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: 15-0047 Worksheet S Peri od: From 06/01/2021 Parts I-III AND SETTLEMENT SUMMARY 05/31/2022 Date/Time Prepared: 10/28/2022 2:52 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 10/28/2022 2:52 pm] Manually prepared cost report use only 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:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
[19] 19. NPR Date:
[10] 19. NPR Date:
[10] 19. NPR Date:
[10] 19. NPR Date:
[11] 19. NPR Date:
[12] 19. NPR Date:
[13] 19. NPR Date:
[14] 19. NPR Date:
[15] 19. NPR Date:
[16] 19. NPR Date:
[17] 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 DOWNTOWN HOSPITAL (15-0047) for the cost reporting period beginning 06/01/2021 and ending 05/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title XVIII				
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	720, 735	-31, 993	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	129	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200. 00 Total		0	720, 864	-31, 993	0	0	200. 00
The ab	nove amounts represent "due to" or "due from"	the applicable	program for th	a alament of t	he above comple	ev indicated	

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

Health Financial Systems LUTHERAN DOWNTOWN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0047 Peri od: Worksheet S-2 From 06/01/2021 Part I 05/31/2022 Date/Time Prepared: 10/28/2022 2:52 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 702 VAN BUREN ST 1.00 PO Box: 1.00 City: FORT WAYNE State: IN 2.00 Zip Code: 46802 County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number 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 DOWNTOWN 150047 23060 07/01/1996 Ν 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF Р LUTHERAN DOWNTOWN SWING 15U047 23060 Р 01/31/2022 N 7 00 7.00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital - Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 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) 05/31/2022 06/01/2021 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Υ 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. 22.01 Did this hospital receive interim uncompensated care payments for this Υ 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) 22.02 Is this a newly merged hospital that requires final uncompensated care

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

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

22.03 Did this hospital receive a geographic reclassification from urban to

22.04 Did this hospital receive a geographic reclassification from urban to

Ν

N

Ν

N

Ν

22.02

22 03

22.04

N

October 1

yes or "N" for no.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

N

N

58 00

59.00

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

	Financial Systems LUTHERAN AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		OWN HOSPITAL Provider CO	CN: 15-0047 P	In Lie	u of Form CMS-2 Worksheet S-2	
					rom 06/01/2021 0 05/31/2022	Part I Date/Time Pre	pared:
				NAHE 413.85	Worksheet A	10/28/2022 2: Pass-Through	52 pm
				Y/N	Li ne #	Qualification Criterion Code	
				1. 00	2.00	3.00	
60. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413.			N			60.00
	instructions) Enter "Y" for yes or "N" for no in col	umn 1.	If column 1				
	is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu		MA payment				
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5. 00	
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61. 00
	column 1. (see instructions)						
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 01
(4.00	instructions)						
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61. 02
	and primary care FTEs added under section 5503 of ACA). (see instructions)						
61. 03	Enter the base line FTE count for primary care						61. 03
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see						
	instructions)						
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
	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						61. 05
	primary care and/or general surgery FTE counts (line						
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being						61. 06
	used for cap relief and/or FTEs that are nonprimary						
	care or general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighted IME	Unwei ghted	
					FTE Count	Direct GME FTE Count	
			1.00	2. 00	3. 00	4.00	
61. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0. 00	0. 00	61. 10
	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						
61. 20	FTE unweighted count. Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61. 20
	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.						
						1.00	
	ACA Provisions Affecting the Health Resources and Ser						
62. 00	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc		d in this cost	reporting peri	od for which	0.00	62. 00
62. 01	Enter the number of FTE residents that rotated from a	Teachi			your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			าร)			
63. 00	Has your facility trained residents in nonprovider se	ttings	during this co			N	63. 00
	"Y" for yes or "N" for no in column 1. If yes, comple	re line	es 64 through 6	37. (see instru Unweighted		Ratio (col. 1/	
				FTEs	FTEs in	(col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
	O II FEOM O II AOA D Y FTE D II I Y			1. 00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			inis base year	is your cost r	eporting	
64. 00	Enter in column 1, if line 63 is yes, or your facilit	y trair	ned residents	0.00	0. 00	0. 000000	64. 00
	in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in	all nor	nprovi der				
	settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in						
	resident FIES that trained in your nospital. Enter in of (column 1 divided by (column 1 + column 2)). (see						

1100111	AL AND HUSPITAL HEALTH CARE COMPL	LEX TOURITH CATTON DA	TA Provider C		om 06/01/ 0 05/31/	′2021 ′2022	Part I Date/Ti	me Pre	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs i Hospi t	n	10/28/2 Ratio (c (col. 3 4)	col. 3/ + col.)	
		1. 00	2. 00	3. 00	4. 00		5. C		
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions)			0.00		0. 00	U.	000000	65. 00
				Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospit	n	Ratio (c (col. 1 2)	+ col .	
				1. 00	2. 00		3.0		
	Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost re	porti	ng perio	ods	
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00		0.00	0.	000000	66. 00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospit	n	Ratio (c (col. 3 4)	+ col .	
		1. 00	2. 00	3. 00	4. 00		5. C		
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00		0.00	U.	333000	67. 00
						1.00	2.00	3 00	
	Inpatient Psychiatric Facility P	PS				1.00	2.00	0.00	
70. 00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does it cont	ain an IPF subp	rovi der?	N			70. 00
71. 00	Enter "Y" for yes or "N" for no. 1.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 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						N	0	71. 00
75. 00	Is this facility an Inpatient Re		(IRF), or does it c	ontain an IRF		N			75. 00
	subprovider? Enter "Y" for yes If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. the facility have ar ing on or before Nove train residents in a r "Y" for yes or "N"	n approved GME teachi ember 15, 2004? Enter new teaching program for no. Column 3: If	ng program in t "Y" for yes or in accordance column 2 is Y,	"N" for	N	N	0	76. 00

