY   0.900000   67.0   067.0   06700   000001   000000   067.0   06	61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61. 00
64. 00   0.6400   INTRAVENOUS THERAPY   0.996163   65. 00	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62. 00
65.00   0.6500   RESPI RATORY THERAPY   0.096163   66.00   0.6600   PMYSI CAL THERAPY   0.196234   66.00   0.6700   0.00700   0.00000   0.681   0.000000   68.00   0.6800   0.8900   0.9900		1 1	1				1
66.00   06000   PhYSI CAL THERAPY   0.196234   66.00   67.00   67.00   67.00   67.00   67.00   67.00   67.00   67.00   68.00   06800   SPECCH PATHOLOGY   0.000000   68.00   68.00   0.00000   ELECTROCADE IOLOGY   0.000000   77.00   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		1 1	1				1
67. 00   06700   06700   0620PATIONAL THERAPY   0.000000   68. 00   08. 00   06. 00   06. 00   06. 00   06. 00   06. 00   06. 00   06. 00   06. 00   06. 00   06. 00   06. 00   07. 0		1 1	1				1
68. 00 06800 SPECCH PATHOLOGY 0.000000 68. 00 06900 LECTROCARD IOLOGY 0.025552 69. 00 070. 00 070.00 010. 00 070.00 010. 00 070.		1 1	1				1
69. 00   06900   ELECTROCARDI OLOGY   0. 025552   0. 90 00000   77. 00   07000   ELECTROCARDI CAPHY   0. 000000   77. 00   07100   07100   MEDI CAL. SUPPLIES CHARGED TO PATIENT   0. 024977   77. 00   07200   MPLD. DEV. CHARGED TO PATIENTS   0. 075342   72. 00   73. 00   07300   MPLD. DEV. CHARGED TO PATIENTS   0. 043626   73. 00   73. 00   07300   MPLD. SCHARGED TO PATIENTS   0. 043626   73. 00   73. 00   07400   RENAL DI ALYSI S   0. 000945   74. 00   74. 00   07400   RENAL DI ALYSI S   0. 000945   75. 00   07500   ASC (NON-DI STI NCT PART)   0. 000000   00   00000   00   00000   00   00000   00   00000   00   000000		1 1	1				1
70. 00   07000   CLECTROENCEPHAL DGRAPHY   0. 000000   70. 00   71. 00		1 1	1				1
17.0		l l	1				1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 075342 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 043426 73. 00 74. 00 07400 RENAL DIALYSIS 0. 0.000945 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000  88. 00 08800 RURAL HEALTH CLINIC 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 90. 00 09000 CLINIC 0. 0.000000 90. 00 91. 00 09100 DIALER RELIBERSABLE COST CENTERS  94. 00 09200 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 0900 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINCT PART 0. 424828 92.00 00 09000 DRESERVATION BEDS (NON-DISTINC		1 1	1				1
73. 00 07300   DRUSC CHARGED TO PATIENTS   0. 043626   73. 00   74. 00 07400   PATAL DI ALYSIS   74. 00   75. 00 07500   ASC (NON-DISTINCT PART)   0. 000000   89. 00 07500   ASC (NON-DISTINCT PART)   0. 000000   89. 00 08900   RURAL HEALTH CLINIC   89. 00   89. 00 08900   PEDERALLY QUALIFIED HEALTH CENTER   89. 00   89. 00 0900   0. 00   0. 000000   90. 00   89. 00 09000   CLINIC   90. 000000   91. 00   89. 00 09100   EMERGENCY   0. 000000   91. 00   89. 00 09400   DURKERENCY   0. 000000   92. 00   89. 00 09400   HOME PROGRAM DIALYSIS   0. 000000   94. 00   89. 00 09400   HOME PROGRAM DIALYSIS   0. 000000   95. 00   89. 00 09400   DURBABLE MEDI CAL EQUI P-RENTED   0. 000000   95. 00   89. 00 09500   AMBULANCE SERVI CES   0. 000000   95. 00   89. 00 09500   AMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   89. 00 09500   OMBULANCE SERVI CES   0. 000000   97. 00   80. 00 10000   1 MEST INTIN   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000		I I	1				1
74. 00 07400   RENAL DI ALYSIS   0,000945   74, 00 07500   ASC (NON-DI STINCT PART)   0,000000   75. 00 000000   75. 00 00000000   75. 00 0000000   75. 00 0000000   75. 00 0000000   75. 00 00000000000000000000000000000000		1 1	1				
75. 00   07500   ASC (NON-DISTINCT PART)   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		1 1	1				1
SERVICE COST CENTERS			1				1
89.00   09900   EDERALLY QUALIFIED HEALTH CENTER   0.000000   090.00   090.00   09100   EMERCENCY   0.000000   91.00   09100   EMERCENCY   0.000000   91.00   09200   095ERVATION BEDS (NON-DISTINCT PART   0.424828   92.00   09200   095ERVATION BEDS (NON-DISTINCT PART   0.424828   92.00   09500   MBULANCE SERVICES   0.000000   95.00   09500   MBULANCE SERVICES   0.000000   96.00   095000   09500   09500   09500   09500   09500   09500   095000   09500   09500   09500   09500   0950							
90. 00   09000   CLINIC   0. 0000000   99. 00   99. 00   991. 00   991. 00   991. 00   991. 00   991. 00   992. 00   09500   BERGENCY   0. 0000000   0. 424828   99. 00   99. 00   09400   HOME PROGRAM DI ALYSI S   0. 000000   95. 00   09500   AMBULANCE SERVICES   0. 000000   96. 00   09600   DURABLE MEDICAL EQUI P-RENTED   0. 000000   97. 00   09700   DURABLE MEDICAL EQUI P-SOLD   0. 000000   97. 00   09700   DURABLE MEDICAL EQUI P-SOLD   0. 000000   99. 00   09850   OTHER REI MBURSABLE COSTS   0. 000000   99. 00   09900   CMHC   99. 00   09910   CORF   99. 10   09910   CORF   99. 10   009110   CORF   99. 10   009110   CORF   99. 10   009110   CORF   99. 10   009110   CORF   99. 10   00910   00910   00910   00910   00	88. 00	08800 RURAL HEALTH CLINIC					88. 00
91. 00   09100   EMERGENCY   0.000000   0.424828   92.00   92.00   09200   DISERNATION BEDS (NON-DISTINCT PART   0.424828   92.00   97. 00   09400   HOME PROGRAM DI ALYSIS   0.000000   95.00   98. 00   09500   AMBULANCE SERVI CES   0.000000   95.00   99. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0.000000   97.00   99. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0.000000   97.00   99. 00   09950   OTHER REI MBURSABLE COSTS   0.000000   97.00   99. 00   09950   OTHER REI MBURSABLE COSTS   0.000000   99. 00   99. 00   09900   CMHC   99. 00   99. 10   09910   CORF   99. 10   100. 00   10000   IAR SERVI CES-NOT APPRVD PRGM   100.00   101. 00   10100   HOME HEALTH AGENCY   101.00   105. 00   10500   KI DURY ACQUI SI TI ON   106.00   107. 00   10700   LI VER ACQUI SI TI ON   106.00   108. 00   10800   LI DURY ACQUI SI TI ON   109. 00   110. 00   10900   PANCREAS ACQUI SI TI ON   109. 00   111. 00   11000   INTESTI NAL ACQUI SI TI ON   110.00   111. 00   11100   INTESTI NAL ACQUI SI TI ON   110.00   111. 00   11100   INTESTI NAL ACQUI SI TI ON   111.00   111. 00   11100   INTESTI NAL ACQUI SI TI ON   111.00   111. 00   11100   INTESTI NAL ACQUI SI TI ON   111.00   113. 00   11300   INTERST EXPENSE   113.00   114. 00   11400   INTERST EXPENSE   113.00   115. 00   11500   AMBULATORY SURGI CAL CENTER (D.P.)   116. 00   11600   LUSES Observation Beds   201.00   200. 00   Subtotal (see instructions)   200. 00							
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0. 424828   92. 00   OTHER REIMBURSABLE COST CENTERS   94. 00   94. 00   09400   HOME PROGRAM DI ALYSIS   0. 000000   95. 00   95. 00   09500   AMBULANCE SERVICES   0. 000000   95. 00   96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0. 000000   97. 00   97. 00   09700   DURABLE MEDI CAL EQUI P-SQLD   0. 000000   97. 00   98. 00   09850   OTHER REIMBURSABLE COSTS   0. 000000   97. 00   99. 10   09910   CORF   99. 10   100. 00   10000   LaR SERVICES-NOT APPRVD PRGM   100. 00   101. 00   10100   HOME HEALTH AGENCY   99. 10   105. 00   10500   KIDNEY ACQUISITION   105. 00   106. 00   10600   HEART ACQUISITION   105. 00   107. 00   10700   LIVER ACQUISITION   107. 00   108. 00   10800   LUNG ACQUISITION   109. 00   109. 00   10900   PANCREAS ACQUISITION   109. 00   110. 00   11000   INTESTINAL ACQUISITION   110. 00   111. 00   11100   INTESTINAL ACQUISITION   110. 00   111. 00   1100   INTESTINAL ACQUISITION   110. 00   110. 00   Subtotal (see instructions)   110. 00   110. 00   Subtotal (see instructions)   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   200. 00   20		1	1				
OTHER REIMBURSABLE COST CENTERS   94. 00   9400   HOME PROGRAM DIALYSIS   0.0000000   95. 00   09500   AMBULANCE SERVICES   0.0000000   95. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0.0000000   97. 00   9700   DURABLE MEDI CAL EQUI P-SOLD   0.000000   97. 00   98. 00   09850   OTHER REI MBURSABLE COSTS   0.000000   97. 00   99. 00   09900   CMHC   99. 00   99. 00   09900   CMHC   99. 10   10000   I RR SERVICES-NOT APPRVD PRGM   100. 00   10000   I RR SERVICES-NOT APPRVD PRGM   101. 00   10100   HOME HEALTH AGENCY   101. 00   10500   KI DNEY ACQUI SI TI ON   107. 00   10700   LI VER ACQUI SI TI ON   107. 00   10800   LUNG ACQUI SI TI ON   108. 00   10800   LUNG ACQUI SI TI ON   109. 00   10900   PANCREAS ACQUI SI TI ON   109. 00   10900   PANCREAS ACQUI SI TI ON   109. 00   110. 00   11000   I NTESTI NAL ACQUI SI TI ON   109. 00   110. 00   11000   I NTESTI NAL ACQUI SI TI ON   110. 00   111. 00   11100   I NTEREST EXPENSE   113. 00   114. 00   11400   I NTEREST EXPENSE   113. 00   11500   MBULLATORY SURGI CAL CENTER (D. P. )   115. 00   11500   MBULLATORY SURGI CAL CENTER (D. P. )   115. 00   1000   LESS Observation Beds   200. 00   201. 00			1				
94. 00   99400   HOME PROGRAM DI ALYSIS   0.000000   95. 00   95. 00   96. 00   96. 00   96. 00   96. 00   96. 00   96. 00   96. 00   96. 00   96. 00   96. 00   97. 00   97. 00   97. 00   97. 00   97. 00   97. 00   97. 00   97. 00   98. 00   99500   DURABLE MEDI CAL EQUI P-SOLD   0.000000   97. 00   98. 00   999. 00   88. SERVI CES-NOT APPRVD PRGM   99. 10   100. 00   10100   HOME HEALTH AGENCY   99. 10   101. 00   10500   KI DNEY ACQUI SI TI ON   105. 00   10500   KI DNEY ACQUI SI TI ON   105. 00   10500   LIVER ACQUI SI TI ON   107. 00   10700   LIVER ACQUI SI TI ON   108. 00   10800   LUNG ACQUI SI TI ON   108. 00   10900   PANCREAS ACQUI SI TI ON   109. 00   11000   INTESTI NAL ACQUI SI TI ON   110. 00   11100   INTESTI NAL ACQUI SI TI ON   111. 00   11100   INTEREST EXPENSE   114. 00   11400   LIVI LI ZATI ON REVI EW-SNF   115. 00   115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   115. 00   11600   HOSPI CE   Subtotal (see instructions)   200. 00   200. 00   Subtotal (see instructions)   201. 00   Less Observation Beds   201. 00	92. 00		0. 424828				92. 00
95. 00   09500   AMBULANCE SERVICES   0.000000   96. 00   96. 00   97. 00   09700   DURABLE MEDI CAL EQUI P-RENTED   0.000000   97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0.000000   97. 00   09800   OTHER REI MBURSABLE COSTS   0.000000   98. 00   09900   CMHC   99. 00   99. 10   09910   CORF   99. 10   09910   CORF   99. 10   100. 00   10000   LAR SERVICES-NOT APPRVD PRGM   100. 00   10000   LAR SERVICES-NOT APPRVD PRGM   101. 00   10100   HOME HEALTH AGENCY   101. 00   10500   KI DNEY ACQUI SITI ON   106. 00   10500   KI DNEY ACQUI SITI ON   106. 00   10700   LI VER ACQUI SITI ON   107. 00   10800   LUNG ACQUI SITI ON   109. 00   10900   PANCREAS ACQUI SITI ON   109. 00   110. 00   11100   INTESTI NAL ACQUI SITI ON   110. 00   11100   INTESTI NAL ACQUI SITI ON   111. 00   11300   INTERST EXPENSE   114. 00   11400   UTI LI ZATI ON REVIEW-SNF   115. 00   115. 00   11500   AMBULATORY SURGICAL CENTER (D. P. )   115. 00   116. 00   HOSPI CE   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	04.00		0.000000				04.00
96. 00		i i	1				
97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0.000000   97. 00   98. 00   99800   OTHER REI MBURSABLE COSTS   0.000000   99. 00   99900   CMHC   99. 00   99900   CMHC   99. 10   09910   CORF   99. 10   09910   CORF   100. 00   10000   1&R SERVI CES-NOT APPRVD PRGM   100. 00   10100   HOME HEALTH AGENCY   101. 00   10100   HOME HEALTH AGENCY   101. 00   10500   KI DNEY ACQUI SI TI ON   106. 00   10500   KI DNEY ACQUI SI TI ON   106. 00   10700   LI VER ACQUI SI TI ON   107. 00   10700   LI VER ACQUI SI TI ON   107. 00   10900   PANCREAS ACQUI SI TI ON   109. 00   10900   PANCREAS ACQUI SI TI ON   109. 00   110. 00   11000   INTESTI NAL ACQUI SI TI ON   110. 00   111. 00   INTESTI NAL ACQUI SI TI ON   111. 00   113. 00   11300   INTEREST EXPENSE   113. 00   114. 00   11400   UTI LI ZATI ON REVI EW-SNF   114. 00   11400   HOSPI CE   116. 00   1000   HOSPI CE   116. 00   1000   CES Observati on Beds   200. 00   201. 00   Less Observati on Beds   201. 00		1 1	1				
98.00   09850   OTHER REIMBURSABLE COSTS   0.000000   99.00   09900   CMHC   99.00   99.00   09910   CORF   99.00   09910   CORF   99.10   0000   I&R SERVI CES-NOT APPRVD PRGM   100.00   101.00   10100   HOME HEALTH AGENCY   101.00   001000   I&R SERVI CES-NOT APPRVD PRGM   100.00   101.00   10100   HOME HEALTH AGENCY   101.00   001000   I&R SERVI CES-NOT APPRVD PRGM   105.00   001000   I&R SERVI CES-NOT APPRVD PRGM   100.00   001.00   IO.00   IO.00   HEART ACQUI SITI ON   105.00   105.00   HEART ACQUI SITI ON   106.00   IO.00   IVER ACQUI SITI ON   107.00   107.00   IVER ACQUI SITI ON   108.00   108.00   10800   LUNG ACQUI SITI ON   108.00   10900   PANCREAS ACQUI SITI ON   109.00   10900   PANCREAS ACQUI SITI ON   109.00   101.00   INTESTI NAL ACQUI SITI ON   110.00   110.00   INTESTI NAL ACQUI SITI ON   111.00   111.00   INTEREST EXPENSE   113.00   113.00   INTEREST EXPENSE   113.00   114.00   11400   UTI LI ZATI ON REVI EW-SNF   114.00   115.00   115.00   HOSPI CE   116.00   100.00   HOSPI CE   116.00   100.00   ESS Observati on Beds   201.00   201.00   ESS Observati on Beds   201.00		1 1					
99. 00 99. 10 99. 10 99. 10 100. 00 10000 1 & SR SERVI CES-NOT APPRVD PRGM 101. 00 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 105. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 107. 00 108. 00 109. 00 109. 00 109. 00 109. 00 109. 00 110. 00 110. 00 110. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 115. 00 115. 00 116.		1 1	1				
99. 10 100. 00 100. 00 100. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 10500   KI DNEY ACQUI SI TI ON 106. 00 107. 00 107. 00 108. 00 108. 00 108. 00 109. 00 10900   PANCREAS ACQUI SI TI ON 109. 00 10900   PANCREAS ACQUI SI TI ON 110. 00 111. 00 111. 00 111. 00 11100   INTESTI NAL ACQUI SI TI ON 111. 00 113. 00 113. 00 114. 00 11500   AMBULATORY SURGICAL CENTER (D. P.) 116. 00 116. 00 100. 00 201. 00 201. 00 201. 00 201. 00 202. 00 201. 00 202. 00 20		1 1	0.000000				
100. 00   10000   18R SERVICES-NOT APPRVD PRGM   100. 00   101. 00   10100   HOME   HEALTH   AGENCY   101. 00   SPECI AL PURPOSE COST   CENTERS   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   107. 00   10700   LI VER   ACQUI SI TI ON   108. 00   10800   LUNG   ACQUI SI TI ON   108. 00   10900   PANCREAS   ACQUI SI TI ON   109. 00   109. 00   10900   PANCREAS   ACQUI SI TI ON   109. 00   11000   INTESTI NAL   ACQUI SI TI ON   110. 00   11000   INTESTI NAL   ACQUI SI TI ON   111. 00   113. 00   11300   INTEREST   EXPENSE   113. 00   114. 00   11400   UTI LI ZATI ON   REVI EW-SNF   114. 00   115. 00   115. 00   115. 00   AMBULATORY   SURGI CAL   CENTER   (D. P. )   115. 00   116. 00   Subtotal   (see instructions)   200. 00   201. 00   Less   Observation   Beds   201. 00							
101. 00   10100   HOME   HEALTH   AGENCY   SPECIAL   PURPOSE   COST   CENTERS   105. 00   10500   KI DNEY   ACQUISITION   106. 00   106. 00   10700   LIVER   ACQUISITION   107. 00   10700   LIVER   ACQUISITION   108. 00   10800   LUNG   ACQUISITION   109. 00   10900   PANCREAS   ACQUISITION   109. 00   10900   PANCREAS   ACQUISITION   110. 00   110. 00   11000   INTESTINAL   ACQUISITION   110. 00   111. 00   113. 00   11300   INTEREST   EXPENSE   113. 00   113. 00   11300   INTEREST   EXPENSE   113. 00   11500   AMBULATORY   SURGICAL   CENTER   (D. P. )   115. 00   11500   AMBULATORY   SURGICAL   CENTER   (D. P. )   115. 00   200. 00   Subtotal   (see instructions)   200. 00   201. 00   Less   Observation   Beds   201. 00		1 1					1
SPECIAL PURPOSE COST CENTERS   105. 00   10500   KI DNEY ACQUI SI TI ON   105. 00   106. 00   106. 00   106. 00   106. 00   107. 00   1070   LI VER ACQUI SI TI ON   107. 00   108. 00   10800   LUNG ACQUI SI TI ON   108. 00   109. 00   109. 00   109. 00   109. 00   109. 00   100. 00		1 1					1
106. 00   10600   HEART ACQUISITION   106. 00   107. 00   10700   LIVER ACQUISITION   107. 00   108. 00   10800   LUNG ACQUISITION   108. 00   10900   PANCREAS ACQUISITION   109. 00   110. 00   110. 00   INTESTINAL ACQUISITION   110. 00   111. 00   113. 00   113. 00   113. 00   113. 00   114. 00   114. 00   114. 00   115. 00   115. 00   115. 00   115. 00   115. 00   115. 00   115. 00   116. 00			<b>'</b>				
107. 00   10700   10700   10700   10800   LUNG ACQUISITION   108. 00   109. 00   10900   PANCREAS ACQUISITION   109. 00   110. 00   110. 00   110. 00   111. 00   111. 00   113. 00   113. 00   113. 00   113. 00   114. 00   114. 00   115. 01   115. 00   115. 00   115. 00   115. 00   115. 00   116. 00   116. 00   116. 00   116. 00   116. 00   116. 00   120. 00   Less Observation Beds   201. 00   109. 00   108. 00   109. 00	105.00	10500 KIDNEY ACQUISITION					105. 00
108. 00   10800   LUNG ACQUISITION   108. 00   10900   PANCREAS ACQUISITION   109. 00   110. 00   11000   INTESTINAL ACQUISITION   110. 00   111.	106.00	10600 HEART ACQUISITION					106. 00
109. 00   10900   PANCREAS ACQUISITION   109. 00   110. 00   11000   INTESTINAL ACQUISITION   110. 00   111. 00   111. 00   111. 00   113. 00   113. 00   113. 00   113. 00   114. 00   114. 00   114. 00   115. 00   115. 00   115. 00   115. 00   115. 00   115. 00   116. 00   116. 00   116. 00   1000   Subtotal (see instructions)   Less Observation Beds   201. 00	107.00	10700 LIVER ACQUISITION					107. 00
110. 00	108.00	10800 LUNG ACQUISITION					
111. 00 113.00 113.00 113.00 113.00 114.00 114.00 115.00 115.00 115.00 115.00 115.00 115.00 116.00 1		1 1					
113. 00   11300   11300   11300   11300   11300   11400   11400   11400   11400   115. 00   115. 00   115. 00   115. 00   116. 00   11600   11		1 1					
114. 00		1 1					
115. 00       115.00       AMBULATORY SURGICAL CENTER (D. P.)       115.00         116. 00       116.00       HOSPICE       116.00         200. 00       Subtotal (see instructions)       200.00         201. 00       Less Observation Beds       201.00		1 1					
116. 00       116.00         200. 00       Subtotal (see instructions)         201. 00       Less Observation Beds		1 1					
200. 00       Subtotal (see instructions)       200. 00         201. 00       Less Observation Beds       201. 00							
201.00 Less Observation Beds 201.00							
202.00							
	202.00	Trotal (300 matruotions)	1				1202.00