SPI TA	Financial Systems LUTHERAN DOWNTO L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	WN HOSPITAL Provider Co	CN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	u of Form CMS- Worksheet S- Part I Date/Time Pr 10/28/2022 2	2 epared:
					1.00	
L	ong Term Care Hospi tal PPS	L HAII C				
I. 00 I	s this a long term care hospital (LTCH)? Enter "Y" for yes s this a LTCH co-located within another hospital for part o Y" for yes and "N" for no.			ng period? Enter	N N	80. 0 81. 0
	EFRA Providers s this a new hospital under 42 CFR Section §413.40(f)(1)(i)	TEEDA2 Ento	r "V" for ve	s or "N" for no	N	85. 0
5. 00	old this facility establish a new Other subprovider (exclude 413,40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	d unit) under	42 CFR Sect	i on	IN	86. 0
	s this hospital an extended neoplastic disease care hospita $886(d)(1)(B)(vi)$? Enter "Y" for yes or "N" for no.	l classified	under sectio	n	N	87. C
	000(d) (1) (b) (v1). Enter 1 101 yes of N 101 Ho.			V	XI X	
				1. 00	2.00	
_	Title V and XIX Services Toes this facility have title V and/or XIX inpatient hospita	L sarvicas? F	nter "V" for	N	Υ	90. (
	res or "N" for no in the applicable column.	i services: L	itter i roi	IN IN	'	70. (
	s this hospital reimbursed for title V and/or XIX through t ull or in part? Enter "Y" for yes or "N" for no in the appl			N	Y	91. (
2. 00 A	re title XIX NF patients occupying title XVIII SNF beds (du	al certificat			N	92. (
	nstructions) Enter "Y" for yes or "N" for no in the applica loes this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. (
	Y" for yes or "N" for no in the applicable column.					
	Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94. (
	fline 94 is "Y", enter the reduction percentage in the app	licable colum	n.	0. 00	0.00	95. (
	loes title V or XIX reduce operating cost? Enter "Y" for yes	or "N" for n	o in the	N	N	96. (
1	upplicable column. fline 96 is "Y", enter the reduction percentage in the app	licable colum	n.	0. 00	0.00	97. (
5	00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Y stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in					
3. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for					98.
3. 02	title XIX. 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					98. (
f 3. 03 [5	for title V, and in column 2 for title XIX.					
f 3. 04 E	For title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH butpatient services cost? Enter "Y" for yes or "N" for no in	reimbursed 10	1% of	N	N	98.
i 1. 05	n column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add ba /kst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c	ck the RCE di	sallowance o	n Y	Y	98.
	column 2 for title XIX.	oranii i ioi t	rtre v, and	'''		
F	Noes title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.
F	Rural Providers					
	Does this hospital qualify as a CAH? f this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of payme	nt N		105. (
1	for outpatient services? (see instructions) column 1: If line 105 is Y, is this facility eligible for co	st raimhursam	ant for I&D			107.
t	raining programs? Enter "Y" for yes or "N" for no in column	1. (see ins	tructions)			107.
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do	,				
	upproved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instruction		unit(S)?			
	s this a rural hospital qualifying for an exception to the	CRNÁ fee sche	dul e? See 4	2 N		108.
C	SFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupation	al Speech	Respi ratory	
0.00	f this bootital qualifier CALL	1.00	2. 00	3. 00	4. 00	100
t	f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. (
					1.00	+ -
0.00	oid this hospital participate in the Rural Community Hospita	Demonstrati	on project (§410A	1. 00 N	110. 0
	Demonstration) for the current cost reporting period? Enter "		(J	1	1

Health Financial Systems LUTHERAN DOWNTOWN HOSP	PI TAL		In Lie	u of Form CMS	S-2552-10
	vider CCN:	15-0047	Peri od: From 06/01/2021	Worksheet S- Part I	
			To 05/31/2022	Date/Time Pr	
				10/28/2022 2	2: 52 pm
			1. 00	2.00	
111.00 of this facility qualifies as a CAH, did it participate in the Fron Health Integration Project (FCHIP) demonstration for this cost repo		,	N N		111. 00
"Y" for yes or "N" for no in column 1. If the response to column 1					
integration prong of the FCHIP demo in which this CAH is participat					
Enter all that apply: "A" for Ambulance services; "B" for additiona for tele-health services.	ai beds; i	and/or C			
112.00Did this hospital participate in the Pennsylvania Rural Health Mode	el	1. 00 N	2. 00	3.00	112. 00
demonstration for any portion of the current cost reporting period?	?				112.00
Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e in column 2, the date the hospital began participating in the	enter				
demonstration. In column 3, enter the date the hospital ceased					
participation in the demonstration, if applicable.					
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" fo	or no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B, or E	onl y)				
in column 2. If column 2 is "E", enter in column 3 either "93" perc for short term hospital or "98" percent for long term care (include					
psychiatric, rehabilitation and long term hospitals providers) base					
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes		N			116. 00
"N" for no.	5 01	N			116.00
117.00 ls this facility legally-required to carry malpractice insurance? E	Enter	N			117. 00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence policy? En	nter 1		1		118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence.			·		1.10.00
		Premi ums	Losses	Insurance	
				0.00	
118.01 List amounts of mal practice premiums and paid losses:		1. 00 117, 8	2. 00 375 21, 056	3.00	0118.01
The office of anounts of marphaser of promising and part of recessor.		,	217000		0110101
110 00 Are mal practice premiums and paid lesses reported in a cost center.	othor th	on the	1. 00 N	2.00	118. 02
118.02 Are malpractice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule lis			IN IN		118.02
and amounts contained therein.	Ü				110.00
119.00 \mid DO NOT USE THIS LINE 120.00 \mid Is this a SCH or EACH that qualifies for the Outpatient Hold Harmle	ess provi:	sion in ACA	A N	N	119. 00 120. 00
§3121 and applicable amendments? (see instructions) Enter in column	n 1, "Y" ⁻	for yes or			
"N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (se			-		
Enter in column 2, "Y" for yes or "N" for no.	ee mstru	cti ons)			
121.00 Did this facility incur and report costs for high cost implantable	devi ces	charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in	n §1903(w)(3) of the	e N		122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y"					
the Worksheet A line number where these taxes are included. Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" for yes a	and "N" f	or no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the	o contifi	cation date			124 00
in column 1 and termination date, if applicable, in column 2.	e certiiii	cation date			126. 00
127.00 If this is a Medicare certified heart transplant center, enter the	certi fi c	ation date			127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 olf this is a Medicare certified liver transplant center, enter the	certi fi c	ation date			128. 00
in column 1 and termination date, if applicable, in column 2.					
129.00 ollf this is a Medicare certified lung transplant center, enter the c column 1 and termination date, if applicable, in column 2.	certi fi ca	tion date i	n		129. 00
130.00 If this is a Medicare certified pancreas transplant center, enter t	the certi	fication			130. 00
date in column 1 and termination date, if applicable, in column 2.	r the sec	ti fi co+! c-			121 00
131.00 f this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in column 2.	i the cer	LITICALION			131. 00
132.00 If this is a Medicare certified islet transplant center, enter the	certi fi c	ation date			132. 00
in column 1 and termination date, if applicable, in column 2. 133.00Removed and reserved					133. 00
134.00 If this is an organ procurement organization (OPO), enter the OPO n	number in	column 1			134. 00
and termination date, if applicable, in column 2.					
All Providers 140.00 Are there any related organization or home office costs as defined	in CMS P	ub. 15-1,	Υ	HB1848	140. 00
	nd home o	ffice costs		HB1848	140. 00

If this facility is part of a chai				name and	address	of the	
home office and enter the home off							
141.00 Name: COMMUNITY HEALTH SYSTEMS							141. 00
142.00 Street: 4000 MERIDIAN BLVD	PO Box:						142. 00
143.00 City: FRANKLIN	State:	N	Zi p Cod	e:	3706	57	143. 00
						1.00	
144.00 Are provider based physicians' cos	sts included in Worksheet	A?				Y	144. 00
					1. 00	2. 00	
145.00 If costs for renal services are cl							145. 00
inpatient services only? Enter "Y"							
no, does the dialysis facility inc		n for this cost	reporting				
period? Enter "Y" for yes or "N"							
146.00 Has the cost allocation methodolog					N		146. 00
Enter "Y" for yes or "N" for no ir		15-2, chapter 4	lo, §4020) I	f			
yes, enter the approval date (mm/c	ld/yyyy) in column 2.						
						1.00	
147.00 Was there a change in the statisti						N	147. 00
148.00 Was there a change in the order of						N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method?	Enter "Y" for ye	s or "N" fo	r no.		N	149. 00
		Part A	Part B	Ti	itle V	Title XIX	
		1.00	2.00		3.00	4. 00	
Does this facility contain a provi	der that qualifies for a	n exemption from	n the applic	cation of	the lowe	er of costs	
or charges? Enter "Y" for yes or '	'N" for no for each compo	nent for Part A	and Part B.	(See 42	CFR §413	3. 13)	
155. 00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovider - IPF		N	N		N	N	156. 00
157.00 Subprovider - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161. 00 CMHC			N		N	N	161.00
		<u>'</u>		<u>'</u>			
						1.00	
Multicampus							
165.00 s this hospital part of a Multica	ampus hospital that has o	ne or more campu	ises in diff	erent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	impus nospi tui that has o	ne or more campe	1303 111 4111	erent ob	<i>or</i> (3 .	.,	100.00
Enter 1 101 year of 14 101 har	Name	County	State Z	ip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each			2.00				166. 00
campus enter the name in column						0.00	1.30.00
O, county in column 1, state in							
column 2, zip code in column 3,							
CDCA in column 4 FTF/Compus in							

Eliter 1 for yes of 11 for he:							4
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166. 00

	1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167. 00
168.00 f 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)	i	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		
169.00 f 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)		
Begi nni ng	Endi ng	

period respectively (mm/dd/yyyy)			170.00
period respectivery (min advyyyy)			
	1. 00	2.00	
171.00 f line 167 is "Y", does this provider have any days for individuals enrolled in	N	0	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

Heal th	Financial Systems LUTHERAN DOWNT	OWN HOSPITAL		In Li∈	eu of Form CMS-	2552-10
HOSPI 7	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0047	Period: From 06/01/2021	Worksheet S-2 Part II	2
				To 05/31/2022	Date/Time Pre	
				Y/N	10/28/2022 2: Date	52 pm
				1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	sponses. Enter			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
1.00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)			
			Y/N	Date	V/I	
0.00	Tu	0.16	1.00	2. 00	3. 00	0.00
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N			2. 00
	voluntary or "I" for involuntary.	o, v 101				
3.00	Is the provider involved in business transactions, includir		Y			3. 00
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			Y/N	Туре	Date	
	Figure 1 Data and Demonts		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Public	l N		I	4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f		l IN			4.00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	N		6. 00
7 00	is the legal operator of the program?	atmusti ana		N		7 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		ed during the	N N		7. 00
0.00	cost reporting period? If yes, see instructions.	a ana or renew	ica darring the			0.00
9.00	Are costs claimed for Interns and Residents in an approved		al education	Υ		9. 00
	program in the current cost report? If yes, see instruction					40.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	ne current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Bad Debts				1. 00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Υ	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection p			st reporting	N N	13. 00
	period? If yes, submit copy.	3	Ü	. 0		
14. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	tructi ons.	N	14. 00
15 00	Bed Complement	na poriod2 lf	vos soo insti	rueti enc	Y	15 00
13.00	Did total beds available change from the prior cost reporti		t A		t B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only?	Y	08/29/2022	Υ	08/29/2022	16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
. 5. 55	Report data for additional claims that have been billed			14		1 .5. 50
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					
	1	ı	1	T .	1	1

Heal th	Financial Systems LUTHERAN DOWNTO	OWN HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet S-2 Part II Date/Time Pre 10/28/2022 2:	epared:
		Descri	pti on	Y/N	Y/N	J piii
		(1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	-	Y/N 1. 00	Date 2.00	Y/N 3. 00	Date 4.00	
21. 00	Was the cost report prepared only using the provider's	N	2.00	N N	4.00	21. 00
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	OSPI TALS)			
22.00	Capital Related Cost	1 4 41			N	1 22 00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense of		als made dur	ing the cost	N N	22. 00 23. 00
	reporting period? If yes, see instructions.			Ü		
24. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	d into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during tinstructions.	the cost repor	ting period?	'If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit	N	27. 00
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or Letters of credit ent</pre>	tered into dur	ing the cost	reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or k	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur	,	N	30.00		
	instructions.					
31. 00	Has debt been recalled before scheduled maturity without iss instructions. Purchased Services	s, see	N	31.00		
32. 00	Have changes or new agreements occurred in patient care serv		d through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instruct of line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		g to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an arr If yes, see instructions.	rangement with	provi der-ba	sed physicians?	N	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exis		ts with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see ins	5 LT UC LT UHS.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			Y		36. 00
37. 00	If line 36 is yes, has a home office cost statement been prooff yes, see instructions.	epared by the	home office?	Y		37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end			Y	12/31/2021	38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the hinstructions.	home office?	If yes, see	N		40. 00
		1.	00	2.	00	
	Cost Report Preparer Contact Information	1.		Σ.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	VI CTORI A		ROMANKO		41. 00
42. 00		COMMUNITY HEAL	TH SYSTEMS			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost (report preparer in columns 1 and 2, respectively.	(615) 925-4333		VI CTORI A_ROMANI	KO@CHS. NET	43.00

Heal th Fi	nancial Systems LUTHERA	N DOWNTO	OWN HOSPI	TAL			In Lie	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI	I RE	Provi	der CCN:		Peri From To	od: 06/01/2021 05/31/2022	Worksheet S-2 Part II Date/Time Pre 10/28/2022 2:	pared:
				3. 00					
Cos	ost Report Preparer Contact Information								
41. 00 En	nter the first name, last name and the title/positi	on l	MANAGER,	REVENUE	MANAGEMENT	•			41.00
he	eld by the cost report preparer in columns 1, 2, an	nd 3,							
re	especti vel y.								
42. 00 En	nter the employer/company name of the cost report								42.00
pr	reparer.								
43. 00 En	nter the telephone number and email address of the	cost							43.00
	eport preparer in columns 1 and 2, respectively.								

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 06/01/2021 Part I
To 05/31/2022 Date/Time Prepared: 10/28/2022 2:52 pm

							10/28/2022 2:	52 pm
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		48	19, 678	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			48	19, 678	0.00	0	7. 00
	beds) (see instructions)						_	
8. 00	INTENSIVE CARE UNIT	31. 00		12	2, 388	0.00	0	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)			60	22, 066	0.00		14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	(0	19. 00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC						_	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			60			_	27. 00
28. 00	Observation Bed Days						0	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)			0	()		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							33.00
33.01	LTCH site neutral days and discharges		l					33. 01

				'	0 03/31/2022	10/28/2022 2:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	•			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	892	467	5, 817			1.00
2.00	HMO and other (see instructions)	1, 628	2, 886				2. 00
3.00	HMO IPF Subprovider	o	0				3.00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	89	0	274			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	981	467	6, 091			7. 00
8.00	INTENSIVE CARE UNIT	196	80	1, 613			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)	1, 177	547	7, 704	0. 85	229. 22	14. 00
15.00	CAH visits	o	0	0			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			14			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0. 85	229. 22	27. 00
28.00	Observation Bed Days		0	774			28. 00
29.00	Ambul ance Tri ps	o					29. 00
30.00	Employee discount days (see instruction)			26			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	o	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	o					33. 01

| Period: | Worksheet S-3 | From 06/01/2021 | Part | To 05/31/2022 | Date/Time Prepared: Provider CCN: 15-0047