	ION OF RATIO OF COSTS TO CHARGES	THERAIN MOSCOLOS		CN: 15-0168	Period: From 01/01/2021	Worksheet C Part I	2002 10
					To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared:
		1	Titl	e XIX	Hospi tal	Cost	UU alli
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
	odst center bescription	(from Wkst. B,	Adj .	10141 00313	Di sal I owance	10141 00313	
		Part I, col. 26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	IPATIENT ROUTINE SERVICE COST CENTERS  BOOO ADULTS & PEDIATRICS	7, 270, 519		7, 270, 51	9 0	7, 270, 519	30.00
31. 00 03	3100 INTENSIVE CARE UNIT	0		7,270,01	0	0	1
	3200 CORONARY CARE UNIT 3300 BURN INTENSIVE CARE UNIT	0			0	0	32. 00 33. 00
	3400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34.00
40.00 04	1000 SUBPROVI DER - I PF	0			0	0	40.00
	1100 SUBPROVIDER - IRF 1300 NURSERY	0			0 0	0	
44. 00 04	1400 SKILLED NURSING FACILITY	0			0 0	Ō	44. 00
	500 NURSING FACILITY  600 OTHER LONG TERM CARE	0			0 0 0	0	
AN	ICILLARY SERVICE COST CENTERS					_	10.00
	5000 OPERATING ROOM 5100 RECOVERY ROOM	26, 348, 140 5, 169, 210		26, 348, 14 5, 169, 21			
	5200 DELIVERY ROOM & LABOR ROOM	0			0 0	3, 107, 210	1
	3300 ANESTHESI OLOGY	74, 459		74, 45			
	5400  RADI OLOGY-DI AGNOSTI C 3630  ULTRA SOUND	1, 143, 092 4, 059		1, 143, 09 4, 05		1, 143, 092 4, 059	
55. 00 05	5500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
	5600 RADIOISOTOPE 5700 CT SCAN	0			0	0	56. 00 57. 00
58. 00 05	5800 MRI	0			0 0	ő	58. 00
	5900 CARDI AC CATHETERI ZATI ON 5000 LABORATORY	0 494, 423		494, 42	0	0 494, 423	
	5001 BLOOD LABORATORY	474, 423		474, 42	0 0	474, 423	1
	5100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	
	5200 WHOLE BLOOD & PACKED RED BLOOD CELL 5300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	62. 00 63. 00
64. 00 06	400 INTRAVENOUS THERAPY	0			0	0	64. 00
1	5500  RESPI RATORY THERAPY 5600  PHYSI CAL THERAPY	72, 789 7, 223, 197		72, 78 7, 223, 19		72, 789 7, 223, 197	
67. 00 06	5700 OCCUPATIONAL THERAPY	0	C	1	0 0	0	1
	5800  SPEECH PATHOLOGY 5900  ELECTROCARDI OLOGY	0 49, 639	C	49, 63	0 9 0	0 49, 639	
70. 00 07	7000 ELECTROENCEPHALOGRAPHY	0		47,03	0 0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT 7200 IMPL. DEV. CHARGED TO PATIENTS	1, 156, 026 21, 837, 764		1, 156, 02 21, 837, 76		1, 156, 026 21, 837, 764	
	7300 DRUGS CHARGED TO PATIENTS	1, 654, 080		1, 654, 08		1, 654, 080	
	7400 RENAL DIALYSIS 7500 ASC (NON-DISTINCT PART)	50 0		5		l	
	ITPATIENT SERVICE COST CENTERS	0			0 0	0	75. 00
88. 00 08	8800 RURAL HEALTH CLINIC	0			0	0	
	3900  FEDERALLY QUALIFIED HEALTH CENTER	0		1	0 0	0 0	89. 00 90. 00
	P100 EMERGENCY	0			0	0	
	P200 OBSERVATION BEDS (NON-DISTINCT PART THER REIMBURSABLE COST CENTERS	2, 222, 270		2, 222, 27	0	2, 222, 270	92. 00
94. 00 09	P400 HOME PROGRAM DIALYSIS	0		1	0 0	0	
	P500 AMBULANCE SERVICES P600 DURABLE MEDICAL EQUIP-RENTED	0		•	0 0	0	
	2700 DURABLE MEDICAL EQUIP-SOLD	0		1	0 0	ő	
	0850 OTHER REIMBURSABLE COSTS	0			0	0	
	9910 CORF	0			0	0	1
1	0000 I&R SERVICES-NOT APPRVD PRGM	0		•	0	l e	100.00
	D100 HOME HEALTH AGENCY DECLAL PURPOSE COST CENTERS	0			0	0	101. 00
105. 00 10	0500 KIDNEY ACQUISITION	0		•	0		105.00
	0600 HEART ACQUISITION 0700 LIVER ACQUISITION	0		•	0		106. 00 107. 00
108. 00 10	0800 LUNG ACQUISITION	0			0	0	108. 00
	0900 PANCREAS ACQUISITION 1000 INTESTINAL ACQUISITION	0			0		109. 00 110. 00
111. 00 11	1100 ISLET ACQUISITION	0			Ö	l	111. 00
	300   INTEREST EXPENSE   400   UTILIZATION REVIEW-SNF						113. 00 114. 00
	400 OTTELZATION REVIEW-SNF   500 AMBULATORY SURGICAL CENTER (D. P. )	0			О	0	115. 00
	600 HOSPI CE	0	_	74 710 71	0		116.00
200. 00	Subtotal (see instructions)	74, 719, 717	(	74, 719, 71	7 0	74, 719, 717	<sub>1</sub> 200.00

Health Financial Systems		LUTHERAN MUSCULOS	LUTHERAN MUSCULOSKELETAL CENTER			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der C	Provi der CCN: 15-0168		Worksheet C Part I Date/Time Prepared: 5/31/2022 11:00 am		
			Titl	e XIX	Hospi tal	Cost		
					Costs			
	Cost Center Description	Total Cost (from Wkst. B, Part L, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs		
		26)						
		1. 00	2.00	3.00	4. 00	5. 00		
201.00	Less Observation Beds	2, 222, 270		2, 222, 27	0	2, 222, 270	201. 00	
202.00	Total (see instructions)	72, 497, 447	0	72, 497, 44	7 0	72, 497, 447	202. 00	

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am Health Financial Systems

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

		T: +1	e XIX	U 12/31/2021	5/31/2022 11: Cost	
		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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	7, 439, 771		7, 439, 771			30.00
31. 00   03000 ADDETS & PEDIATRICS	7, 439, 771		7, 439, 771			31.00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	O		c			33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0		C			34.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	0					40. 00 41. 00
43. 00   04300   NURSERY						43.00
44.00 04400 SKILLED NURSING FACILITY	0		C			44. 00
45. 00 04500 NURSING FACILITY	0		C			45. 00
46.00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0					46. 00
50. 00 05000 OPERATING ROOM	57, 802, 138	208, 001, 469	265, 803, 607	0. 099126	0. 000000	50.00
51. 00   05100   RECOVERY ROOM	6, 722, 072	45, 717, 417	1		0.000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0. 000000	0. 000000	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	6, 488, 209	16, 879, 998		0.003186	0. 000000 0. 000000	53. 00 54. 00
54. 00   03400   RADI OLOGI - DI AGNOSTI C 54. 01   03630   ULTRA SOUND	2, 630, 844 14, 310	14, 667, 128 575	1	0. 066082 0. 272691	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0. 000000	0. 000000	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0	C	0. 000000	0.000000	56. 00
57. 00   05700   CT   SCAN 58. 00   05800   MRI	0	0	O	0. 000000 0. 000000	0. 000000 0. 000000	57.00
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON		0		0. 000000	0. 000000	58. 00 59. 00
60. 00   06000   LABORATORY	5, 023, 825	6, 522, 890	11, 546, 715		0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	C		0. 000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL 63. 00   06300   BLOOD STORING, PROCESSING & TRANS.		0		0. 000000 0. 000000	0. 000000 0. 000000	62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0	ď	0. 000000	0. 000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	529, 793	227, 137	756, 930		0. 000000	65. 00
66. 00   06600   PHYSI CAL THERAPY	3, 664, 077	33, 145, 054	1	0. 196234	0. 000000	66. 00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	0	C	0. 000000 0. 000000	0. 000000 0. 000000	67. 00 68. 00
69. 00   06900   ELECTROCARDI OLOGY	673, 169	1, 269, 513	1, 942, 682		0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	o c	0. 000000	0. 000000	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	15, 618, 205	30, 664, 710			0.000000	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	143, 107, 584 12, 518, 528	146, 739, 532 25, 396, 348			0. 000000 0. 000000	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	52, 919	23, 370, 340			0. 000000	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	C	0. 000000	0. 000000	75. 00
OUTPATIENT SERVICE COST CENTERS		0	J	0.000000	0.000000	00.00
88.00   08800   RURAL HEALTH CLINIC 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0 0	0	1		0. 000000 0. 000000	88. 00 89. 00
90. 00   09000   CLI NI C	l o	0	ď		0. 000000	
91. 00   09100   EMERGENCY	0	0	C	0. 000000	0.000000	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	659, 905	4, 571, 085	5, 230, 990	0. 424828	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS  94. 00 09400 HOME PROGRAM DI ALYSI S	l	0	0	0. 000000	0. 000000	94. 00
95. 00 09500 AMBULANCE SERVICES	O	0			0. 000000	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C		0.000000	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0. 000000	97.00
98. 00   09850   OTHER REI MBURSABLE COSTS 99. 00   09900   CMHC		0		0. 000000	0. 000000	98. 00 99. 00
99. 10 09910 CORF		0	ď			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	o c			100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	0			101. 00
SPECIAL PURPOSE COST CENTERS   105.00   10500   KIDNEY ACQUISITION	l	0	0			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0				106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	C			107. 00
108. 00 10800 LUNG ACQUISITION	0	0	C			108.00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION		0				109. 00 110. 00
111.00 11100 I SLET ACQUISITION		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.) 116. 00 11600 HOSPICE	0	0				115. 00 116. 00
200.00 Subtotal (see instructions)	262, 945, 349	533, 802, 856	796, 748, 205			200.00
201.00 Less Observation Beds						201. 00

Health Financial Systems LL	LUTHERAN MUSCULOSKELETAL CENTER			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2021	Worksheet C		
				To 12/31/2021	Part I Date/Time Pre 5/31/2022 11:		
		Ti tl	e XIX	Hospi tal	Cost		
		Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA		
			+ col. 7)	Ratio	I npati ent		
					Ratio		
	6.00	7.00	8. 00	9. 00	10.00		
202.00 Total (see instructions)	262, 945, 349	533, 802, 856	796, 748, 20	5		202. 00	

Cost Center Description  INPATIENT ROUTINE SERVICE COST CENTERS  30.00   03000   ADULTS & PEDIATRICS	PPS Inpati ent Rati o 11.00	Title XIX	Hospi tal	Cost
	11.00			
				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00   03400   SURGI CAL I NTENSI VE CARE UNIT				34.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF				40. 00 41. 00
43. 00   04300   NURSERY				43. 00
44.00 04400 SKILLED NURSING FACILITY				44.00
45.00 04500 NURSING FACILITY				45. 00
46.00 O4600 OTHER LONG TERM CARE				46. 00
ANCI LLARY SERVI CE COST CENTERS				
50. 00   05000   OPERATI NG ROOM	0. 000000			50.00
51. 00   05100   RECOVERY ROOM	0.000000			51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	0. 000000 0. 000000			52. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 000000			54.00
54. 01   03630   ULTRA   SOUND	0. 000000			54. 01
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00   05600 RADI 0I SOTOPE	0. 000000			56. 00
57. 00   05700   CT   SCAN	0. 000000			57. 00
58. 00   05800   MRI	0. 000000			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000 0. 000000			59.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	0. 000000			60. 00 60. 01
61. 00   06100   PBP CLINI CAL LAB SERVI CES-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. 000000			65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0.000000			68.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0. 000000 0. 000000			69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74.00   07400   RENAL DI ALYSI S	0. 000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
OUTPATIENT SERVICE COST CENTERS	0.000000			
88. 00   08800   RURAL HEALTH CLINIC 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0.000000			88. 00   89. 00
90. 00   09000   CLINIC	0. 000000 0. 000000			90.00
91. 00   09100   EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000			94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
97. 00   09700   DURABLE MEDICAL EQUIP-SOLD 98. 00   09850   OTHER REIMBURSABLE COSTS	0. 000000 0. 000000			97. 00 98. 00
98. 00   09850 OTHER REI MBURSABLE COSTS 99. 00   09900 CMHC	0.000000			99.00
99. 10   09910   CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON				105. 00
106. 00 10600 HEART ACQUI SI TI ON				106.00
107. 00 10700 LI VER ACQUI SI TI ON				107. 00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION				108. 00 109. 00
110. 00 11000   NTESTINAL ACQUISITION				110.00
111. 00 11100   SLET ACQUISITION				111.00
113. 00 11300   NTEREST EXPENSE				113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				115. 00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds	1			201. 00 202. 00
202.00   Total (see instructions)	1			J202. UC

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (	2720	Drovi der C	CN: 15-0168	Peri od:	Worksheet D	2552-10
AFFORTIONWENT OF THEATTENT ROUTINE SERVICE CAFTIAL	20313	Frovider C	CN. 13-0100	From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre	
					5/31/2022 11:	<u>00 am</u>
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total_Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos			
	Part II, col.		(col . 1 - co	J		
	26)	0.00	2)	4.00	F 00	
LAIDATI FAIT DOUTLAIF CERVILOF COCT CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4 407 400		1 407 4	00 5 000	0,000	
30. 00 ADULTS & PEDIATRICS	1, 437, 123	C	1, 437, 1		269. 98	
31. 00   INTENSIVE CARE UNIT	0			0 0	0.00	
32. 00 CORONARY CARE UNIT	0			0	0.00	
33. 00 BURN INTENSIVE CARE UNIT	0			0	0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT	0			0	0.00	
40. 00 SUBPROVI DER - I PF	0	C	2	0	0.00	
41. 00 SUBPROVI DER - I RF	0	C	)	0	0.00	
43. 00 NURSERY	0			0	0.00	
44.00 SKILLED NURSING FACILITY	0			0	0.00	
45. 00 NURSING FACILITY	0		4 407 4	0 0	0.00	45. 00
200.00 Total (lines 30 through 199)	1, 437, 123		1, 437, 1	23 5, 323		200. 00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		•				
	6. 00	6) 7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	785	211, 934	il			30.00
31. 00 INTENSIVE CARE UNIT	785	211, 734	1			31.00
32. 00 CORONARY CARE UNIT	0					32.00
33. 00 BURN INTENSIVE CARE UNIT	0					33. 00
34. 00 SURGI CAL INTENSI VE CARE UNI T	0					34. 00
40. 00   SUBPROVI DER -   PF	0					40.00
41. 00 SUBPROVI DER – I RF	0					41.00
43. 00   NURSERY	0					43.00
TO, OU INDICATION	U		(			44. 00
44 OO SKILLED NURSING EACHLITY	Λ					
44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY	0					45.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS  Provider CCN: 15-0168   Period: From 01/01/2021   To 12/31/2021   Date/Time Prepared:	
From 01/01/2021   Part II   To 12/31/2021   Date/Time Prepared:	
	al.
5/31/2022 11:00 am	ມ: m
Title XVIII Hospital PPS	
Cost Center Description Capital Total Charges Ratio of Cost 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)	
50. 00 05000 OPERATI NG ROOM 3, 343, 092 265, 803, 607 0. 012577 11, 597, 076 145, 856 50. 00	00
51. 00   05100   RECOVERY ROOM   886, 044   52, 439, 489   0. 016897   1, 408, 884   23, 806   51. 00	
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   52. 00	
53. 00   05300   ANESTHESI OLOGY   876   23, 368, 207   0. 000037   1, 372, 224   51   53. 00	
54. 00   05400   RADI OLOGY - DI AGNOSTI C 271, 523 17, 297, 972 0. 015697 547, 942 8, 601 54. 00	
54. 01   03630   ULTRA SOUND 3 14, 885 0. 000202 4, 588 1 54. 01	
55. 00   05500 RADI OLOGY-THERAPEUTI C	
56. 00   05600   RADI 0I SOTOPE   0   0. 000000   0   56. 00	
57. 00   05700   CT SCAN   0   0   0. 000000   0   57. 00	
58. 00   05800   MRI   0   0   0,000000   0   58. 00	
59. 00   05900   CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 0 59. 00	
60. 00   06000   LABORATORY   2, 221   11, 546, 715   0. 000192   1, 193, 729   229   60. 00	
60. 01 06001 BLOOD LABORATORY 0 0 0. 000000 0 0 60. 01	
61. 00   06100   PBP   CLI NI CAL   LAB   SERVI CES-PRGM   ONLY   61. 00	
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0. 000000   0   62. 00	
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 0   0, 0000000   0   63. 00	
64. 00   06400   NTRAVENOUS THERAPY   0   0   0. 000000   0   64. 00	
65. 00 06500 RESPI RATORY THERAPY 214 756, 930 0. 000283 135, 080 38 65. 00	
66. 00   06600   PHYSI CAL THERAPY   1, 751, 876   36, 809, 131   0. 047594   828, 213   39, 418   66. 00	
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0. 000000   0   67. 00	00
68. 00   06800   SPEECH PATHOLOGY   0   0   0. 000000   0   68. 00	
69. 00   06900   ELECTROCARDI OLOGY   125   1, 942, 682   0. 000064   149, 218   10   69. 00	00
70. 00   07000   ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0 0 70. 00	00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   15, 095   46, 282, 915   0. 000326   3, 834, 649   1, 250   71. 00	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 354,983 289,847,116 0.001225 32,623,399 39,964 72.00	00
73. 00   07300   DRUGS CHARGED TO PATIENTS   21,759   37,914,876   0.000574   2,590,632   1,487   73.00	00
74. 00   07400   RENAL DI ALYSI S   0   52, 919   0. 000000   18, 704   0   74. 00	00
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0 0 75.00	00
OUTPATIENT SERVICE COST CENTERS	
88. 00   08800   RURAL HEALTH CLINIC   0   0   0. 000000   0   0   88. 00	00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0.000000   0   0   89.00	00
90. 00   09000  CLI NI C   0   0   0. 000000   0   0   90. 00	00
91. 00   09100   EMERGENCY   0   0, 000000   0   0   91. 00	
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   439, 263   5, 230, 990   0. 083973   279, 416   23, 463   92. 00	00
OTHER REIMBURSABLE COST CENTERS	
94. 00   09400   HOME PROGRAM DIALYSIS   0   0, 000000   0   0   94. 00	
95. 00   09500   AMBULANCE   SERVI CES   95. 00	
96. 00   09600  DURABLE MEDI CAL EQUI P-RENTED   0 0 0. 000000 0 0 0 96. 00	
97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0 0 0. 000000 0 0 0 97. 00	
98. 00   09850   OTHER REI MBURSABLE COSTS   0 0 0. 000000 0 0 98. 00	
200.00   Total (lines 50 through 199)   7,087,074   789,308,434     56,583,754   284,174   200.00	00

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

Health Financial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	₹	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	TS Provider Co	CN: 15-0168	Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021		nared.
					5/31/2022 11:	00 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health		
	Program Post-Stepdown	Program	Post-Stepdow		Medical	
	Adj ustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	171	1.00		2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	)	0 0	0	31. 00
32.00 03200 CORONARY CARE UNIT	0	0	)	0 0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	)	0 0	0	33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	1	34. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0	1	0 0	1	40. 00
41. 00   04100   SUBPROVI DER - I RF	0	0		0	1	41. 00
43. 00   04300   NURSERY	0	0	1	0 0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0	)	44. 00
45. 00 04500 NURSING FACILITY	0	0	1	0 0	l .	45. 00
200.00   Total (lines 30 through 199)	0	0	T D .:	0 0		200. 00
Cost Center Description	Swing-Bed	Total Costs (sum of cols.		t Per Diem (col.	Inpatient	
	Adjustment Amount (see	1 through 3,	Days	5 ÷ col. 6)	Program Days	
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 32	0. 00	785	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	)	0.00	0	31.00
32. 00 03200 CORONARY CARE UNIT		0	1	0.00	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	1	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00	1	34. 00
40. 00   04000   SUBPROVI DER -   I PF	0			0.00	1	40. 00
41. 00   04100   SUBPROVI DER -   RF	0	1		0.00		41.00
43. 00   04300   NURSERY		0		0.00	1	43. 00
44. 00   04400   SKILLED NURSING FACILITY		0		0.00	•	44.00
45. 00   04500   NURSI NG FACILITY		0		0.00		
200.00   Total (lines 30 through 199)  Cost Center Description	I npati ent	0	5, 32	23	/85	200. 00
cost denter bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS		T				
30. 00   03000   ADULTS & PEDI ATRI CS	0	l .				30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	l .				31.00
32. 00   03200   CORONARY CARE UNIT	0					32.00
33. 00   03300   BURN INTENSIVE CARE UNIT	0					33.00
34.00   03400   SURGI CAL INTENSIVE CARE UNIT 40.00   04000   SUBPROVI DER - I PF	_					34.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	0					40.00
41. UU IU4IUUI SUDEKUVI DEK - IKE						1 4 I. UU
	0					12 00
43. 00   04300   NURSERY	0	•				43.00
43.00   04300   NURSERY 44.00   04400   SKILLED   NURSING FACILITY	0					44. 00
43. 00   04300   NURSERY	0					1

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2021 | Part IV | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Ti Provider CCN: 15-0168 THROUGH COSTS

					10 12/31/202	5/31/2022 11:	
			Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown	۱	
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	II.	-	0	1
51. 00	05100 RECOVERY ROOM	0	0	)	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0	0	
53. 00	05300 ANESTHESI OLOGY	0	0	)	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0	0	
54. 01	03630 ULTRA SOUND	0	0	)	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	)	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	1	0	0	56. 00
57. 00	05700 CT SCAN	0	0	1	0	0	
58. 00	05800 MRI	0	0	1	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	1
60.00	06000 LABORATORY	0	0	1	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	9	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	2	0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	2	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	2	0	0	
65. 00	06500 RESPI RATORY THERAPY	0	0	1	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	1	0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	1	0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0	0 0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0		(	0	0 0	
72.00	07200   I MPL. DEV. CHARGED TO PATIENTS   07300   DRUGS CHARGED TO PATIENTS	0		1	0		
73.00	07400 RENAL DIALYSIS	0	,	1	0	~) ·	1
74. 00 75. 00	07500 ASC (NON-DISTINCT PART)	0	0	1	-	0 0 0	
75.00	OUTPATIENT SERVICE COST CENTERS	0		′1	U .	<u>oj</u>	75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	1	0	ol o	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		•			
90.00	09000 CLINIC	0		1	0		
91. 00	09100 EMERGENCY	0		1	Ö	ol ö	70.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1	Ö		
72.00	OTHER REIMBURSABLE COST CENTERS			1	<u> </u>		72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0	0 0	94. 00
95. 00	09500 AMBULANCE SERVICES	1					95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		О	ol o	1
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0			О	ol o	
98. 00	09850 OTHER REIMBURSABLE COSTS	0	O		0	0 0	1
200.00	1	0	O		O	0 0	200.00
	, , ,	•	•	•	•	•	•

Health Financial Systems	LUTHERAN MUSCULOSKE	LETAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0168	Peri od:	Worksheet D
			E 04 /04 /0004	

From 01/01/2021 To 12/31/2021 Part IV Date/Time Prepared: THROUGH COSTS 5/31/2022 11:00 am Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 265, 803, 607 0.000000 50.00 00000000000000 05100 RECOVERY ROOM 0 0 52, 439, 489 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 23, 368, 207 53 00 0.000000 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 17, 297, 972 0.000000 54.00 54.01 03630 ULTRA SOUND 14, 885 0.000000 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55 00 05600 RADI OI SOTOPE 56.00 0 0 0.000000 56.00 57.00 05700 CT SCAN 0 0.000000 57.00 0 58.00 05800 MRI 0 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0 0 000000 59 00 59 00 60.00 06000 LABORATORY 0 11, 546, 715 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 62 00 0000000000000 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0.000000 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 756, 930 0.000000 65.00 06600 PHYSI CAL THERAPY 0 0.000000 66.00 36, 809, 131 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 1, 942, 682 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 70.00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 46, 282, 915 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 289, 847, 116 0.000000 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 37, 914, 876 0.000000 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 52, 919 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 88.00 C 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER C 0 0.000000 89.00 0 0 90.00 09000 CLI NI C 0 0 0.000000 90.00 09100 EMERGENCY 0 91.00 0 0.000000 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 5, 230, 990 92.00 0 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0.000000 94.00 95.00 09500 AMBULANCE SERVICES 95 00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0.000000 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 0.000000 97.00 0 98. 00 09850 OTHER REIMBURSABLE COSTS 0 0.000000 98.00 0 789, 308, 434 200.00 Total (lines 50 through 199) 200.00

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

From 01/01/2021 Part IV Date/Time Prepared: THROUGH COSTS 12/31/2021 5/31/2022 11:00 am Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col.  $(col. 6 \div col$ Costs (col. x col. 12) 13.00 7) x col. 10) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 11, 597, 076 33, 294, 416 50.00 0 0 05100 RECOVERY ROOM 51.00 0.000000 1, 408, 884 7, 054, 929 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0.000000 1, 372, 224 0 2, 341, 747 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 547, 942 54.00 1, 869, 107 54.00 0 54.01 03630 ULTRA SOUND 0.000000 4, 588 0 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 o 05600 RADI OI SOTOPE 0.000000 0 56.00 56 00 Ω 0 05700 CT SCAN 0 57.00 0.000000 C 0 57.00 58.00 05800 MRI 0.000000 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0 0 0 59.00 06000 LABORATORY 1, 193, 729 0.000000 O 1, 362, 591 60 00 60 00 0 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62 00 0 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 63.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 0.000000 135,080 49, 506 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 828, 213 316, 921 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0 0 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 149, 218 335, 766 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 70 00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 3, 834, 649 4, 822, 849 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 32, 623, 399 0 33, 450, 013 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 590, 632 0 4, 005, 637 73.00 73.00 0.000000 0 0 07400 RENAL DIALYSIS 0.000000 74.00 18, 704 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 88. 00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89 00 89 00 C 0 0 90.00 09000 CLI NI C 0.000000 0 0 90.00 09100 EMERGENCY 0 91.00 0.000000 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 279, 416 0.000000 0 1, 080, 467 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0.000000 0 0 Λ 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00 98. 00 09850 OTHER REIMBURSABLE COSTS 0.000000 0 98.00 0 0 200.00

56, 583, 754

89, 983, 949

200.00

Total (lines 50 through 199)

APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0168	Peri od:	Worksheet D	
					From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	narod:
					10 12/31/2021	5/31/2022 11:	00 am
-			Title	XVIII	Hospi tal	PPS	
	·			Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
	TANGLE LABOUR DE DOOT DENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.000407	22 224 447	ı		0.000.040	F0 00
50.00	05000 OPERATING ROOM	0. 099126	33, 294, 416		0	-,,	50.00
51.00	05100 RECOVERY ROOM	0. 098575	7, 054, 929		0		1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 003186	2, 341, 747		0 0	.,	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 066082	1, 869, 107		0		54.00
54. 01	03630 ULTRA SOUND	0. 272691	0		0	1	54. 01
55. 00	05500  RADI OLOGY-THERAPEUTI C	0. 000000	0		0	1	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0		56. 00
57. 00	05700 CT SCAN	0. 000000	0		0		57. 00
58. 00	05800  MRI	0. 000000	0	1	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	1	59. 00
60. 00	06000 LABORATORY	0. 042819	1, 362, 591		0	,	60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 096163	49, 506		0	.,	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 196234	316, 921		0	62, 191	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 025552	335, 766		0 0	8, 579	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 024977	4, 822, 849		0 0	120, 460	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 075342	33, 450, 013		0 0	2, 520, 191	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 043626	4, 005, 637		0 1, 516	174, 750	73. 00
74.00	07400 RENAL DIALYSIS	0. 000945	0		0 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS	,					
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000  CLI NI C	0. 000000	0		0	0	90. 00
91.00	09100 EMERGENCY	0. 000000	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 424828	1, 080, 467		0 0	459, 013	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0		94. 00
95. 00	09500 AMBULANCE SERVI CES	0. 000000			0		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COSTS	0. 000000	0		0	0	98. 00
200.00			89, 983, 949		0 1, 516	7, 535, 047	
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	[	89, 983, 949	1	0 1, 516	7, 535, 047	202. 00