					То	05/31/2022	Date/Time Pre 10/28/2022 2:	
		Full Time Equivalents	<u> </u>		Di scha	irges		
	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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	204	778	1, 501	1. 00
2.00	HMO and other (see instructions)				283	0		2. 00
3.00	HMO IPF Subprovider					0		3. 00
4.00	HMO I RF Subprovi der			1		0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF			1				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			ł				6. 00
7. 00	Total Adults and Peds. (exclude observation							7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT			ł				8. 00
9. 00	CORONARY CARE UNIT			ł				9. 00
10. 00	BURN INTENSIVE CARE UNIT			l				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT			l				11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)			İ				12. 00
13.00	NURSERY			ĺ				13. 00
14.00	Total (see instructions)	0.00		0	204	778	1, 501	14. 00
15.00	CAH visits			l				15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER			1				18. 00
19. 00	SKILLED NURSING FACILITY	0. 00		1				19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE			1				21. 00
22. 00	HOME HEALTH AGENCY			l				22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)			ł				23. 00
24. 00	HOSPICE			ł				24. 00 24. 10
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC			ł				25. 00
26. 00	RURAL HEALTH CLINIC			ł				26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00		l				26. 25
27. 00	Total (sum of lines 14-26)	0.00		l				27. 00
28. 00	Observation Bed Days	0.00		l				28. 00
29. 00	Ambulance Trips			l				29. 00
30. 00	Employee discount days (see instruction)			İ				30. 00
31.00	Employee discount days - IRF			İ				31.00
32.00	Labor & delivery days (see instructions)			l				32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
	LTCH non-covered days				0			33. 00
33. 01	LTCH site neutral days and discharges				0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0047

| Peri od: | Worksheet S-3 | From 06/01/2021 | Part II | To 05/31/2022 | Date/Time Prepared:

					To	o 05/31/2022	Date/Time Pre 10/28/2022 2:	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							1
1.00	Total salaries (see instructions)	200. 00	17, 473, 234	0	17, 473, 234	476, 782. 00	36. 65	1.00
2.00	Non-physician anesthetist Part		C	0	0	0.00	0.00	2.00
3. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		C	0	0	0.00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00	l .	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		C	0	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0.00	0. 00	8. 00
9. 00	SNF	44. 00	C	0	0	0.00	l .	
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		C	0	0	0.00	0. 00	10.00
11. 00	Contract labor: Direct Patient Care		4, 273, 457	0	4, 273, 457	31, 682. 00	134. 89	11. 00
12. 00	Contract labor: Top level management and other management and administrative		C	0	0	0. 00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		941, 880	0	941, 880	18, 151. 00	51. 89	13. 00
14. 00	Home office and/or related organization salaries and		C	0	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		1, 633, 068	o	1, 633, 068	37, 590. 00	43. 44	14. 01
14. 02	Related organization salaries		C	0	0	0.00	l .	
15. 00	Home office: Physician Part A - Administrative		C	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract		C	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		4, 843, 325	0	4, 843, 325			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00 20. 00	(see instructions) Excluded areas Non-physician anesthetist Part		C	0	0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		(0				21. 00
22. 00	B Physician Part A -		C	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		C	0	0			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		() ()	_	0 0 0			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		364, 450	0	364, 450			25. 50
25. 51	(core) Related organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		C	0	0			25. 52

					T	o 05/31/2022	Date/Time Pre 10/28/2022 2:	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries			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		140 100	0	140 100	4 052 00	27 57	27.00
26. 00	Employee Benefits Department	4. 00	148, 190		148, 190	.,		
27. 00	Administrative & General	5. 00	3, 439, 207	-241, 756		93, 903. 00		
28. 00	Administrative & General under		308, 867	Ü	308, 867	776. 00	398. 02	28. 00
29. 00	contract (see inst.)	, 00	0		_	0.00	0.00	20.00
30.00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	945, 358	0	945, 358			29. 00 30. 00
31.00	, ·	7. 00 8. 00	945, 358	0	945, 358	37, 102.00		30.00
31.00	Laundry & Linen Service Housekeeping	9.00	469, 269	0	469, 269			
32.00		9.00				,		
33.00	Housekeeping under contract (see instructions)		1, 350	U	1, 350	48.00	28. 13	33. 00
34.00	Di etary	10. 00	618	-123	495	10. 54	46. 96	34.00
35. 00	Di etary under contract (see instructions)		441, 339	0	441, 339	21, 518. 00	20. 51	35. 00
36.00	Cafeteri a	11. 00	0	123	123	1. 46	84. 25	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38.00	Nursing Administration	13. 00	1, 339, 382	241, 756	1, 581, 138	30, 271. 00	52. 23	38. 00
39.00	Central Services and Supply	14. 00	198, 812	0	198, 812	8, 381. 00	23. 72	39. 00
40.00	Pharmacy	15. 00	643, 595	0	643, 595	11, 977. 00	53. 74	40. 00
41.00	Medical Records & Medical	16. 00	3, 061	0	3, 061	117. 00	26. 16	41. 00
	Records Library							
42.00	Social Service	17. 00	242, 075	0	242, 075	5, 812. 00	41. 65	42. 00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 06/01/2021 | Part III | To 05/31/2022 | Date/Time Prepared:

					'	0 03/31/2022	10/28/2022 2:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		18, 224, 790	0	18, 224, 790	499, 124. 00	36. 51	1.00
	instructions)							
2.00	Excluded area salaries (see		0	0	0	0.00	0. 00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		18, 224, 790	0	18, 224, 790	499, 124. 00	36. 51	3.00
	minus line 2)							
4.00	Subtotal other wages & related		6, 848, 405	0	6, 848, 405	87, 423. 00	78. 34	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		5, 207, 775	0	5, 207, 775	0.00	28. 58	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		30, 280, 970	0	30, 280, 970	586, 547. 00	51. 63	6. 00
7.00	Total overhead cost (see		8, 181, 123	0	8, 181, 123	241, 212. 00	33. 92	7.00
	instructions)							

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0047	Peri od: Worksheet S-3 From 06/01/2021 Part IV

	To 05/31/2022	Date/Time Pre 10/28/2022 2:	
		Amount	<u> </u>
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	325, 853	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, 949, 031	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	4, 902	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	12, 654	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	7, 112	13.00
14.00		0	14.00
15. 00		268, 981	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		
17. 00		1, 007, 512	
18. 00	Medicare Taxes - Employers Portion Only	235, 628	18. 00
19. 00		0	19. 00
20. 00	State or Federal Unemployment Taxes	31, 652	20. 00
04 00	OTHER	0	04 00
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
22. 00	instructions)) Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	22. 00
24. 00		- 1	24. 00
24. UU	Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost	4, 843, 325	∠4. 00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
23.00	TOTAL WASE RELATED GOSTO (SEESTED)		25.00

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet S-3 Part V Date/Time Prepared: 10/28/2022 2:52 pm

		10 05/31/2022	10/28/2022 2:	
	Cost Center Description	Contract Labor		JZ piii
	·	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	4, 273, 457	4, 843, 325	1. 00
2.00	Hospi tal	4, 273, 457	4, 843, 325	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF			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	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10. 00
11.00	Hospi tal -Based HHA			11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17.00	RENAL DIALYSIS I			17. 00
18. 00	Other	0	0	18. 00

10SPI	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN: 15-0047	Peri od:	Worksheet S-1	<u>2552-1</u> 0
			From 06/01/2021	5 . (7) 5	
			To 05/31/2022	Date/Time Pre 10/28/2022 2:	
				1.00	
	Uncompensated and indigent care cost computation				١
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 dividedical descriptions for each line)	ded by line 202 col	umn 8)	0. 338881	1.0
. 00	Net revenue from Medicaid			10, 463, 704	2.0
. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental	l payments from Med	i cai d?	Υ	4.0
. 00	If line 4 is no, then enter DSH and/or supplemental payments from	m Medicaid		0	
. 00	Medicaid charges Medicaid cost (line 1 times line 6)			100, 058, 222 33, 907, 830	
. 00	Difference between net revenue and costs for Medicaid program (1)	ine 7 minus sum of	lines 2 and 5 if	23, 444, 126	
. 00	< zero then enter zero)	THE 7 III HUS SUII OF	Triles 2 and 0, 11	20, 111, 120	0.0
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
. 00	Net revenue from stand-alone CHIP			0	
0.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)			0	1
2. 00		ine 11 minus line 9	· if < zero then		
2.00	enter zero)	THE TI III HAS TIME 7	, 11 (2010 (11011		12.0
	Other state or local government indigent care program (see instru				
3.00	et revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13.00 harges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00				
4. 00	10)	program (Not includ	ed in lines 6 or	0	14. 0
5. 00	1 '			0	15.0
6. 00	Difference between net revenue and costs for state or local indig		line 15 minus line	0	16.0
	13; if < zero then enter zero)		J!	/	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and State/Tocal In	digent care program	ns (see	
7. 00		5		1	17. C
8. 00 9. 00		•	ame (sum of lines	0 23, 444, 126	1
7. 00	8, 12 and 16)	indigent care progr	allis (salli of fiftes	25, 444, 120	17.0
		Uni nsure		Total (col. 1	
		pati ent		+ col . 2)	
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00	
0. 00	Charity care charges and uninsured discounts for the entire facil	lity 5,854	, 632 0	5, 854, 632	20.0
1. 00	(see instructions) Cost of patients approved for charity care and uninsured discoun	ts (see 1, 984	. 024	1, 984, 024	21.0
	instructions)	1,70	, 52 .	1,701,021	2
2. 00		ff as 5	, 495 0	5, 495	22.0
3. 00	charity care Cost of charity care (line 21 minus line 22)	1, 978	, 529 0	1, 978, 529	23. 0
		·		1 00	
4 00	Does the amount on line 20 column 2, include charges for patient	days beyond a Leng	th of stay limit	1. 00 N	24. C
5. 00	imposed on patients covered by Medicaid or other indigent care pr	rogram?	•	0	
	stay limit		. a 3 Tongtii oi		l
6.00		,		4, 729, 846	
7. 00 7. 01	Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see	,		92, 979 143, 044	
8. 00		c manuchons)		4, 586, 802	1
	· · · · · · · · · · · · · · · · · · ·	nse (see instructio	ns)	1, 604, 445	1
29. 00				1	1
80. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line			3, 582, 974 27, 027, 100	

		LUTHERAN DOWNTO	WN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	CN: 15-0047 P	eri od:	Worksheet A	
				F	rom 06/01/2021	D 1 /T' D	
				T	o 05/31/2022	Date/Time Pre 10/28/2022 2:	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati		JZ piii
	COST CONTENT DESCRIPTION	Sararres	Other	+ col . 2)	ons (See A-6)	Trial Balance	
				1 (01. 2)	0113 (300 / 0)	(col. 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS			0.00			
1.00	00100 CAP REL COSTS-BLDG & FLXT		7, 574, 433	7, 574, 433	3, 971, 327	11, 545, 760	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		8, 240, 159			8, 975, 936	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	148, 190	144, 041	292, 231	3, 601, 120	3, 893, 351	4. 00
5. 01	00590 REVENUE CYCLE	892, 758	3, 899, 244	4, 792, 002	-158, 863	4, 633, 139	5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	17, 462	57, 123	74, 585	-2	74, 583	5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	2, 528, 987	16, 824, 447	19, 353, 434	-7, 782, 902	11, 570, 532	5. 03
7.00	00700 OPERATION OF PLANT	945, 358	2, 245, 679	3, 191, 037	427, 436	3, 618, 473	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	114, 403	114, 403	0	114, 403	8. 00
9.00	00900 HOUSEKEEPI NG	469, 269	277, 428	746, 697	-5, 496	741, 201	9. 00
10.00	01000 DI ETARY	618	1, 311, 594	1, 312, 212	-642, 413	669, 799	10. 00
11. 00	01100 CAFETERI A	0	0	0	634, 683	634, 683	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 339, 382	126, 953	1, 466, 335	241, 624	1, 707, 959	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	198, 812	394, 095	592, 907	-452, 533	140, 374	14. 00
15. 00	01500 PHARMACY	643, 595	1, 423, 392	2, 066, 987	-1, 234, 829	832, 158	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 061	199, 295	202, 356	96	202, 452	16. 00
17. 00	01700 SOCIAL SERVICE	242, 075	51, 296	293, 371	0	293, 371	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	68, 774	68, 774	0	68, 774	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 362, 168	2, 371, 725	5, 733, 893	-3, 879	5, 730, 014	30. 00
31.00	03100 INTENSIVE CARE UNIT	768, 114	2, 246, 639	3, 014, 753	-2, 777	3, 011, 976	31. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	405, 084	1, 430, 082				1
51. 00	05100 RECOVERY ROOM	157, 994	240, 249			397, 927	1
53.00	05300 ANESTHESI OLOGY	0	912, 303			912, 303	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	671, 249	213, 133			1, 275, 940	
54. 01	03630 ULTRA SOUND	201, 410	28, 704			0	54. 01
56. 00	05600 RADI OI SOTOPE	50, 226	49, 876			0	56. 00
57. 00	05700 CT SCAN	142, 473	99, 946			0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	71, 140	5, 105			0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	45, 181	64, 347			87, 598	
60.00	06000 LABORATORY	1, 256, 956	1, 072, 720			2, 255, 187	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	61, 050			61, 050	•
65. 00	06500 RESPI RATORY THERAPY	699, 382	111, 616			804, 731	1
66.00	06600 PHYSI CAL THERAPY	145, 621	13, 243			159, 419	1
67. 00	06700 OCCUPATI ONAL THERAPY	99, 900	7, 810			107, 710	1
68.00	06800 SPEECH PATHOLOGY	8, 414	684			9, 098	1
69.00	06900 ELECTROCARDI OLOGY	158, 153	12, 405			170, 168	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			238, 255 23, 987	
	07300 DRUGS CHARGED TO PATIENTS		0				1
	03950 MISC ANCILLARY		0			1, 012, 126	73. 00 76. 00
	03951 SLEEP LAB		0	· ·	_	0	•
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0			0	•
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		0	0	0	70.02
90. 00	09000 CLINIC	ما	0	<u> </u>	0	0	90. 00
91. 00	09100 EMERGENCY	1, 800, 202	3, 499, 512	5, 299, 714	-2, 155		•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,000,202	3, 477, 312	3, 277, 714	-2, 133	3, 277, 337	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		17, 473, 234	55, 393, 505	72, 866, 739	0	72, 866, 739	118 00
110.00	NONREI MBURSABLE COST CENTERS	11, +13, 234	33, 373, 303	12,000,737		12,000,739	11.10.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	0	n	n	n	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES		0		0		192. 00
	07950 MEALS ON WHEELS		0	ا م	0		194. 00
200.00		17, 473, 234	55, 393, 505	72, 866, 739	_	72, 866, 739	
	1		, ,	, , , , , , , , , , , , , , , , , , , ,	,	,,	

Health FinancialSystemsLUTHERAN DORECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Peri od: Worksheet A From 06/01/2021 To 05/31/2022 Date/Time Prepared: 10/28/2022 2:52 pm Provider CCN: 15-0047