Provider CCN: 15-0168 Peri od: Worksheet D From 01/01/2021 Part V To 12/31/2021 Date/Ti me Prepared:

					5/31/2022 11:	00 am
		Title	XVIII	Hospi tal	PPS	
	Cos	ts		· · · · · · · · · · · · · · · · · · ·		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00   05100   RECOVERY   ROOM		0				51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM		0				52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
	0	0				
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	٧,				54.00
54. 01   03630   ULTRA   SOUND	0	0				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00   05600   RADI 01 SOTOPE	0	0				56. 00
57. 00  05700   CT SCAN	0	0				57. 00
58. 00   05800   MRI	0	0				58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00  06000   LABORATORY	0	0				60.00
60. 01   06001   BLOOD LABORATORY	0	0				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	O				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	l ol	o				64. 00
65. 00 06500 RESPI RATORY THERAPY	l ol	o				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	أم	0				67. 00
68. 00 06800 SPEECH PATHOLOGY		0				68. 00
69. 00 06900 ELECTROCARDI OLOGY		0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		Ö				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0				71.00
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS		66				73.00
						1
74. 00   07400   RENAL DI ALYSI S		0				74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
OUTPATIENT SERVICE COST CENTERS						00 00
88. 00 08800 RURAL HEALTH CLINIC						88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	_	_				89. 00
90. 00 09000 CLI NI C	0	0				90.00
91. 00   09100   EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00   09500 AMBULANCE SERVICES	0					95. 00
96. 00   09600   DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98.00 09850 OTHER REIMBURSABLE COSTS	0	0				98. 00
200.00 Subtotal (see instructions)	0	66				200. 00
201.00 Less PBP Clinic Lab. Services-Program						201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	66				202. 00
1 1 1 1 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-1		1			

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0168	Peri od: From 01/01/2021	Worksheet D Part V	norod.
					To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared: 00 am
			Ti tl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To Ded. & Coins	Subject To . Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 099126	0		0 1, 018, 289	0	50.00
51.00	05100 RECOVERY ROOM	0. 098575	0		0 179, 590	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 003186	0		0 106, 509	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 066082	0		0 90, 222	0	54.00
54. 01	03630 ULTRA SOUND	0. 272691	0		0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0. 000000	0		0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MRI	0. 000000	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00	06000 LABORATORY	0. 042819	0		0 22, 698	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 096163	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 196234	0		0 48, 973	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0.000000	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0.000000	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 025552	0		0 3, 190	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000 0. 024977	0		0 0 42 877	0	70. 00 71. 00
71. 00 72. 00	07100   MEDICAL SUPPLIES CHARGED TO PATIENT   07200   MPL. DEV. CHARGED TO PATIENTS	0. 024977	0		0 42, 877 0 429, 251		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.073342	0		0 274, 376	0	73.00
74. 00	07400 RENAL DIALYSIS	0. 000945	0		0 274, 370	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000	0		0 0		75. 00
73.00	OUTPATIENT SERVICE COST CENTERS	0. 000000			0 0		73.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0. 000000	0		0 0	Ō	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 424828	0		0 5, 073	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0 0		94.00
95.00	09500 AMBULANCE SERVICES	0. 000000	0		0		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COSTS	0. 000000	0		0 0	0	98. 00
200.00	,		0		0 2, 221, 048	0	200. 00
201.00					0		201. 00
202 22	Only Charges		_		2 224 212	_	202 22
202.00	Net Charges (line 200 - line 201)	1	0	I	0 2, 221, 048	1 0	202. 00

 
 Heal th Financial
 Systems
 LUTHERAN MUSCULO

 APPORTI ONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-0168

					5/31/2022 11:	00 am
		Ti tl	e XIX	Hospi tal	Cost	
	Cos	ts				
Cost Center Description	Cost	Cost				
p	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
	0	100, 939				50.00
50. 00 05000 OPERATI NG ROOM	١					1
51. 00   05100   RECOVERY ROOM	0	17, 703				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00   05300   ANESTHESI OLOGY	0	339				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	5, 962				54.00
54. 01   03630   ULTRA SOUND	0	0				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	ol				55. 00
56. 00   05600   RADI OI SOTOPE	ol	ol				56.00
57. 00   05700 CT SCAN	ol	o				57. 00
58. 00   05800 MRI	0	Ö				58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON		0				59.00
60. 00   06000   LABORATORY		972				60.00
	1					1
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61. 00   06100   PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0	_				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64. 00   06400   I NTRAVENOUS THERAPY	0	0				64.00
65. 00   06500   RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	9, 610				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	o				67.00
68. 00 06800 SPEECH PATHOLOGY	o	ol				68. 00
69. 00 06900 ELECTROCARDI OLOGY	ol	82				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	1, 071				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		32, 341				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		11, 970				73. 00
74. 00   07400   RENAL DI ALYSI S		0				74.00
		0				75. 00
	l ol	U				1 /5.00
0UTPATIENT SERVICE COST CENTERS 88. 00   08800   RURAL HEALTH CLINIC						88. 00
						1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	_	_				89. 00
90. 00   09000   CLI NI C	0	0				90.00
91. 00   09100   EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 155				92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00 09500 AMBULANCE SERVICES	0					95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	ol				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00 09850 OTHER REI MBURSABLE COSTS	0	o l				98.00
200.00 Subtotal (see instructions)		183, 144				200.00
201.00 Less PBP Clinic Lab. Services-Program		103, 144				201.00
Only Charges	١					201.00
		102 144				202 00
202.00   Net Charges (line 200 - line 201)	0	183, 144				202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0168	From 01/01/2021	Worksheet D-1  Date/Time Prepared: 5/31/2022 11:00 am
	Title XVIII	Hospi tal	PPS

MART   - ALL REWOVER COMPONENS   1.00   1.					5/31/2022 11:	00 am
PART 1 - ALL PROVIDER COMPONENTS			Title XVIII	Hospi tal	PPS	
		Cost Center Description				
IMPAILENT DAYS   1.00   Impatient days (including private room days and swing-bed days, excluding neaborn days)   5,323   1.00   Impatient days (including private room days, excluding swing-bed and neaborn days)   5,323   3.00   70   3.00   70   3.00   70   3.00   70   3.00   70   3.00   70   3.00   70   3.00   70   3.00   70   3.00   70   3.00   70   3.00   70   3.00   3.00   70   3.00   3.00   70   3.00   3.					1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)						
Impatient days (Including private room days, excluding saing-bed and newborn days)   5,323   2,00						
Delivate room days, (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendary year, enter 0 on this line).  7.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  7.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  8.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (in the private room days) applicable to the Program (excluding swing-bed and newborn days) (see instructions) days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to the Itis XVIII only (including private room days) after becember 31 of the cost reporting period (if calendary year, enter 0 on this line) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed days) 11.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed days) 11.00 Swing-bed SMF type inpatient days applicable to the program (excluding swing-bed days) 11.00 Swing-be						
do not complete this line.  4. 05 Sell-private room days (excluding swing-bed and observation bed days)  1. Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed KP type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed KP type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed KP type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total swing-bed KP type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10. 00 Swing-bed SW type inpatient days applicable to the Frogram (excluding private room days)  10. 00 Swing-bed SW type inpatient days applicable to the Program (excluding private room days)  12. 00 Swing-bed KP type inpatient days applicable to the SW type inpatient days applicable to SW type						
5.00 Total swing-bot SRF type inpatient days (including private room days) after December 31 of the cost reporting period reporting period of the cost reporting	3.00		ys). If you have only pr	ivate room days,	0	3. 00
Total swing-bod SNF type inpatient days (including private room days) after December 31 of the cost operating period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) so wing-bod NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year) reporting p	4 00				0 (0)	4 00
report in giperiod  1. OI Total sying-bed SNF type Inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  1. OI Total sying-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line)  1. OI Total sying-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  1. OI Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  1. OI Swing-bed SNF type inpatient days applicable to it it exitil only (including private room days) after through December 31 of the cost reporting period (see instructions)  1. OI Swing-bed SNF type inpatient days applicable to it it exitil only (including private room days) after through December 31 of the cost reporting period (see instructions)  1. OI Swing-bed SNF type inpatient days applicable to it it exitil only (including private room days) after through December 31 of the cost reporting period (see instructions)  1. OI Swing-bed SNF type inpatient days applicable to it it exities vor xIX only (including private room days) after December 31 of the cost reporting period (see instructions)  1. OI Swing-bed SNF type inpatient days applicable to it it is vor xIX only (including private room days)  1. OI ON Swing-bed MF type inpatient days applicable to it it is vor xIX only (including private room days)  1. OI ON Swing-bed MF type inpatient days applicable to it it is vor xIX only (including private room days)  1. OI ON Swing-bed MF type inpatient days applicable to it is vor xIX only (including private room days)  1. OI ON Swing-bed MF type inpatient days applicable to it is vor xIX only (including private room days)  1. OI ON Swing-bed MF type inpatient days applicable to it is vor xIX only (including private room days)  1. OI ON Swing-bed MF type inpatient routine servic				04 0 11	3, 696	
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Period (if calendar year, enter 0 on this line)   Properting Peri	5.00		om days) through Decembe	r 31 of the cost	0	5.00
reporting period (if calendar year, eiter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 10 cost of the swing-bed NF type inpatient days (including private room days) after December 31 of the cost 10 cost of the swing-bed NF type inpatient days (including private room days) after December 31 of the cost 10 cost of the swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and 10 cost of through December 31 of the cost reporting period (including private room days) 11 cost of through December 31 of the cost reporting period (including private room days) 12 cost of through December 31 of the cost reporting period (including private room days) 13 cost of the cost reporting period (including private room days) 14 cost of through December 31 of the cost reporting period (including period (including private room days) 15 cost of through December 31 of the cost reporting period (including period (including private room days) 16 cost of through December 31 of the cost reporting period (including period (including period private room days) 17 cost of through December 31 of the cost reporting period (including period (including period private room days) 18 cost of the cost reporting period (including period of the cost of the cost reporting period (including period of the cost of the co				04 6 11		, 00
Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost proporting period   Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost proporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days)   Total inpatient days applicable to title XVIII only (including private room days)   Total private room days)   Total private room days applicable to title XVIII only (including private room days)   Total private room days applicable to title XVIII only (including private room days)   Total private room days applicable to title XVIII only (including private room days)   Total Program (excluding swing-bed days)   Total Program (excluding swing-bed days)   Total Program (excluding swing-bed days)   Total Program (excluding private room days)   Total Program (excluding swing-bed program (excluding swing-bed program (excluding swing-bed program (excluding swing-bed p	6.00		om days) after December	31 of the cost	0	6.00
reporting period 8. 00 Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after 0 through Becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 through Becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 16. 00 101 mursery days (itlle V or XIX only) 0 15. 00 101 mursery days (itlle V or XIX only) 0 15. 00 101 mursery days (itlle V or XIX only) 0 15. 00 101 mursery days (itlle V or XIX only) 0 15. 00 101 mursery days (itlle V or XIX only) 0 15. 00 101 mursery days (itlle V or XIX only) 0 15. 00 101 mursery days (itlle V or XIX only) 0 15. 00 10 101 mursery days (itlle V or XIX only) 0 15. 00 10 101 mursery days (itlle V or XIX only) 0 15. 00 10 10 10 mursery days (itlle V or XIX only) 0 15. 00 10 10 mursery days (itlle V or XIX only) 0 15. 00 10 10 10 mursery days (itlle V or XIX only) 0 15. 00 10 10 10 10 10 10 10 10 10 10 10 10	7 00		a daya) thraugh Dagambar	21 of the cost	0	7 00
Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in Calendar year, enter 0 on this line)   7,000	7.00		ii days) through becember	31 Of the Cost	U	7.00
reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days)  11.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) after through becember 31 of the cost reporting period (see instructions)  11.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) after on through becember 31 of the cost reporting period  12.00 Swing-bed SRF type inpatient days applicable to title V or XIX only (including private room days)  13.00 Swing-bed NR type inpatient days applicable to title V or XIX only (including private room days)  13.00 Swing-bed NR type inpatient days applicable to title V or XIX only (including private room days)  13.00 Swing-bed NR type inpatient days applicable to title V or XIX only (including private room days)  13.00 Swing-bed NR type inpatient days applicable to title V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 SWING-BIBER ADUSTRIAN  18.00 Medically necessary private room days applicable to services through December 31 of the cost  17.00 Control of the BIBER ADUSTRIAN  18.00 Medically necessary private room days applicable to services after December 31 of the cost  17.00 Control of the BIBER ADUSTRIAN  18.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  18.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  18.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  18.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cos	0 00		days) after December 2	1 of the cost	0	0 00
1.00   Notal inpatient days including private room days applicable to the Program (excluding swing-bed and mays)   0.00	0.00		ii days) ai tei beceilibei s	1 Of the cost	U	0.00
newborn days) (see Instructions)   0   10.00	0 00		the Program (excluding	swing-had and	785	a nn
10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   10.00   through December 31 of the cost reporting period (see instructions)   11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00   13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0.12.00   13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0.13.00   after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00   lotal nursery days (title V or XIX only)   0.15.00   lotal nursery days (title V or XIX only)   0.15.00   lotal nursery days (title V or XIX only)   0.15.00   lotal nursery days (title V or XIX only)   0.15.00   lotal nursery days (title V or XIX only)   0.16.00   lotal care rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17.00   lotal care rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   17.00   lotal care rate for swing-bed NF services applicable to services after December 31 of the cost   0.00   17.00   lotal cale day rate for swing-bed NF services applicable to services after December 31 of the cost   0.00   17.00   lotal cale days   17.00	7.00		The frogram (excruding	Swifig-bed and	703	7.00
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through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nervery days (title V or XIX only)  17.00 Medical rear rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  21.01 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  22.02 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost	12.00			e room days)	0	12.00
after December'31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00   10.01   10			3 (	,		
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00	13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including privat	e room days)	0	13.00
15. 00   Total nursery days (title V or XIX only)   0   15. 00   16. 00   16. 00   17. 00   18. 00		after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)		
16. 00   Nursery days (title V or XIX only)   16. 00   17. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   19. 00	14.00		am (excluding swing-bed	days)	0	14.00
SWING BED ADJUSTMENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	15. 00				0	15.00
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17. 00   18. 00   18. 00   19. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   19. 00	16.00	Nursery days (title V or XIX only)			0	16.00
reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00)  Medicald rate for swing-bed NF services applicable to services after December 31 of the cost (19.00)  Descripting period (19.00)  Medicald rate for swing-bed NF services applicable to services after December 31 of the cost (19.00)  Descripting period (19.00)  Descripting period (19.00)  Total general inpatient routine service cost (see instructions) (19.00)  Total general inpatient routine service strough December 31 of the cost reporting period (19.00)  Total general inpatient routine service strough December 31 of the cost reporting period (19.00)  Total general inpatient routine service strough December 31 of the cost reporting period (19.00)  Total swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00)  Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (19.00)  Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (19.00)  Total swing-bed cost (see instructions) (19.00						
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reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period reporting period Proporting P						
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x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00  Total swing-bed cost (see instructions) 0 26.00  Total swing-bed cost swing-bed cost (line 21 minus line 26) 7, 270, 519  Total swing-bed cost swing-bed cost (line 21 minus line 26) 7, 270, 519  Total swing-bed cost swing-bed cost (line 21 minus line 26) 7, 270, 519  Total swing-bed cost swing-bed cost (line 21 minus line 28) 0 28.00  Total swing-bed cost swing-bed cost and private room cost differential (line 7, 270, 519  Total swing-bed cost swing-bed cost and private room cost differential (line 7, 270, 519  Total swing-bed cost swing-bed cost and private room cost differential (line 7, 270, 519  Total swing-bed cost swing-bed cost and private room cost differential (line 7, 270, 519  Total swing-bed cost swing-bed cost and private room cost differential (line 7, 270, 519  Total swing-bed cost swing-bed cost and private room cost differential (line 7, 270, 519  Total swing-bed cost swing-bed cost and private room cost different	23 00	· · · · · · · · · · · · · · · · · · ·	31 of the cost reportin	a period (line 6	0	23 00
24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25. 00 x line 20)  26. 00 Total swing-bed cost (see instructions)  26. 00 Total swing-bed cost (see instructions)  27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Average per diem private room per diem charge (line 29 ÷ line 3)  31. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  32. 00 Average per diem private room cost differential (line 34 x line 31)  33. 00 Average per diem private room cost differential (line 3 x line 35)  34. 00 Average per diem private room cost differential (line 3 x line 35)  35. 00 Average per diem private room cost differential (line 3 x line 35)  36. 00 Private room cost differential (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  37. 00 Average per diem private room cost differential (line 3 x line 35)  38. 00 Agiusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23.00		of the cost reportin	g perrod (Trile o	0	23.00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 3 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  38.00 Agusted general inpatient routine service cost per of dem (see instructions)  38.00 Adjusted general inpatient routine service cost per of dem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24 00	/	31 of the cost reporti	na period (line	0	24 00
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26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
27. 00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   7, 270, 519   PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00   29. 00   Pri vate room charges (excluding swing-bed charges)   0   29. 00   30.			, ,	` `		
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  Private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  30. 00  General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00  32. 00  Average private room per diem charge (line 29 + line 3)  32. 00  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00  Average per diem private room cost differential (line 34 x line 31)  36. 00  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  7, 270, 519  Adjusted general inpatient routine service cost per diem (see instructions)  1, 365. 87  38. 00  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  20. 00  30. 0	26.00	Total swing-bed cost (see instructions)			0	26.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  32.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  29.00  20.00  20.00  30.00	27.00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		7, 270, 519	27.00
29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 + line 3)  33.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  34.00 Average per diem pri vate room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  36.00 Pri vate room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 7, 270, 519)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35)  0 29.00  30.00  30.00  30.00  30.00  30.00  31.00  32.00  32.00  32.00  34.00  35.00  40.00		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 10.00 30.00 0 0.00 32.00 0 0.00 33.00 0 0.00 33.00 0 0.00 35.00 0 0.00	28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.000 000 32.00  0.000 33.00  0.000 34.00  34.00  35.00 Private room cost differential (line 3 x line 31)  0.000 34.00  36.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  37.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  36.00  37.00  38.00  1.365.87  1.072,208  39.00  40.00		,	: line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  36.00 7, 270, 519  7, 270, 519  1, 365.87  38.00  1, 072, 208  39.00						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 365.87 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 270, 519 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Available 1.00 Ava						
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 365.87 38.00 Program general inpatient routine service cost (line 9 x line 38)  1, 072, 208 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,		66 11 1 (1)		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 365.87 38.00 Program general inpatient routine service cost (line 9 x line 38)  1, 072, 208 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00	,	and private room cost di	fferential (line	7, 270, 519	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 365.87  38.00 Program general inpatient routine service cost (line 9 x line 38)  1, 072, 208  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 365.87 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1, 365.87 38.00 1, 072, 208 39.00 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,072,208 39.00 40.00	20 00				1 2/5 07	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			,			
		5 5	•			
1,072,200 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	<del>-</del> 1. 00	Trotal Trogram general impatrent routine service cost (Time 37		ı	1,072,200	<del>-</del> 1.00