				10/28/2022	2: 52 pm
	Cost Center Description	Adjustments	Net Expenses		·
	'	(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	155, 322	11, 701, 082		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	4, 639, 392	13, 615, 328		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-63, 698	3, 829, 653		4. 00
5.01	00590 REVENUE CYCLE	286, 736	4, 919, 875		5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	0	74, 583		5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	-754, 369	10, 816, 163		5. 03
7.00	00700 OPERATION OF PLANT	-10, 731	3, 607, 742		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	114, 403		8. 00
9.00	00900 HOUSEKEEPI NG	0	741, 201		9. 00
10.00	01000 DI ETARY	0	669, 799		10. 00
11.00	01100 CAFETERI A	0	634, 683		11. 00
13.00	01300 NURSING ADMINISTRATION	0	1, 707, 959		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	140, 374		14. 00
15.00	01500 PHARMACY	0	832, 158		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-174	202, 278		16. 00
17. 00	01700 SOCIAL SERVICE	0	293, 371		17. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	68, 774		22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		. ,		
30.00	03000 ADULTS & PEDI ATRI CS	-1, 292, 016	4, 437, 998		30.00
31.00	03100 INTENSIVE CARE UNIT	0	3, 011, 976		31. 00
44.00	04400 SKILLED NURSING FACILITY	0	o		44. 00
	ANCILLARY SERVICE COST CENTERS		,		
50.00	05000 OPERATI NG ROOM	-250, 000	1, 344, 743		50.00
51.00	05100 RECOVERY ROOM	0	397, 927		51. 00
53.00	05300 ANESTHESI OLOGY	0	912, 303		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 275, 940		54.00
54. 01	03630 ULTRA SOUND	0	o		54. 01
56.00	05600 RADI OI SOTOPE	0	o		56. 00
57.00	05700 CT SCAN	0	o		57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	o		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	-41, 610	45, 988		59. 00
60.00	06000 LABORATORY	0	2, 255, 187		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	61, 050		62. 00
65.00	06500 RESPIRATORY THERAPY	0	804, 731		65. 00
66.00	06600 PHYSI CAL THERAPY	0	159, 419		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	107, 710		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	9, 098		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	170, 168		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	238, 255		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	23, 987		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 012, 126		73. 00
	03950 MISC ANCILLARY	0	0		76. 00
76. 01	03951 SLEEP LAB	0	o		76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	O		76. 02
70.02	OUTPATIENT SERVICE COST CENTERS		5		70.02
90. 00	09000 CLINIC	0	0		90. 00
	09100 EMERGENCY	-1, 173, 016	•		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	.,,	.,,		92.00
	SPECIAL PURPOSE COST CENTERS	I.			.=
118.00		1, 495, 836	74, 362, 575		118. 00
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , ,			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	o		192. 00
	07950 MEALS ON WHEELS	0	o		194. 00
200.00		1, 495, 836	74, 362, 575		200. 00
					1

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 06/01/2021 To 05/31/2022 Date/Time Prepared: Provider CCN: 15-0047

COST_CENTED* LIPS 2 Salary Other						10	03/31/2022	10/28/2022 2: 52 pm
1.00		Cost Conton		Colomi	0+b o x			
1.00								
2			0.00	11.00	0.00			
1		EMPLOYEE BENEFITS DEPARTMENT		0	3, 603, 191			•
C. LEASE AND REMTAL OLAP ELC COSTS-MULE SOUP P 2 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 00 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 3 0 0 PREL COSTS-MULE SOUP P 4 0 PREL COSTS-MULE SOUP P 4 0 PREL COSTS-MULE SOUP P 4 0 PREL COSTS-MULE SOUP P 4 0 PREL COSTS-MULE SOUP P 4 0 PREL COSTS-MULE SOUP P 4 0 PREL COSTS-	2. 00		0.00					2. 00
ACM PIT CORTS MANUE FOUR P 2.00		C _ LEASE AND DENTAL		O	3, 603, 191			
APPRICE COSTS-BLOS & FIXT	1.00		2.00	O	725, 268			1.00
4.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00		•	•	1				1
5.00 6.00 7.00 7.00 7.00 7.00 7.00 7.00 7		MEDICAL RECORDS & LIBRARY		-				•
6.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00			•					1
7.00 0.00 0.00 0 0 0 0 0			•	-				1
0.00			•	o				•
10.00			0.00	О	0			8. 00
11.00			•	0				1
12 00								
13.00			•	ĭ				
0 - OTHER CAPITAL COSTS 1.00				ő	Ö			
CAP REL COSTS-BLOG & FLXT		0			825, 314			
CAP REL COSTS-BUDG & FIXT	4 00		1 00	ما	0/5 440			4.00
CAP REL COSTS MYBLE EQUIP								1
O								1
1.00 OPERATION OF PLANT	0.00							0.00
2.00 4.00 4.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6								
3.00 4.00 5.00 5.00 6.00 7.00 8.00 7.00 8.00 9.00 10.00 10.00 10.00 10.00 10.00 11.0			•	-				1
4. 00		PHYSICAL THERAPY	•	-				1
5.00			•	-				•
7.00 0.00 0.00 0 0.00 0 0.00 0			•					•
8.00			•	-				•
9.00 10.00 11.00 10.00 11.00 10.00 11.00 1								•
10.00				-				•
11.00			•					1
13.00	11. 00		0.00	О				11.00
14. 00				0				
15.00			•					
16.00			•	~ 	-			
18.00								
1.00				О	0			17. 00
The content of the	18. 00		0.00	•	0			18. 00
1.00		F - CNO WAGES RECLASS		U]	385, 409			
C - MEDI CAL SUPPLIES	1. 00		13. 00	241, 756	0			1.00
1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 238, 255 2. 00 3. 00 2. 00 3. 00		0		241, 756				
PATI ENT IMPL. DEV. CHARGED TO 72.00 0 23,987 2.00 3.00 0 0 0 0 0 0 0 0 0								
2. 00 IMPL. DEV. CHARGED TO 72. 00 0 23, 987 2. 00 3. 00 0 0 0 0 0 0 0 0 0	1. 00		71. 00	0	238, 255			1.00
A	2.00		72. 00	o	23. 987			2. 00
1.00 DRUGS AND I V COSTS]
H - DRUGS AND IV COSTS	3.00		0.00		0			3. 00
1. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 012, 126 0 1, 000 0 0 0 0 0 0 0 0		O L. DDUCC AND LV COSTS		0	262, 242			
1.00	1 00		73 00	O	1 012 126			1 00
1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 465, 249 92, 818 1. 00 2. 00 3. 00 0. 00 0 0 0 3. 00 4. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00	0						1.00
2.00 3.00 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
3.00 4.00 0.00 0.00 0.00 0.00 0.00 0.00		RADI OLOGY-DI AGNOSTI C		465, 249				
4. 00			•	0				
Table Tabl				0	-			•
1. 00 CAFETERIA 11. 00 123 634, 560 0 1. 00 123 634, 560 1. 00 123 634	50	0		465, 249				
0 123 634, 560 M - UTILITIES RECLASS 1. 00 OPERATION OF PLANT 7. 00 0 57, 457 1. 00 2. 00 0. 00 0 0 2. 00 3. 00 0. 00 0 0 3. 00								
M - UTILITIES RECLASS 1.00 OPERATION OF PLANT 7.00 0 57,457 1.00 2.00 0.00 0 0 2.00 3.00 0.00 0 0 3.00	1.00	CAFETERI A						1.00
1. 00 OPERATI ON OF PLANT 7. 00 0 57, 457 1. 00 2. 00 0. 00 0 0 2. 00 3. 00 0. 00 0 0 0		M _ HITHLITIES PECLASS		123	634, 560			
2.00 3.00	1. 00		7.00	Ol	57. 457			1.00
	2.00		0.00					
0 57, 457	3.00		0.00	•				3.00
		lo		0	57, 457			

Heal th	Financial Systems		LUTHERAN DOWN	TOWN HOSPITAL		In Lie	u of Form CMS-25	552-10
RECLAS	SIFICATIONS			Provi der (CCN: 15-0047	Peri od: From 06/01/2021	Worksheet A-6	
							Date/Time Prepa 10/28/2022 2:52	
		Increases						
	Coot Conton	line #	Colors	O+hor				

					10/28/2022 2	:52 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4.00	5. 00		
	N - NON-CAPITALIZED EQUIPMENT	Ţ				
1.00	OPERATING ROOM	50.00	0	14, 940		1. 00
2.00		0.00	0	0		2. 00
	0		0	14, 940		
500.00	Grand Total: Increases		707, 128	10, 769, 943		500.00

						10/28/2022 2:	52 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.		
	6.00 A - EMPLOYEE BENEFITS	7. 00	8. 00	9. 00	10. 00		
1.00	A - EMPLOYEE BENEFITS ADMINISTRATIVE AND GENERAL	5. 03	0	3, 603, 167	0		1.00
2. 00	REVENUE CYCLE	5. 01	ő	24	1		2.00
2.00	0		— — o f	3, 603, 191			2.00
	C - LEASE AND RENTAL		<u>'</u>	· · · · · · · · · · · · · · · · · · ·	<u>'</u>		1
1.00	ADMINISTRATIVE AND GENERAL	5. 03	0	20, 297	10		1. 00
2. 00	OPERATION OF PLANT	7. 00	0	349			2. 00
3.00	DI ETARY	10. 00	0	990			3. 00
4.00	NURSING ADMINISTRATION	13. 00	0	132	1		4. 00
5.00	PHARMACY	15. 00	0	219, 408	1		5.00
6.00	ADULTS & PEDIATRICS RADIOLOGY-DIAGNOSTIC	30. 00 54. 00	0	107 96, 078	0		6. 00 7. 00
7. 00 8. 00	LABORATORY	60.00	0	70, 158			8.00
9. 00	CARDIAC CATHETERIZATION	59.00	0	14, 853			9. 00
10. 00	REVENUE CYCLE	5. 01	o	136	1		10.00
11. 00	OPERATING ROOM	50.00	o	232, 883			11. 00
12.00	CENTRAL SERVICES & SUPPLY	14. 00	O	167, 852			12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	2, 071	0		13.00
	0		0	825, 314]
	D - OTHER CAPITAL COSTS	,					4
1.00	ADMINISTRATIVE AND GENERAL	5. 03	0	3, 881, 886			1.00
2.00		0.00	0	0			2.00
3. 00				0	12		3. 00
	E - REPAIRS & MAINTENANCE		0	3, 881, 886			1
1. 00	INTENSIVE CARE UNIT	31.00	0	2, 777	O		1.00
2. 00	REVENUE CYCLE	5. 01	ő	140, 822			2. 00
3.00	ADMINISTRATIVE AND GENERAL	5. 03	o	28, 291	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	O	5, 496	0		4. 00
5.00	RECOVERY ROOM	51.00	O	316	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	0	23, 083	0		6.00
7.00	ADULTS & PEDIATRICS	30. 00	0	3, 772			7. 00
8. 00	PHARMACY	15. 00	0	3, 295	1		8. 00
9.00	OPERATING ROOM	50.00	0	22, 480	1		9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	37, 946	1		10.00
11. 00 12. 00	ULTRA SOUND PURCHASING RECEIVING AND	54. 01 5. 02	0	13, 414 2	0		11. 00 12. 00
12.00	STORES	5. 02	٥	2	U		12.00
13. 00	CT SCAN	57.00	o	77, 399	0		13.00
14. 00	LABORATORY	60.00	ō	4, 331			14. 00
15.00	RESPIRATORY THERAPY	65.00	O	6, 013	1		15. 00
16.00	DI ETARY	10.00	O	6, 740	0		16.00
17.00	CARDIAC CATHETERIZATION	59. 00	0	7, 077			17. 00
18. 00	EMERGENCY	<u>91.</u> 00	0	<u>2, 1</u> 55			18. 00
	0		0	385, 409			1
1 00	F - CNO WAGES RECLASS	F 03	241 754	0			1 00
1.00	ADMINISTRATIVE AND GENERAL 0		24 <u>1, 7</u> 56 241, 756	<u>0</u>		•	1.00
	G - MEDICAL SUPPLIES		241, 750	0			1
1. 00	CENTRAL SERVICES & SUPPLY	14.00	0	261, 598	0		1.00
2. 00	RESPI RATORY THERAPY	65. 00	Ö	254			2. 00
3.00	ELECTROCARDI OLOGY	69. 00	ol		0		3.00
	0		0	262, 242			ļ
	H - DRUGS AND IV COSTS						
1. 00	PHARMACY	1500	•	1,012,126			1.00
	0		0	1, 012, 126			1
1 00	J - RADIOLOGY	E4 01	201 410	15 200			1 00
1. 00 2. 00	ULTRA SOUND RADI OI SOTOPE	54. 01 56. 00	201, 410 50, 226	15, 290 49, 876			1. 00 2. 00
3.00	CT SCAN	57. 00	142, 473	22, 547			3.00
4. 00	MAGNETIC RESONANCE IMAGING	58.00	71, 140	5, 105			4. 00
	(MRI)		` ` ` `		<u> </u>		
	0		465, 249	92, 818]
	K - DIETARY						4
1. 00	DI ETARY	10.00		634, 560			1.00
	U UTILLITIES DESIASS		123	634, 560			1
1 00	M - UTILITIES RECLASS	F 001	<u>a</u>	7 505			1 00
1. 00 2. 00	ADMINISTRATIVE AND GENERAL RADIOLOGY-DIAGNOSTIC	5. 03 54. 00	0	7, 505 32, 485			1. 00 2. 00
3.00	REVENUE CYCLE	5. 01	0	32, 485 17, 467			3.00
5.00	0	— — 	— — — ў] 3.00
		1	٩	2.,	ı I	l	1

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0047	Period: Worksheet A-6 From 06/01/2021
		To 05/31/2022 Date/Time Prepared:

						10/28/2022 2:	:52 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	N - NON-CAPITALIZED EQUIPMENT						
1.00	REVENUE CYCLE	5. 01	0	414			1. 00
2.00	OPERATION OF PLANT	7. 00	0	14, 526			2. 00
	0		0	14, 940			
500.00	Grand Total: Decreases		707, 128	10, 769, 943	3	1	500.00

					05/31/2022	Date/Time Pre 10/28/2022 2:	
				Acqui si ti ons		10/20/2022 2.	OZ PIII
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	9, 348, 028	0	C	0	0	1. 00
2.00	Land Improvements	1, 775, 835	0	C	0	1, 764, 691	2. 00
3.00	Buildings and Fixtures	28, 513, 304	85, 396, 042	C	85, 396, 042		3. 00
4.00	Building Improvements	31, 930, 883	120, 472	C	120, 472		4. 00
5.00	Fi xed Equi pment	18, 375, 197	961, 755	C	961, 755		5. 00
6.00	Movable Equipment	65, 013, 592	23, 386, 552	C	23, 386, 552		6. 00
7.00	HIT designated Assets	2, 855, 680	0	C	0	·	7. 00
8.00	Subtotal (sum of lines 1-7)	157, 812, 519	109, 864, 821	C	109, 864, 821	117, 494, 804	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10. 00	Total (line 8 minus line 9)	157, 812, 519	109, 864, 821	C	109, 864, 821	117, 494, 804	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
		/ 00	Assets				
	DART I ANALYCIC OF CHANCEC IN CARLTAL ACCE	6.00 BALANCES	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				1. 00
	Land	9, 348, 028	0				
2.00	Land Improvements	11, 144	U				2.00
3.00	Buildings and Fixtures	87, 111, 232	U				3. 00
4.00	Building Improvements	1, 409, 723	U				4. 00
5. 00 6. 00	Fixed Equipment	1, 114, 536	U				5. 00
	Movable Equipment	48, 332, 193	0				6.00
7.00	HIT designated Assets	2, 855, 680	U				7. 00
8. 00 9. 00	Subtotal (sum of lines 1-7)	150, 182, 536	0				8. 00 9. 00
	Reconciling Items	150 100 534	0				
10. 00	Total (line 8 minus line 9)	150, 182, 536	υĮ				10. 00