Provider Cot. 15-016	Heal th	Financial Systems LU	THERAN MUSCULOSKE	ELETAL CENTER	₹	In Lie	eu of Form CMS-2	2552-10
Cost Center Description						Peri od:		
Total   Program Days   Program Day								
Total   Program Brown   Program Brown   Program Brown   Program Brown   Program Cost				Title	· XVIII	Hospi tal		00 am_
1.00   2.00   3.00   4.00   5.00   4.00   5.00   4.00		Cost Center Description		Total	Average Per	Program Days	Program Cost	
1.00   2.00   3.00   4.00   5.00   4.20			Inpatient Cost In	patient Days		÷		
Internsive Care Type Input int Hospital Units			1.00	2. 00		4. 00		
	42.00		0	0	0. (	00 00	0	42. 00
44.00   CORRMANY CARE INIT	43. 00		O	0	0.0	0 00	0	43. 00
6.00   SURGICAL INTERSIVE CARE BUILT   0   0   0.00   0   0.40   0   0.00   0   0.40   0   0.00   0   0   0.40   0   0   0   0   0   0   0   0   0								
47.00   OTHER SPECIAL CASE (SPECIFY)   47.00   1.		1	1		1			
28.00 Program inpatient ancillary service cost (West. D-3, col. 3, line 2005)		1	0	U	0.0	0	0	
4.00   Program   Inpati ent and			·		•			
10.00   Pass through costs applicable to Program inpatient routine services (From Wkst. D. sum of Parts I and 211, 934   50.00	49.00	Program i posti ont ancillary corvice cost (We	st D 2 col 2	Lino 200)				19 00
PASS_THROUGH_COST_ADUISTNEMTS   50.00   Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts II and 211, 934   50.00   Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II   264, 174   51.00   70.00					ons)			•
111   28s through costs applicable to Program Inpatient ancillary services (from Wkst. D, sum of Parts II 284, 174   51.00 and IV)   29.00   Total Program excludable cost (sum of lines 50 and S1)   496, 108   52.00   10tal Program inpatient operating cost oxcluding capital related, non-physician anesthetist, and   4,921, 257   53.00   10tal Program inpatient operating cost oxcluding capital related, non-physician anesthetist, and   4,921, 257   53.00   10tal Program inpatient operating cost oxcluding capital related, non-physician anesthetist, and   4,921, 257   53.00   10tal Program inpatient operating cost oxcluding capital related, non-physician anesthetist, and   4,921, 257   53.00   10tal Program inpatient operating cost oxcluding capital related, non-physician anesthetist, and   4,921, 257   53.00   10tal Program inpatient operating cost and target amount (line 50   0.00   0.56, 00.00   0.56, 00.00   0.		PASS THROUGH COST ADJUSTMENTS					044.004	
51.00   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II   284,174   51.00   201   101al Program inpatient operating cost excluding capital related, non-physician aneisthetist, and page 197   101al Program inpatient operating cost excluding capital related, non-physician aneisthetist, and page 197   101al Program inpatient operating cost excluding capital related, non-physician aneisthetist, and page 197   101al Program inpatient operating cost excluding capital related, non-physician aneisthetist, and page 197   101al Program inpatient operating cost and target amount (line 56 minus line 53)   10 st. 00	50.00		atient routine se	rvices (from	n Wkst. D, sur	n of Parts I and	211, 934	50.00
10   Total Program excludable cost (sum of lines 50 and 51)   496, 108   52, 00   53. 00   Total Program inspite not operating cost excluding capital related, non-physician anesthetist, and   4,922, 257   53. 00   10   10   10   10   10   10   10	51.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	284, 174	51. 00
Table   Program inpatient operating cost excluding capital related, non-physician anesthetist, and needed education costs (fine 44 pinus line 52)	52 00		50 and 51)				496 108	52 00
TARCET ANOUNT AND LIMIT COMPUTATION   0   54		,	,	ted, non-phy	sician anesth	netist, and		
24. 00   Program discharges   0. 0   54. 00   55. 00   Target amount per discharge   0. 00   55. 00   Target amount per discharge   0. 00   55. 00   Target amount (line 54 x line 55)   0. 75. 00			52)					
1.55	54.00						0	54. 00
57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0   57.00		Target amount per discharge					0.00	55. 00
88.00 Bonus payment (see instructions) 9.00 Losser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 Losser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 Losser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.00 Losser of lines 63/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.00 Losser of lines 63/54 or 55 from prior year cost reporting of 10% of			ing soot and tang	at amount (I	ino E/ minuo	line E2)		
Design of Liesser of Lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 fol.00 line 53/54 is less than the lower of Lines 55/5 or 06 enter the lesser of 50% of the amount by 0 61.00 which operating costs (Line 53) are less than expected costs (Lines 54 x 60), or 1% of the target amount (Line 56), otherwise enter zero (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 64.00 more provided care swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (Litle XVIII only) 0 66.00 Total Medicare swing-bed SNF inpatient routine costs (Line 64 plus Line 65) (Litle XVIII only). For 0 66.00 Total Medicare swing-bed SNF inpatient routine costs (Line 64 plus Line 65) (Litle XVIII only). For 0 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Line 12 x Line 19) 0 66.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (Line 12 x Line 19) 0 66.00 Total title V or XIX swing-bed NF inpatient routine costs (Line 67 + Line 68) 0 69.00 Total title V or XIX swing-bed NF inpatient routine costs (Line 67 + Line 68) 0 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (Line 67 + Line 68) 0 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (Line 67 + Line 25) 70.00 Medically necessary private room cost applicable to Program (Line 67 + Line 25) 71.00 Total title V or XIX swing-bed NF inpatient routine service costs (Line 67 + Line 75) 71.00 Total Program general inpatient routine service costs (Line 77 + Line 78) 71.00 Total Program reportal service costs (Line 78 x Line 79) 71.00 Program			ing cost and targ	et amount (i	The 56 III hus	11 ne 53)		
Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   60.00		Lesser of lines 53/54 or 55 from the cost re	porting period en	ding 1996, u	updated and co	ompounded by the	0.00	
61.00   If line 53/54 is less than the lower of lines 55, 50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	60.00	1	cost report unda	ted by the m	narket hasket		0.00	60.00
amount (line 56), otherwise enter zero (see instructions) 62.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF Inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF Inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only) 67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 2) 60.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 2) 60.03 Adjusted general inpatient routine service costs (line 70 + line 2) 60.04 December 31 of the cost reporting period (line 37) 60.05 All title Allows and the service cost (line 67 x line 37) 60.06 December 31 of the cost reporting period (line 37) 60.07 December 31 of the cost reporting period (line 37) 60.08 December 31 of the cost reporting period (line 37) 60.09 Total Program inpatient routine service costs (line 37) 60.00 Total Program general inpatient routine service costs (line 37) 60.00 Total Program general inpatient routine service costs (line 37) 60.00 Total Program general inpatient routine service costs (line 37) 60.00 Total Program routin						the amount by	1	
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85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Review - physician compensation (see instructions)  88.00 Review		1	,					
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88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,365.87 88.00	87 ∩∩						1 627	87 00
89.00   Observation bed cost (line 87 x line 88) (see instructions)   2,222,270   89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			1, 365. 87	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				2, 222, 270	89. 00

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 11:	
		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, 437, 123	7, 270, 519	0. 19766	4 2, 222, 270	439, 263	90. 00
91.00 Nursing Program cost	0	7, 270, 519	0.00000	0 2, 222, 270	0	91.00
92.00 Allied health cost	0	7, 270, 519	0.00000	0 2, 222, 270	0	92. 00
93.00 All other Medical Education	0	7, 270, 519	0. 00000	0 2, 222, 270	0	93. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0168	From 01/01/2021	Worksheet D-1 Date/Time Prepared:
			5/31/2022 11:00 am
	Title XIX	Hospi tal	Cost

				5/31/2022 11:	00 am
Title XIX Hospital				Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			5, 323	
2.00	Inpatient days (including private room days, excluding swing-k	ped and newborn days)		5, 323	2.00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			3, 696	
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	01	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			,	
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
0.00	reporting period		1 -6	,	0.00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	or the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (eveluding	cwing had and	281	9. 00
9.00	newborn days) (see instructions)	the Program (excluding	Swifig-bed and	2011	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruct		Join days)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er		Join day Joy di toi	ا	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
	through December 31 of the cost reporting period	3 (	,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)			0	
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.001	17. 00
10 00	reporting period	o often December 21 of	the cost	0.00	10 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	s through becember 31 or	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instructions			7, 270, 519	21.00
22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)			_ '	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18)	- 21 -6	(1:		24 00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (iine	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	R1 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perrou (rine o	١	20.00
26. 00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		7, 270, 519	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				Ī
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	, ,	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line			7, 270, 519	37. 00
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			1
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1 2/5 07	20 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see	*		1, 365. 87 383. 809	
40.00		•		363, 609	
	Total Program general inpatient routine service cost (line 39	•		383, 809	
	1	,	ı	333,307	, 50

Heal th	Financial Systems LU	THERAN MUSCULOS	KELETAL CENTE	R	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 15-0168	Peri od:	Worksheet D-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
			Ti t	le XIX	Hospi tal	5/31/2022 11: Cost	00 am_
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	col. 1	÷	(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	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		0.0		l	1
45. 00	BURN INTENSIVE CARE UNIT	0		0. (			
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	(	0.0	00 0	0	46. 00 47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 94, 494	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		478, 303	1
50. 00	Pass through costs applicable to Program inp	atient routine s	services (fro	m Wkst. D, sur	n of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpand IV)	-	y services (f	rom Wkst. D, s	sum of Parts II	0	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	ding capital rel	ated, non-phy	ysician anesth	netist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00						0	54.00
55. 00	Target amount per discharge					l	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	rget amount (	line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ing cost and tar	get amount (	1110 00 11111103	11110 00)	ő	58. 00
59. 00	00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the i	market basket		0.00	60.00
	If line 53/54 is less than the lower of line	s 55, 59 or 60 e	enter the less	ser of 50% of		0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62. 00							62. 00
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reportino	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line d	64 plus line (	65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				)		70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (li					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v li	ino 25)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)				Part II, column		75. 00
76. 00	Per diem capital related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der recor	ds)			79. 00
80.00	Total Program routine service costs for comp		ost limitatio	n (line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (	see instructions					83. 00
84.00	Program inpatient ancillary services (see in		ae)				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					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			1, 627 1, 365. 87	
	Observation bed cost (line 87 x line 88) (se	•	2)			2, 222, 270	1

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	!	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 11:0	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	1, 437, 123	7, 270, 519	0. 19766	4 2, 222, 270	439, 263	90.00
91.00 Nursing Program cost	0	7, 270, 519	0.00000	0 2, 222, 270	0	91.00
92.00 Allied health cost	0	7, 270, 519	0.00000	0 2, 222, 270	0	92. 00
93.00 All other Medical Education	o	7, 270, 519	0. 00000	0 2, 222, 270	0	93. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0168	Peri od: Worksheet D-3 From 01/01/2021
		To 12/31/2021 Date/Time Prepared:

			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 11:	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description	Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS		_		
1	3000 ADULTS & PEDI ATRI CS		1, 570, 876		30.00
1	03100 INTENSIVE CARE UNIT		0		31. 00
1	03200 CORONARY CARE UNIT		0		32. 00
1	03300 BURN INTENSIVE CARE UNIT		0		33. 00
	3400 SURGICAL INTENSIVE CARE UNIT		0		34. 00
	14000 SUBPROVI DER - I PF		0		40. 00
1	94100 SUBPROVI DER - I RF		0		41. 00
	04300  NURSERY				43. 00
	NCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0. 09912		1	50.00
	05100 RECOVERY ROOM	0. 0985		1	1
	05200 DELIVERY ROOM & LABOR ROOM	0.00000		0	52.00
	05300 ANESTHESI OLOGY	0.00318		4, 372	53. 00
	05400 RADI OLOGY - DI AGNOSTI C	0.06608		36, 209	1
	03630 ULTRA SOUND	0. 2726		1, 251	54. 01
	05500 RADI OLOGY-THERAPEUTI C	0.00000		0	55. 00
	05600 RADI OI SOTOPE	0.00000		0	56.00
	05700 CT SCAN	0.00000		0	57.00
	15800 MRI	0.00000		0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0.00000		0	59.00
1	06000 LABORATORY	0. 0428			60.00
1	06001 BLOOD LABORATORY	0.00000		0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000		0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.00000		0	62.00
1	06300 BLOOD STORING, PROCESSING & TRANS.	0.00000		0	63. 00 64. 00
1	16400   Intravenous Therapy 16500   Respiratory Therapy	0. 00000 0. 09610		12, 990	1
1	16600 PHYSI CAL THERAPY	0. 09616		l	66. 00
	06700 OCCUPATI ONAL THERAPY	0. 1902		102, 324	67. 00
	06800 SPEECH PATHOLOGY	0.00000		0	68. 00
1	06900 ELECTROCARDI OLOGY	0. 0255!		1	1
1	07000 ELECTROENCEPHALOGRAPHY	0. 00000		0,013	70.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 0249			1
1	17200 I MPL. DEV. CHARGED TO PATIENTS	0. 07534		l	72. 00
1	07300 DRUGS CHARGED TO PATIENTS	0. 04362			1
	17400 RENAL DI ALYSI S	0. 00094		l	ı
1	07500 ASC (NON-DISTINCT PART)	0. 00000		l .	1
-	UTPATIENT SERVICE COST CENTERS		-		
	08800 RURAL HEALTH CLINIC	0.00000	00	0	88. 00
89. 00 0	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 00000	00	0	89. 00
90.00 0	99000 CLI NI C	0.0000	00	0	90.00
91.00 0	9100 EMERGENCY	0.0000	00	0	91. 00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 42482	28 279, 416	118, 704	92. 00
	THER REIMBURSABLE COST CENTERS	·			
94.00 0	9400 HOME PROGRAM DIALYSIS	0.00000	00	0	94. 00
95.00 0	9500 AMBULANCE SERVICES				95. 00
96.00 0	99600 DURABLE MEDICAL EQUIP-RENTED	0.0000	00	0	96. 00
	19700 DURABLE MEDICAL EQUIP-SOLD	0.00000		0	
	19850 OTHER REIMBURSABLE COSTS	0.00000		0	98. 00
200. 00	Total (sum of lines 50 through 94 and 96 through 98)		56, 583, 754	4, 346, 157	1
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)	0		201. 00
202. 00	Net charges (line 200 minus line 201)		56, 583, 754	l	202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER		In Lieu of Form CMS-2552-10		
INDATIENT ANGLILADY SERVICE COST ADDODTLONMENT	D	rovidor CCN: 15 0160	Pari ad:	Workshoot D 2	

Health Financial Systems LUTHERAN MUSCULOSKELE	IAL CENTER	Υ	In Lie	u of Form CMS-2	<u> 2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre	
	<b></b>	V/1 V/		5/31/2022 11:	oo am
	11 11	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00  03000  ADULTS & PEDI ATRI CS			98, 990		30.00
31.00  03100 INTENSIVE CARE UNIT			0		31.00
32.00 O3200 CORONARY CARE UNIT			0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00   04000   SUBPROVI DER -   PF			0		40.00
41. 00   04100   SUBPROVI DER -   IRF			0		41.00
43. 00   04300   NURSERY			0		43. 00
ANCI LLARY SERVI CE COST CENTERS			0		43.00
50. 00 05000 OPERATI NG ROOM		0. 09912	408, 706	40, 513	50.00
		1		1	1
51. 00   05100   RECOVERY ROOM		0. 09857	· ·	7, 367	1
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0.00000		0	
53. 00   05300   ANESTHESI OLOGY		0.00318		l	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0.06608	· ·	2, 190	1
54.01  03630 ULTRA SOUND		0. 27269	0	0	
55. 00  05500  RADI OLOGY-THERAPEUTI C		0.00000	0	0	55.00
56. 00  05600  RADI 0I SOTOPE		0.00000	0 0	0	56.00
57. 00  05700 CT SCAN		0.00000	0	0	57.00
58. 00   05800   MRI		0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	
60. 00   06000   LABORATORY		0. 04281		2, 637	1
60. 01 06001 BLOOD LABORATORY		0.00000		0	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		o o	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000		ő	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		ő	1
64. 00 06400 I NTRAVENOUS THERAPY		0. 00000		Ö	
65. 00   06500   RESPI RATORY THERAPY		0. 09616			
66. 00   06600   PHYSI CAL THERAPY		0. 19623		5, 348	1
		1			1
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	1
68. 00   06800   SPEECH PATHOLOGY		0.00000		0	
69. 00   06900   ELECTROCARDI OLOGY		0. 02555		199	1
70. 00   07000   ELECTROENCEPHALOGRAPHY		0.00000		0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 02497		l e	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 07534			1
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 04362		6, 109	1
74. 00   07400   RENAL DI ALYSI S		0.00094	.5	0	74.00
75. 00 O750O ASC (NON-DISTINCT PART)		0.00000	0 0	0	75. 00
OUTPATIENT SERVICE COST CENTERS					
88.00   08800   RURAL HEALTH CLINIC		0.00000	0 0	0	88. 00
89.00  08900  FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0 0	0	89. 00
90. 00   09000   CLI NI C		0.00000	0	0	90.00
91. 00 09100 EMERGENCY		0.00000	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 42482		0	92.00
OTHER REIMBURSABLE COST CENTERS		•	_		
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0	0	94.00
95. 00 09500 AMBULANCE SERVICES					95.00
96. 00   09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000	0	0	
97. 00   09700 DURABLE MEDICAL EQUIP-SCLD		0.00000		0	
98. 00   09850 OTHER REIMBURSABLE COSTS		0.00000			
		0.00000			
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1:50 (1)		1, 229, 586	94, 494	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (	(Title 61)		1 220 527		201. 00
202.00 Net charges (line 200 minus line 201)		I	1, 229, 586	I	202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/31/2022 11:00 am

-		Title XVIII	Hospi tal	5/31/2022 11: 0 PPS	00 am
		THE AVITE	nospi tai		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1. 00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prinstructions)	rior to October 1 (s	see	3, 695, 711	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring or instructions)	n or after October 1	l (see	1, 051, 234	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for dis 1 (see instructions)	scharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for disoctober 1 (see instructions)	scharges occurring o	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02 2. 03	Outlier payment for discharges for Model 4 BPCI (see instructions)	inctructions)		0 82, 625	2. 02 2. 03
2. 03	Outlier payments for discharges occurring prior to October 1 (see Foutlier payments for discharges occurring on or after October 1 (see	•		25, 503	2. 03
3. 00	Managed Care Simulated Payments	se mstructrons)		5, 873, 730	3.00
4. 00	Bed days available divided by number of days in the cost reporting	neriod (see instru	rtions)	34. 54	4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the most record before 12/31/1996. (see instructions)	ent cost reporting p	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the crinew programs in accordance with 42 CFR 413.79(e)	iteria for an add-or	n to the cap for	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under	42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 Cl cost report straddles July 1, 2011 then see instructions.	FR §412.105(f)(1)(i\	/)(B)(2) If the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots up	nder § 5503 of the /	ACA. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots for	rom a closed teachir	ng hospital	0.00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8	, 8,01 and 8,02) (s	see	0. 00	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the current ye	ear from your record	ds	0. 00	10. 00
11.00	FTE count for residents in dental and podiatric programs.	J		0.00	11. 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 penultimate year if that year en	ded on or after Sept	tember 30, 1997,	0. 00	14. 00
45.00	otherwise enter zero.			0.00	45.00
15. 00	Sum of lines 12 through 14 divided by 3.				15.00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital closure				16. 00 17. 00
18. 00	Adjusted rolling average FTE count				18.00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident ca		R 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C).			0.00	24.00
25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower	of line 23 or line	24 (see	0. 00 0. 00	24. 00 25. 00
26. 00	Instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0.000000	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient	t days (see instruct	tions)	0.00	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	(000 motruo)	,	0. 00	
32. 00	Sum of lines 30 and 31			0. 00	
33.00	Allowable disproportionate share percentage (see instructions)			0.00	33. 00
34. 00	Disproportionate share adjustment (see instructions)			0	34. 00

	Financial Systems LUTHERAN MUSCULOSKI ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Peri od:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2021 To 12/31/2021	Part A Date/Time Prep 5/31/2022 11:0	
		Title XVIII	Hospi tal	PPS	00 alli
			Prior to 10/1		
			1. 00	2. 00	
25 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0	35.00
35. 00 35. 01	Factor 3 (see instructions)		0. 00000000	0. 000000000	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se		0. 000000000	35. 02
35. 03	instructions) Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	0	0	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0	03)	0		36. 00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu			
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	ti ana)	0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct		0		41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	ry for adjustment)	0.00		42.00
43. 00 44. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		43. 00 44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instructions	-)	0.00		45. 00
	Total additional payment (line 45 times line 44 times line 41		0.00		46.00
47. 00	Subtotal (see instructions)	1.01)	4, 855, 073		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48. 00
	only. (see instructions)				
				Amount	
40.00	T-t-1	->		1. 00	40.00
49. 00 50. 00	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I ar	•		4, 855, 073 379, 999	1
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. 1 al			379, 999	51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			0	52.00
53. 00	Nursing and Allied Health Managed Care payment	The Tr See Thistractrons,		0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54. 01	Islet isolation add-on payment			0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	55. 00
56.00	Cost of physicians' services in a teaching hospital (see intr	ructions)		0	56. 00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I	II, column 9, lines 30 t	hrough 35).	0	57. 00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	
59. 00	Total (sum of amounts on lines 49 through 58)			5, 235, 072	1
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		5, 235, 072	1
62.00	Deductibles billed to program beneficiaries			434, 432	1
63.00	Coinsurance billed to program beneficiaries			0	63.00
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			5, 385 3, 500	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		1, 484	1
67. 00	,	tructrons)		4, 804, 140	
	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	4, 004, 140	
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	11		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(	-,	0	
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	1
70. 87	Demonstration payment adjustment amount before sequestration	, ,	<i>,</i>	0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)			70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 92	Bundled Model 1 discount amount (see instructions)			0	1
70. 93	HVBP payment adjustment amount (see instructions)			0	
70. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			0	

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	KELETAL CENTER In Li		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168		Worksheet E Part A Date/Time Prepared: 5/31/2022 11:00 am	

				rom 01/01/2021 o 12/31/2021	Part A Date/Time Pre 5/31/2022 11:	
		Title	XVIII	Hospi tal	PPS	
				(уууу)	Amount	
70.01				0	1.00	70.0/
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0	•	0	0	70. 97
70. 77	the corresponding federal year for the period ending on or after			9	O	70.77
70. 98	Low Volume Payment-3	,			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	8 70)			4, 804, 140	71. 00
71. 01	Sequestration adjustment (see instructions)				0	71. 01
	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
	Interim payments				4, 800, 640	1
	Interim payments-PARHM				0	72. 01
	Tentative settlement (for contractor use only)				0	73.00
73. 01 74. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.02,	72 and			3, 500	73. 01 74. 00
74.00	73)	72, and			3, 500	74.00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
	Protested amounts (nonallowable cost report items) in accordance	e with			498, 698	1
	CMS Pub. 15-2, chapter 1, §115.2				,	
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	2.03			0	90. 00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
	Operating outlier reconciliation adjustment amount (see instruc	,			0	92.00
	Capital outlier reconciliation adjustment amount (see instructi				0	93.00
94. 00 95. 00	The rate used to calculate the time value of money (see instructions)	ti ons)			0.00	94. 00 95. 00
96. 00		ons)	•		0	1
70.00	Trine varie of money for capital related expenses (see first detr	0113)		Prior to 10/1		70.00
				1. 00	2. 00	
-	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	1
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102. 00
400.00	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	•
104.00	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra	tion) Adiu	uctmont	0	0	104. 00
200.00	Is this the first year of the current 5-year demonstration peri					200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	ou unuer t	TIE ZIST			200.00
	Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201. 00
202.00	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in f	irst year	of the current	5-year demonst	rati on	
	peri od)			1		
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00 206. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement					J206. 00
207.00	Program reimbursement under the §410A Demonstration (see instru	ictions)				207. 00
	Trogram retimbar sement under the 34 Ton bemonstration (see Thistie	,				208. 00
208 00	Medicare Part A inpatient service costs (from Wkst F Pt A L	ine 59)				
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I Adjustment to Medicare IPPS payments (see instructions)	ine 59)				
209.00		ine 59)				208.00 209.00 210.00
209. 00 210. 00	Adjustment to Medicare IPPS payments (see instructions)	ine 59)				209. 00
209. 00 210. 00	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ine 59)				209. 00 210. 00
209. 00 210. 00 211. 00 212. 00	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 21	ŕ				209. 00 210. 00 211. 00 212. 00
209. 00 210. 00 211. 00 212. 00 213. 00	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 21 Low-volume adjustment (see instructions)	1)				209. 00 210. 00 211. 00 212. 00 213. 00
209. 00 210. 00 211. 00 212. 00 213. 00	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 21	1)	nbursement)			209. 00 210. 00 211. 00 212. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168	From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/31/2022 11:00 am

		Title XVIII	Hospi tal	5/31/2022 11: PPS	00 am
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			66	1
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	ions)		7, 535, 047 8, 427, 032	
4. 00	Outlier payment (see instructions)			57, 817	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		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	ı
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V. col. 13. line 200		0	1
10.00	Organ acqui si ti ons	.,,		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			66	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12. 00	Reasonable charges Ancillary service charges			1, 516	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13)			1, 516	14. 00
45.00	Customary charges		<del></del>		45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for	3	0	0 0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e	. 3	i a chargebasis		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	17. 00
	Total customary charges (see instructions)			1, 516	
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y if line 18 exceeds lii	ne 11) (see	1, 450	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	v if line 11 exceeds lin	ne 18) (see	0	20. 00
20.00	instructions)	ye execede	.0 .0) (000		20.00
	Lesser of cost or charges (see instructions)			66	1
	Interns and residents (see instructions)	wati ana)		0	22. 00
24. 00	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		0 8, 484, 849	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0, 404, 047	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	)		18, 436	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line			1, 246, 245	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p instructions)	lus the sum of lines 22	and 23] (see	7, 220, 234	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	1
	Subtotal (sum of lines 27 through 29)			7, 220, 234	
31. 00	Primary payer payments Subtotal (line 30 minus line 31)			1, 199	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	FS)		7, 219, 035	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
	Allowable bad debts (see instructions)			12, 233	
	Adjusted reimbursable bad debts (see instructions)			7, 951	
	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		5, 720 7, 226, 986	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions				39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration	and dovices (see instruc	tions)	0 0	
39. 90 39. 99	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see ilistruc	ti ons)	0	1
40. 00	Subtotal (see instructions)			7, 226, 986	
40. 01	Sequestration adjustment (see instructions)			0	
40. 02	Demonstration payment adjustment amount after sequestration			0	1
	Sequestration adjustment-PARHM pass-throughs Interim payments			7, 219, 271	40. 03 41. 00
41. 01	Interim payments  Interim payments-PARHM			7,217,271	41.00
	Tentative settlement (for contractors use only)			0	
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00	Balance due provider/program (see instructions)			7, 715	
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2	chanter 1	0	43. 01 44. 00
44.00	\$115. 2	ice with clastrab. 13-2, t	snapter i,		44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0.00	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94. 00

Health Financial Systems LUTHERA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am Provider CCN: 15-0168

Title XVIII   Hospital   PPS						5/31/2022 11:0	00 am_
Maintain					Hospi tal	PPS	
1.00   Total Interim payments paid to provider   1.00   2.00   3.00   4.00   7.219.271   1.00   2.00   Interim payments payable on individual bills, either   4.800,640   7.219.271   1.00   2.00   Interim payments payable on individual bills, either   3.00   3				t Part A	Par	t B	
Total Interim payments paid to provider   4,800,640   7,219,271   1.00							
Interim payments payable on Individual bills, either submitted or to be submitted for the cost reporting period. If none, write "NoNE" or enter a zero.    It is separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero. (1)   Program to Provider			1. 00		3. 00		
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				4, 800, 640			
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero test a payment. If none, the cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero. (1)	2.00			0		0	2. 00
write "NONE" or enter a zero							
3.00   List separately each retroactive Lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   ADJUSTMENTS TO PROVIDER   0 0 0 3.01 3.03 3.03 0 0 0 0 3.03 3.03							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3 00						3 00
For the cost reporting period. Also show date of each   payment. If none, write "NONE" or enter a zero. (1)							
Dayment   If none, write "NONE" or enter a zero. (1)		for the cost reporting period. Also show date of each					
ADJUSTMENTS TO PROVIDER		payment. If none, write "NONE" or enter a zero. (1)					
3.02 3.03 3.04 3.05 Provider to Program  3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.03 3.03 3.04 3.05 Provider to Program  3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.51 3.52 3.53 3.54 0 0 0 3.51 3.52 3.53 3.54 0 0 0 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 3.55 3.59 3.50-3, 98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Provider to Program  TENTATIVE TO PROVIDER  5.00 Frovider to Program  TENTATIVE TO PROGRAM  0 0 0 5.02 5.03 Provider to Program  TENTATIVE TO PROGRAM  5.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 5.55 5.51 5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 5.55 5.51 5.52  0 0 0 7.219, 271 4.00 4.800, 640 7.219, 271 4.00 7.219, 271 4.00 7.219, 271 4.00 7.219, 271 4.00 7.219, 271 4.00 7.219, 271 4.00 7.219, 271 4.00 7.219, 271 4.00 7.219, 271 4.00 7.219, 271 7.210, 271 7.210, 271 7.210, 2							
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 3.50-3.59 3.50 3.50 3.51 3.52 3.53 3.54 3.99 3.50-3.98) 4.00   0		ADJUSTMENTS TO PROVIDER		_			
3.04   0						1	
Solid   Provider to Program   Solid				_			
Provider to Program				_			
3.50   ADJUSTMENTS TO PROGRAM   0   0   3.50	3.05	Provider to Program		U		0	3. 05
3.51   3.52   3.53   3.54   3.50   0   0   3.51   3.52   3.53   3.54   3.59   3.50-3.99   3.50-3.99   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4.800,640   7,219,271   4.00   4.800,640   7,219,271   4.00   4.800,640   7,219,271   4.00   4.800,640   7,219,271   4.00   4.800,640   7,219,271   4.00   6.0	3 50			0		0	3 50
3.52   3.53   3.54   3.99   3.50   3.52   3.54   3.99   3.50   3.50   3.54   3.99   3.50		THE TO THE TO THE		-			
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4.800,640   7,219,271   4.00				0		0	
3. 99   Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 05-3. 98)   3. 50-3. 98)   4. 800,640   7. 219, 271   4. 00	3.53			0		0	3. 53
3.50-3.98    Total interim payments (sum of lines 1, 2, and 3.99)   4,800,640   7,219,271   4.00				_			
4.00   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E-07 Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	3. 99			0		0	3. 99
Contractor   Con	4 00			4 000 (40		7 040 074	4 00
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00			4, 800, 640		7, 219, 271	4.00
TO BE COMPLÈTED BY CONTRACTOR							
Solid   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER							
S. 02   S. 03   Determined net settlement amount (balance due) based on the cost report. (1)   SETTLEMENT TO PROGRAM   O							
Description		TENTATI VE TO PROVIDER		-			
Provider to Program				-			
Tentative To Program   0	5.03	Provider to Program		U		0	5. 03
5.51	5 50			0		0	5 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 3,500 7,715 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 4,804,140 7,226,986 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				0		o o	
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7,715 6.01 6.02 Total Medicare program liability (see instructions) 7,226,986 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 52			0		0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7,715 6.01 7,715 6.01 7,715 6.01 7,715 6.01 7,715 6.01 7,726,986 7.00 7,00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7,715 6.01 6.02 Total Medicare program liability (see instructions) 7,226,986 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7,715 6.01 6.02 Total Medicare program liability (see instructions) 7,715 6.01 6.02 7,00 Total Medicare program liability (see instructions) 7,715 6.01 6.02 7,715 6.01 6.02 7,715 6.01 6.02 7,00 7,00 7,00 7,226,986 7,00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 0 0 6.02 7,226,986 7.00  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	4 01			2 500		7 715	4 01
7.00 Total Medicare program liability (see instructions)  4,804,140  7,226,986  7.00  Contractor Number (Mo/Day/Yr)  0  1.00  2.00				3, 500		7,715	
Contractor Number         NPR Date (Mo/Day/Yr)           0         1.00         2.00				4 804 140		7 226 986	
Number         (Mo/Day/Yr)           0         1.00         2.00		1.212		1, 551, 140	Contractor		00
8.00   Name of Contractor   8.00				)	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Heal th	Financial Systems LUTHERAN MUSCULOSKE	ELETAL CENTER	In Lie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0168   Period:   W. From 01/01/2021   Provider CCN: 15-0168   Provider CCN: 15-0168			Worksheet E-1 Part II Date/Time Pre 5/31/2022 11:	pared:
	<u> </u>	Title XVIII	Hospi tal	PPS	
	TO DE COMPLETED DV CONTRACTOR FOR MONOTANDADO COOT DEPORTO			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		1.4		1 00
1. 00 2. 00	Total hospital discharges as defined in AARA §4102 from Wkst.				1. 00 2. 00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and reporting periods beginning on or after 10/01/2013, line 32)	8 through 12, and prus i	or cost		2.00
3.00					
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1 and 8 through 12 and	nlus for cost		3. 00 4. 00
1. 00	reporting periods beginning on or after 10/01/2013, line 32)	r, and o through 12, and	prus roi cost		1.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	MUSCULOSKELETAL CENTER In Lieu of Form CMS-2	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168	From 01/01/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2022 11:00 am

PART_VII - CALCULATION_OF_RELIMBURSENENT - ALL_OTHER HEALTH SERVICES   1.00   2.00				10 12/31/2021	5/31/2022 11:	
PART VII - CALCULATION OF RET MOURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		
PART VII - CALCILIATION OF REIMBURSCHEMT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			<u> </u>		Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   Injust the hospital SNE/ARP services   3.8, 3.4   2.00   Medical and other services   3.8, 3.4   3.00   1.8, 3.44   3.00   3.8, 3.44   3.00   3.8, 3.44   3.00   3.8, 3.44   3.00   3.8, 3.44   3.00   3.8, 3.44   3.00   3.8, 3.44   3.00						
Inpati ent hospital /SMF/MF services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	X SERVICES		
Inpati ent hospital /SMF/MF services		COMPUTATION OF NET COST OF COVERED SERVICES				
3.00   Organ acquisition (certified transplant centers only)   0   3   48, 303   183, 144   49, 500   19patient primary payer payments   0   0   0   0   0   0   0   0   0	1.00			478, 303		1.00
3.00   Subtotal (sum of lines 1, 2 and 3)   183,144   4   5.00   Inpatient primary payer payments   0   0   5   5.00   Inpatient primary payer payments   0   0   6   5.00   Inpatient primary payer payments   0   0   6   7.00   Subtotal (line 4 less sum of lines 5 and 6)   478,303   183,144   7.00   183,144	2.00	Medical and other services			183, 144	2. 00
Inpati ent primary payer payments   0   0   6   6   6   0   0   0   6   6	3.00	Organ acquisition (certified transplant centers only)		0		3.00
0	4.00	Subtotal (sum of lines 1, 2 and 3)		478, 303	183, 144	4.00
Subtotal (line 4 less sum of lines 5 and 6)	5.00	Inpatient primary payer payments		0		5. 00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable Charges   Reasonable Charges   Routine service charges   0   0   0   0   0   0   0   0   0	6.00	Outpatient primary payer payments			0	6. 00
Reasonable Charges	7.00	Subtotal (line 4 less sum of lines 5 and 6)		478, 303	183, 144	7. 00
Routine service charges						
Ancillary service charges   1, 229, 586   2, 221, 048   9, 10.00   Organ acquisition charges, net of revenue   1.00   Incentive from target amount computation   1. 1, 229, 586   2, 221, 048   9, 12.00   1. 1, 12.00   Total reasonable charges (sum of lines 8 through 11)   1, 229, 586   2, 221, 048   1. 1, 12.00   Total reasonable charges (sum of lines 8 through 11)   1, 229, 586   2, 221, 048   1. 1, 12.00   Total reasonable charges (sum of lines 8 through 11)   1, 229, 586   2, 221, 048   1. 1, 229, 586   2, 221, 048						
10.00   Organ acquisition charges, net of revenue   1.00   1.1.   1.00   Intentive from target amount computation   1.00   1.1.   1.229, 586   2.221, 048   1.229, 586   2.2				٩		8. 00
11.00				1, 229, 586	2, 221, 048	
12.00   Total reasonable charges (sum of lines 8 through 11)   1,295,586   2,221,048   12.00   CISTOMARY CHARGES				0		10.00
CUSTOMARY CHARGES   13.00   Amount actually collected from patients liable for payment for services on a charge   0   0   13.				0		11. 00
13.00   Amount actually collected from patients liable for payment for services on a charge basis has is   14.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.000000   15.0000000   0.0000000   15.0000000   0.0000000   15.0000000   0.0000000   15.0000000   0.0000000   15.0000000   0.0000000   15.0000000   0.0000000   15.00000000   0.0000000   15.00000000000   0.0000000   15.000000000000000000000000000000000000	12. 00			1, 229, 586	2, 221, 048	12. 00
basis   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   0.0000000   15.			<del></del>			
14.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   16.00   Total customary charges (see instructions)   0.000000   1.229, 586   2.221, 048   16.00   16.00   Total customary charges over reasonable cost (complete only if line 16 exceeds   1.229, 586   2.221, 048   16.00   1	13. 00		services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  Ratio of line 13 to line 14 (not to exceed 1.000000)  15.00  Ratio of line 13 to line 14 (not to exceed 1.000000)  17.00  Excess of customary charges (see instructions)  18.00  Excess of customary charges over reasonable cost (complete only if line 16 exceeds  18.00  Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)  19.00  Interns and Residents (see instructions)  19.00  Cost of physicians' services in a teaching hospital (see instructions)  20.00  Cost of proyerid cans' services in a teaching hospital (see instructions)  20.01  Cost of proyerid cans' services in a teaching hospital (see instructions)  21.00  Cost of proyerid cans' services in a teaching hospital (see instructions)  22.00  Cost of proyerid cans' services in a teaching hospital (see instructions)  23.00  Cost of proyerid cans' services in a teaching hospital (see instructions)  24.00  Cost of covered services (enter the lesser of line 4 or line 16)  PROSPECTIVE PRAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  24.00  Countlier payments  25.00  Cutlier payments  26.00  Cutlier payments  27.00  Countlie and Ancillary service other pass through costs  28.00  Cutlier payments  29.00  Cutlier payments (see instructions)  Cutlier payments  Countlie and Ancillary service other pass through costs  Cutlies Vor XIX (Sum of lines 21 and 27)  Countlies All of the service of the proyer of the payment services only)  Countlies and Ancillary service other pass through costs  Consumary charges (title V or XIX PPS covered services only)  Consumary charges (title V or XIX PPS covered services only)  Consumary charges (title V or XIX PPS covered services only)  Consumary charges (title V or XIX PPS covered services only)  Consumary charges (title V or XIX PPS covered services only)  Consumary charges (title V or XIX PPS covered services only)  Consumary charges (title V or XIX PPS covered servic	14 00				0	14.00
15.00	14.00			U	Ü	14. 00
16.00   Total customary charges (see instructions)   1, 229,586   2, 221,048   16.	15 00		12 CFR 9413. 13(e)	0.000000	0.000000	15. 00
17.00   Excess of Customary Charges over reasonable cost (complete only if line 16 exceeds   751, 283   2, 037, 904   17.		,				
			v if line 16 exceeds			
18.00   Excess or reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   0   0   19.	17.00		y IT TITLE TO EXCEEDS	751, 203	2,037,704	17.00
16) (see instructions)	18. 00		vifline 4 exceeds line	0	0	18. 00
19.00   Interns and Residents (see instructions)   0   0   0   20.			ye . executee		ŭ	
20. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   0   20.	19.00			0	0	19.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.	20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
22. 00       Other than outlier payments       0       0       22.         23. 00       Outlier payments       0       0       23.         24. 00       Program capital payments       0       0       23.         25. 00       Capital exception payments (see instructions)       0       0       25.         26. 00       Routine and Ancillary service other pass through costs       0       0       0       26.         27. 00       Subtotal (sum of lines 22 through 26)       0       0       0       27.         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       27.         29. 00       Titles V or XIX (sum of lines 21 and 27)       478, 303       183, 144       29.         COMPUTATION OF REIMBURSEMENT SETTLEMENT       0       0       30.         31. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       478, 303       183, 144       31.         32. 00       Deductibles       0       0       32.         33. 00       Coinsurance       0       0       33.         34. 00       Allowable bad debts (see instructions)       0       0       34.         35. 00       Utilization review       0       35.	21.00	Cost of covered services (enter the lesser of line 4 or line 1	6)	478, 303	183, 144	21.00
23.00 Outlier payments 24.00 Program capital payments 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 PPS PAYMENT METHOD UPDATE 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41)  0 23. 24. 00 October and Ancillary service other pass through costs 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 PPS payment medical education payments (from Wkst. E-4) 42. 00 Balance due provider/program (line 40 minus line 41)		PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
24.00       Program capital payments       0       24.         25.00       Capital exception payments (see instructions)       0       25.         26.00       Routine and Ancillary service other pass through costs       0       0       26.         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.         29.00       Titles V or XIX (sum of lines 21 and 27)       478,303       183,144       29.         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Excess of reasonable cost (from line 18)       0       0       30.         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       478,303       183,144       31.         32.00       Deductibles       0       0       32.         33.00       Coinsurance       0       0       33.         34.00       Allowable bad debts (see instructions)       0       0       34.         35.00       Utilization review       0       0       35.         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       478,303       183,144       36.         37.0	22. 00	Other than outlier payments		0	0	22. 00
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Titles V or XIX (sum of lines 21 and 27) 20. 00 Excess of reasonable cost (from line 18) 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 PPS PAYMENT METHOD UPDATE 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Interim payments				0	0	
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Excess of reasonable cost (from line 18) 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 PPS PAYMENT METHOD UPDATE 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Interim payments 40. 00 Bal ance due provider/program (line 40 minus line 41) 40. 00 Bal ance due provider/program (line 40 minus line 41)		9   1   3		٩		24. 00
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 29. 00 Titles V or XIX (sum of lines 21 and 27) 478, 303 183, 144 29. COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 0 0 30. 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 478, 303 183, 144 31. 32. 00 Deductibles 0 0 0 32. 33. 00 Coinsurance 0 0 0 33. 34. 00 Allowable bad debts (see instructions) 0 0 34. 35. 00 Utilization review 0 0 35. 00 Utilization review 0 0 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 478, 303 183, 144 36. 37. 00 PPS PAYMENT METHOD UPDATE -478, 303 -183, 144 37. 38. 00 Subtotal (line 36 ± line 37) 0 Direct graduate medical education payments (from Wkst. E-4) 0 39. 0 0 10 10 10 10 10 10 10 10 10 10 10 10				0		25. 00
28.00 Customary charges (title V or XIX PPS covered services only)  7				Ĭ	-	
29.00   Titles V or XIX (sum of lines 21 and 27)   478, 303   183, 144   29.				ı	-	
COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   0   0   30.				٩	-	
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 30.00 Allowable bad debts (see instructions) 31.00 Utilization review 32.00 Utilization review 33.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 PPS PAYMENT METHOD UPDATE 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 40.00 Interim payments 40.00 Balance due provider/program (line 40 minus line 41)	29.00			478, 303	183, 144	29. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32.00 Deductibles  33.00 Coinsurance  34.00 Allowable bad debts (see instructions)  35.00 Utilization review  36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 PPS PAYMENT METHOD UPDATE  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  478,303  478,303  478,303  -478,303  -478,303  -183,144  37.  39.00 Direct graduate medical education payments (from Wkst. E-4)  10 0 0 38.  39.00 Interim payments  40.00 Balance due provider/program (line 40 minus line 41)	20.00				0	20.00
32.00 Deductibles 33.00 Coinsurance 30 0 32. 33.00 Coinsurance 31.00 Allowable bad debts (see instructions) 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 PPS PAYMENT METHOD UPDATE 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41)		, ,		٩		
33.00   Coinsurance   0 0 33. 34.00   Allowable bad debts (see instructions)   0 0 34. 35.00   Utilization review   0 0 35. 36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   478,303   183,144   36. 37.00   PPS PAYMENT METHOD UPDATE   -478,303   -183,144   37. 38.00   Subtotal (line 36 ± line 37)   0 0 38. 39.00   Direct graduate medical education payments (from Wkst. E-4)   0 0 0 39. 40.00   Total amount payable to the provider (sum of lines 38 and 39)   0 0 40. 41.00   Interim payments   0 0 41. 42.00   Balance due provider/program (line 40 minus line 41)   0 0 42.				478, 303		
34.00       Allowable bad debts (see instructions)       0       0       34.00         35.00       Utilization review       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       478,303       183,144       36.01         37.00       PPS PAYMENT METHOD UPDATE       -478,303       -183,144       37.01         38.00       Subtotal (line 36 ± line 37)       0       0       38.01         39.00       Direct graduate medical education payments (from Wkst. E-4)       0       0       39.01         40.00       Total amount payable to the provider (sum of lines 38 and 39)       0       0       0       41.01         41.00       Interim payments       0       0       41.01         42.00       Balance due provider/program (line 40 minus line 41)       0       0       42.01				0	-	
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 PPS PAYMENT METHOD UPDATE 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 478, 303 478, 303 478, 303 -183, 144 37. 0 0 38. 0 0 0 39. 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41)				ı		
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 PPS PAYMENT METHOD UPDATE  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  478, 303  -478, 303  -478, 303  -478, 303  -478, 303  -183, 144  37.  38.  0  0  38.  183, 144  37.  38.  0  0  0  38.  39.  10  10  10  10  10  10  10  10  10  1				0	U	35. 00
37.00 PPS PAYMENT METHOD UPDATE  38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41)  -478, 303 -183, 144 37. 38.00 June 38. 00 June 38. 00 June 39. 00 Jun			1 33)	478 303	193 144	
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41)  0 0 38. 39. 0 0 0 0 38. 39. 0 0 0 40. 41. 0 0 0 42.			1 33)	· ·		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41)  39. 40. 41. 42. 42. 43. 44. 45. 46. 46. 47. 48. 48. 49. 40. 40. 40. 40. 40. 40. 40. 40. 40. 40						
40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  0 40.40.  0 40.40.  0 41.00 0 0 42.					O	39.00
41.00 Interim payments 0 0 41. 42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.					n	
42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.		, , , , , , , , , , , , , , , , , , , ,				
				-		
43, OU TELUTESTEU ANDUMITS THOUATTOWADTE COST TEDOLT TUMBS THE ACCOLUBANCE METH CMS PUB 13-2. T UI UI 43	43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	ő	0	
chapter 1, §115.2					ŭ	

Health Financial Systems

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

Provider CCN: 15-0168

Period: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/31/2022 11:00 am

Different Asserts   1.00   2.00   3.00   4.00	nı y)				10 12/01/2021	5/31/2022 11:	00 am
CURRENT ASSETS			General Fund		Endowment Fund	Plant Fund	
Cosh on hand in bunks			1.00		3. 00	4. 00	
Temporary investments			1				
Notes receivable   0 0 0 0			-338, 179		0	0	
Accounts recel vable			0	1		0	
Other receivable   -4, 334,031   0   0   0   0   0   0   0   0   0			30 716 234	1	1	0	
Inventorry			0		o o	Ö	
Propaid expenses	. 00	Allowances for uncollectible notes and accounts receivable	-4, 334, 031		0	0	6.00
Other current assets			2, 935, 603	(	0	0	
10.00   Due from other funds					0	0	
11.00   Total current assets (sum of lines 1-10)   29, 489, 283   0   0			55, 127		1	0	
IXED_ASSETS			20 400 202			0	•
12.00   Land   Improvements			27, 407, 203		<u> </u>	0	11.00
14.00   Accumul ated depreciation   -17, 844   0   0   0   0   16.00   Buildings   96,529   0   0   0   17.00   Leasehold improvements   4,618,235   0   0   0   17.00   Leasehold improvements   4,618,235   0   0   0   17.00   Leasehold improvements   -1,506,409   0   0   0   0   17.00   Leasehold improvements   -1,506,409   0   0   0   0   0   0   0   0   0	T T		0	) (	0	0	12. 00
15.00   Buildings   96.529   0   0   0   1.00   0   0   0   0   0   0   0   0   0	1	Land improvements	26, 765	i (	0	0	
16.00 Accumul ated depreciation	4. 00	Accumulated depreciation	-17, 844	. (	0		
17.00   Leasehold improvements   4,618,235   0   0     19.00   Fixed equipment   1,932,290   0   0     19.00   Fixed equipment   1,932,290   0   0     20.00   Accumulated depreciation   -499,971   0   0     21.00   Automobiles and trucks   28,303   0   0     22.00   Accumulated depreciation   -28,303   0   0     23.00   Major movable equipment   15,606,552   0   0     24.00   Accumulated depreciation   -9,662,844   0   0   0     25.00   Minor equipment depreciable   3,476,919   0   0     25.00   Minor equipment depreciable   3,476,919   0   0     27.00   HIT designated Assets   0   0   0   0     29.00   Minor equipment-nondepreciable   0   0   0   0     29.00   Minor equipment-sesses   0   0   0   0     20.00   Total fixed assets (sum of lines 12-29)   11,960,226   0   0     31.00   Increase   0   0   0   0     32.00   Deposits on leases   0   0   0   0     30.00   Deform owners/officers   0   0   0     30.00   Total other assets (sum of lines 31-34)   19,345,870   0   0     30.00   Total assets (sum of lines 31)   30, and 35)   60,795,379   0     39.00   Payroll taxes payable   4,724,013   0   0     39.00   Payroll taxes payable   595   0   0     39.00   Payroll taxes payable   595   0   0     39.00   Payroll taxes payable   595   0   0     39.00   Payroll taxes payable   596   0   0     39.00   Payroll taxe				1	-	0	
18.00   Accumul ated depreciation   -1,506,409   0   0   0   0   0   0   0   0   0				1	-	0	•
19.00   Fixed equipment	- 1	•		1	-	0 1 0	
20.00   Accumulated depreciation   -499,971   0   0				1	-		
21.00		• •		1		Ö	
22.00   Accumul ated depreciation   -28, 303   0   0   0   0   0   0   0   0   0		•		1	o o	Ö	
24.00 Accumulated depreciation					0	0	
25.00	3. 00	Major movable equipment	15, 606, 552	2	0	0	23.00
26.00 Accumulated depreciation				1	0	0	
27.00					-	0	
Accumulated depreciation			-2, 094, 738		0	0	
29, 00		3	0			0	
Total fixed assets (sum of lines 12-29)   11,960,226   0   0   0   0   0   0   0   0   0		•		1	-		
OTHER ASSETS   1   1   1   1   1   1   1   1   1		• •	11, 960, 226	1	-		
32.00   Deposits on leases   0   0   0   0   0   0   0   0   0					-		
33.00   Due from owners/officers   0   0   0   0   0   0   0   0   0			0	(	0		
34.00   Other assets   19,345,870   0   0   0   0   0   0   0   0   0		·	0	1	-		
35.00   Total other assets (sum of lines 31-34)   19, 345, 870   0   0   0   0   0   0   0   0   0			0	1	-	0	1
Total assets (sum of lines 11, 30, and 35)   60,795,379   0   0				•	-	0	
CURRENT LIABILITIES   37.00   Accounts payable   4,724,013   0   0   0   0   0   0   0   0   0		,		1	٦	l .	
37. 00			00/1/0/0/1		51 5		1 00.00
39.00   Payrol   taxes payable			4, 724, 013	(	0	0	37. 00
40.00 Notes and Loans payable (short term) 2, 379, 745 0 0 11.00 Deferred income 41.00 Deferred income 42.00 Accelerated payments 0 0 42.00 Accelerated payments 0 0 43.00 Due to other funds 44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 45.00 Total current liabilities 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured Loans 48.00 Unsecured loans 49.00 Other long term liabilities 49, 311, 226 50.00 Total long term liabilities (sum of lines 46 thru 49) 51.00 Total liabilities (sum of lines 45 and 50) 51.00 Total liabilities (sum of lines 45 and 50) 52.00 General fund balance 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance 55.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion Total Indu balances (sum of lines 52 thru 58) 376, 362, 454 0 0			2, 693, 091		0		
41.00   Deferred income   0   0   0   0   0   0   0   0   0			l .	1	0	0	•
42.00   Accelerated payments   0   0   0   0   0   0   0   0   0			2, 379, 745		0	0	
43.00   Due to other funds   -390, 462, 484   0   0   0   0   0   0   0   0   0			0		J U	0	41. 00 42. 00
44.00       Other current liabilities       2, 263, 136       0       0         45.00       Total current liabilities (sum of lines 37 thru 44)       -378, 401, 904       0       0         46.00       Mortgage payable       0       0       0         47.00       Notes payable       0       0       0         48.00       Unsecured loans       0       0       0         49.00       Other long term liabilities       49, 311, 226       0       0         50.00       Total long term liabilities (sum of lines 46 thru 49)       62, 834, 829       0       0         51.00       Total liabilities (sum of lines 45 and 50)       -315, 567, 075       0       0         CAPITAL ACCOUNTS       0       0       0       0         52.00       General fund balance       376, 362, 454       0         53.00       Specific purpose fund       0       0         54.00       Donor created - endowment fund balance - unrestricted       0         55.00       Governing body created - endowment fund balance       0         57.00       Plant fund balance - invested in plant       0         58.00       Piant fund balance - reserve for plant improvement, replacement, and expansion       376, 362, 454       0	- 1		-390 462 484		0	0	•
Total current liabilities (sum of lines 37 thru 44)   -378, 401, 904   0   0				1	o o	l	
46.00 Mortgage payable					0	0	•
47.00 Notes payable 48.00 Unsecured Loans 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50) 52.00 General fund balance 52.00 General fund balance 53.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 55.00 Donor created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of Lines 52 thru 58)  13, 523, 603 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
48.00 Unsecured Loans  0 0 0 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50)  CAPITAL ACCOUNTS  52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of Lines 52 thru 58)  376, 362, 454  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	1	٦	0	
49.00       Other long term liabilities       49, 311, 226       0       0         50.00       Total long term liabilities (sum of lines 46 thru 49)       62, 834, 829       0       0         51.00       Total liabilities (sum of lines 45 and 50)       -315, 567, 075       0       0         CAPITAL ACCOUNTS         52.00       General fund balance       376, 362, 454       0         53.00       Specific purpose fund       0         54.00       Donor created - endowment fund balance - restricted       0         55.00       Donor created - endowment fund balance - unrestricted       0         66.00       Governing body created - endowment fund balance       0         57.00       Plant fund balance - invested in plant       0         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       376, 362, 454       0         59.00       Total fund balances (sum of lines 52 thru 58)       376, 362, 454       0       0			13, 523, 603	1			•
50.00 Total long term liabilities (sum of lines 46 thru 49) 62, 834, 829 0 0 Total liabilities (sum of lines 45 and 50)  CAPITAL ACCOUNTS  52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 55.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 Total fund balances (sum of lines 52 thru 58)  376, 362, 454 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			40 211 226		-	· -	
51.00 Total Liabilities (sum of Lines 45 and 50)  CAPITAL ACCOUNTS  52.00 General fund balance  Specific purpose fund  53.00 Donor created - endowment fund balance - restricted  Donor created - endowment fund balance - unrestricted  55.00 Donor created - endowment fund balance - unrestricted  Governing body created - endowment fund balance  For 00 Plant fund balance - invested in plant  For 00 Plant fund balance - reserve for plant improvement, replacement, and expansion  Total fund balances (sum of Lines 52 thru 58)  376, 362, 454  0  0  0  0  0  0  0  0  0  0  0  0  0				1		l	
CAPITAL ACCOUNTS  52.00 General fund balance  53.00 Specific purpose fund  54.00 Donor created - endowment fund balance - restricted  55.00 Donor created - endowment fund balance - unrestricted  56.00 Governing body created - endowment fund balance  57.00 Plant fund balance - invested in plant  Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 Total fund balances (sum of lines 52 thru 58)  376, 362, 454  0  0  376, 362, 454  0  0  0  0  0  0  0  0  0  0  0  0  0		· · · · · · · · · · · · · · · · · · ·				l .	
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60.00 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 88.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 Total fund balances (sum of lines 52 thru 58) 376,362,454 0 0	Ì						
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 78.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 Total fund balances (sum of lines 52 thru 58) 376,362,454 0			376, 362, 454				52. 00
55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 75.00 Plant fund balance - invested in plant 75.00 Plant fund balance - reserve for plant improvement, 75.00 replacement, and expansion 75.00 Total fund balances (sum of lines 52 thru 58) 75.00 Total fund balances (sum of lines 52 thru 58) 75.00 Total fund balances (sum of lines 52 thru 58)		1 1		(	O C		53. 00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58)  376,362,454  0				1	0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 376,362,454 0 0					0		55. 00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 376,362,454 0 0				1		0	56. 00 57. 00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 376,362,454 0 0		·					
59.00 Total fund balances (sum of lines 52 thru 58) 376, 362, 454 0 0	55			1			55. 50
60 00 Total Liabilities and fund balances (sum of lines 51 and 60 795 379 0	9. 00		376, 362, 454		0	О	59. 00
		Total liabilities and fund balances (sum of lines 51 and	60, 795, 379	) (	0	0	60.00
[59]		59)	I	1		l	

Provider CCN: 15-0168

					10 12/31/2021	5/31/2022 11:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 339, 650, 052	3. 00	4.00	5. 00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		36, 712, 402			ή	2.00
3.00	Total (sum of line 1 and line 2)		376, 362, 454				3. 00
4. 00	Additions (credit adjustments) (specify)	o	070,002,101		0	1 0	4. 00
5. 00	(	l ol			ō	0	5. 00
6.00		O			0	0	6. 00
7.00		O			0	0	7. 00
8.00		0			0	0	8. 00
9.00		O			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0		(		10.00
11.00	Subtotal (line 3 plus line 10)		376, 362, 454				11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14. 00
15.00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		(		18. 00
19. 00	Fund balance at end of period per balance		376, 362, 454		(	)	19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Eund			
		Lildowillett Taria	TTAIT	T dild			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00		_	0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	O O	0		U		11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00 14. 00			0				13. 00 14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)		o l		0		18.00
19. 00	Fund balance at end of period per balance				0		19.00
	sheet (line 11 minus line 18)				-		1
				•	•		•

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

			10	12/31/2021	Date/IIme Prep 5/31/2022 11:0	
	Cost Center Description	11	npati ent	Outpati ent	Total	
	'		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES		<u> </u>			
	General Inpatient Routine Services					
1.00	Hospi tal		7, 439, 771		7, 439, 771	1.00
2.00	SUBPROVI DER - I PF		0		0	2.00
3.00	SUBPROVI DER - I RF		0		0	3.00
4.00	SUBPROVI DER					4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY		0		0	7. 00
8.00	NURSING FACILITY		0		0	8. 00
9.00	OTHER LONG TERM CARE		7 420 771		7 420 771	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)		7, 439, 771		7, 439, 771	10. 00
11. 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT		0		0	11. 00
12. 00	CORONARY CARE UNIT		0		0	12. 00
13. 00	BURN INTENSIVE CARE UNIT		0		0	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT		0		0	
15. 00	OTHER SPECIAL CARE (SPECIFY)				ĭ	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes	0		0	
	11-15)				-	
17.00	Total inpatient routine care services (sum of lines 10 and 16)		7, 439, 771		7, 439, 771	17.00
18.00	Ancillary services	2	254, 845, 673	529, 231, 771	784, 077, 444	18.00
19.00	Outpatient services		659, 905	4, 571, 085	5, 230, 990	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY			0	0	22.00
23. 00	AMBULANCE SERVI CES		0	0	0	23. 00
24. 00	CMHC			0	0	24.00
24. 10	CORF		0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		0	0	0	25. 00
26. 00	HOSPI CE		0	0	0	26. 00
27. 00 28. 00	OTHER (SPECIFY)	. What	042 045 240	E22 002 0E4	704 749 205	27. 00 28. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to G-3, line 1)	WKSL. 2	262, 945, 349	533, 802, 856	796, 748, 205	28.00
	PART II - OPERATING EXPENSES	l l				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			110, 168, 628		29. 00
30. 00	ADD (SPECIFY)		О	110, 100, 020		30.00
31. 00	(6. 26.1.1)		Ö			31. 00
32. 00			Ö			32. 00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transter		110, 168, 628		43. 00
	to Wkst. G-3, line 4)	I			I	

		LOSKELETAL CENTER		u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0168	Peri od: From 01/01/2021	Worksheet G-3	
			To 12/31/2021	Date/Time Pre	nared:
			10 12/01/2021	5/31/2022 11:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			796, 748, 205	
2.00	Less contractual allowances and discounts on patients' ac	counts		652, 106, 882	
3.00	Net patient revenues (line 1 minus line 2)			144, 641, 323	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I			110, 168, 628	
5.00	Net income from service to patients (line 3 minus line 4)			34, 472, 695	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	,
8.00	Revenues from telephone and other miscellaneous communica	ition services		0	
9.00	Revenue from television and radio service			0	,
10. 00	Purchase di scounts			0	1
11. 00	Rebates and refunds of expenses			0	
12. 00	Parking lot receipts			0	1 . 2 . 00
	Revenue from Laundry and Linen service			0	1
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to oth	ner than patients		0	
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	23. 00
	OTHER I NCOME			408, 435	
	COVI D-19 PHE Fundi ng			1, 831, 272	
	Total other income (sum of lines 6-24)			2, 239, 707	
	Total (line 5 plus line 25)			36, 712, 402	
27. 00	OTHER EXPENSES (SPECIFY)			0	
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00

0 27. 00 0 28. 00 36, 712, 402 29. 00

24.00 OTHER INCOME
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	Financial Systems LUTHERAN MUSCULO  ATION OF CAPITAL PAYMENT	OSKELETAL CENTER Provi der CCN: 15-0168	Peri od:	u of Form CMS-2 Worksheet L	
			From 01/01/2021 To 12/31/2021	Parts I-III Date/Time Prep	
		Title XVIII	Hospi tal	5/31/2022 11: 0 PPS	00 am
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			367, 494	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			12, 505	
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	tructions)	10. 13	3.00
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)			0	
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)		E, part A line	0. 00	
8. 00	Percentage of Medicaid patient days to total days (see ins	structions)		0. 00	
9.00	Sum of lines 7 and 8	`		0.00	
10. 00 11. 00		ons)		0. 00 0	
12. 00	, , , , , , , , , , , , , , , , , , , ,			379, 999	
12.00	Total prospective capital payments (see mistructions)			3/7, 777	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			_	
1.00	Program inpatient routine capital cost (see instructions)			0	
2. 00 3. 00	Program inpatient ancillary capital cost (see instructions Total inpatient program capital cost (line 1 plus line 2)	5)		0	
4. 00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
0.00	The tall the program eapt tall east (The e x The T)				0.0.
	DADT III COMPUTATION OF EVOEDTION DAYMENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4. 00	Applicable exception percentage (see instructions)			0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00
6. 00	Percentage adjustment for extraordinary circumstances (see	•		0.00	
7. 00	Adjustment to capital minimum payment level for extraordir	nary circumstances (line 2 >	k line 6)	0	
8. 00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as ap			0	
10. 00 11. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over			0	
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	nayments (line 10 nlue lin	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, er			0	
14. 00			,	0	
	(if line 12 is negative, enter the amount on this line)	The service of the se			
				ا م	1 45 00
	Current year allowable operating and capital payment (see	instructions)		0	15.00
15. 00 16. 00		•		0	16.00