Heal th	Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022		pared:
			SU	IMMARY OF CAP	I TAL	10/28/2022 2.	52 piii
	Cost Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)	,	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2	<u> </u>		
1.00	CAP REL COSTS-BLDG & FIXT	7, 574, 433	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	8, 240, 159	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	15, 814, 592	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	7, 574, 433				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8, 240, 159				2. 00
	1 - 1 - 6 - 6 - 1 - 1 - 6 - 6 - 1		45 044 500				

0 0 0

7, 574, 433 8, 240, 159 15, 814, 592

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 06/01/2021 To 05/31/2022	Worksheet A-7 Part III Date/Time Pre 10/28/2022 2:	pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		1.00	2.00	2) 3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT	97, 880, 127	С	97, 880, 12	7 0. 651741	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	52, 302, 409	0	52, 302, 40	9 0. 348259	0	2. 00
3.00	Total (sum of lines 1-2)	150, 182, 536		150, 182, 53	6 1. 000000	0	3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		/ 00	d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FLXT	I		1	0 6, 662, 034	99, 950	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0 12, 878, 477		2.00
3.00	Total (sum of lines 1-2)	0			0 19, 540, 511		3. 00
			Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11 00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 067, 721	365, 140	3, 506, 23	7 0	11, 701, 082	1. 00
2.00	CAP REL COSTS-BEDG & TTXT	1,007,721			0 0		2.00
3.00	Total (sum of lines 1-2)	1, 067, 721		1			
			1 -1-7017	1 2,223,20	1		

| Period: | Worksheet A-8 | From 06/01/2021 | To 05/31/2022 | Date/Time Prepared:

10/28/2022 2.52 pm 10/28/2
Cost Center Description Sasis/Code (2) Amount Cost Center Line # Nest. A.7 Ref.
1.00 Investment Income - CAP REL OCAP REL COSTS-BLDG & FIXT (Chapter 2)
1.00 Investment Income - CAP REL OCAP REL COSTS-BLDG & FIXT (Chapter 2)
1.00 Investment Income - CAP REL OCAP REL COSTS-BLDG & FIXT (Chapter 2)
Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 O 1.00
2.00 Investment income - CAP REL (COSTS-MVBLE EQUIP (COSTS-MVBLE FOUIP (CAPTER 2) 3.00 Investment income - other (Chapter 2) 1 (Chapter 2) 4.00 Ireatment income - other (Chapter 8) 5.00 Refunds and rebates of expenses (Chapter 8) 5.00 Refunds and rebates of expenses (Chapter 8) 6.00 Rental of provider space by suppliers (Chapter 8) 7.00 Ielephone services (pay station excluded) (Chapter 2) 7.00 Ielephone services (pay station excluded) (Chapter 2) 7.00 Ielephone services (pay station excluded) (Chapter 2) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision and radio service (Chapter 21) 8.00 Ielevision (Chapter 21) 8.00
COSTS-WVBLE EQUIP (chapter 2) 0 0 0 0 0 0 0 0 0
(chapter 2) 1.00 Telede, quantity, and time discounts (chapter 8) 8.00 Refunds and rebates of expenses (chapter 8) 8.00 Refunds and rebates of expenses (chapter 8) 8.00 Refunds and rebates of expenses (chapter 8) 8.00 Television and radio service (chapter 21) 9.00 Parking lot (chapter 21) 9.00 Parking lot (chapter 21) 9.00 Parking lot (chapter 21) 9.00 Parking lot (chapter 21) 9.00 Parking lot (chapter 21) 9.00 Refunder-based physician A-8-2 -2.843.45 11.00 Sale of Scrap, waste, etc. (chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and linen service and transactions (chapter 10) 14.00 Cafeteria-employees and guests of the supplies to other than patients 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of medical end it in fees, books, etc.) 19.01 Nursing and allied health education (tuit ion, fees, books, etc.) 19.00 Vending machines B -399 ADMINISTRATIVE AND GENERAL 5.03 0.00 0.21.00 0.00 0.00 0.00 0.00 0.00 0
1.00 Trade, quantity, and time 0 0.00 0 4.00 0 0.00 0 4.00 0 0.00 0 0.00 0 0.00 0
Solid Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers (chapter 8) Rental of provider space by suppliers (chapter 8) Rental of provider space by suppliers (chapter 8) Rental of provider space by suppliers (chapter 8) Rental of provider space by stations excluded) (chapter 21) Rental of provider space by stations excluded) (chapter 21) Rental of space by stations excluded) (chapter 21) Rental of space by side and substance of the space by side and sp
0
Suppliers (Chapter 8)
Stations excluded Cchapter 21
Television and radio service (chapter 21)
9.00 Parking lot (chapter 21) 10.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and linen service 14.00 Cafeteria-employees and guests 16.00 Sale of modical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 17.00 Sale of modical records and abstracts 17.00 Sale of modical records and abstracts 18.00 Sale of medical records and abstracts 19.00 Nursing and allied heal th education (tuition, fees, books, etc.) 19.01 Nursing and allied heal th education (tuition, fees, books, etc.) 20.00 Vending machines 21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Income from imposition of interest, finance or penalty charges (chapter 21) 23.00 Algustment for respiratory 23.00 Algustment for respiratory 24.84.451 25.00 ORESPIRATORY THERAPY 25.00 ORESPIRATORY THERAPY 26.00 ORESPIRATORY THERAPY 26.00 ORESPIRATORY THERAPY 26.00 ORESPIRATORY THERAPY 27.00 ORESPIRATORY THERAPY 28.00 ORESPIRATORY THERAPY
Adjustment Sale of Scrap, waste, etc. O O O O O O O O
11.00 Sale of scrap, waste, etc. (chapter 23)
12.00 Related organization 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0 0.00 0.00 0.13.0 0.00 0.00 0.14.0 0.00 0
13.00 Laundry and Linen service 0 14.00 Cafeteria -employees and guests 0 0.00
15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees, books, etc.) 19.01 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines B -399 ADMINISTRATIVE AND GENERAL 10.00 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
and others 3ale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees, books, etc.) 19.01 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines B -399 ADMINISTRATIVE AND GENERAL 10.00 O 21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory 10.00 O 16.0 O 0 0 17.0 O 0 0 17.0 O 0 0 17.0 O 0 0 17.0 O 0 0 18.0 O 0 0 19.0 O 0 0 0 19.0 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
patients Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees, books, etc.) 19.01 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines B -399 ADMINISTRATIVE AND GENERAL C -399 ADMINISTRATI
patients Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees, books, etc.) 19.01 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines B
abstracts Nursing and allied health education (tuition, fees, books, etc.) 19.01 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines B -399 ADMINISTRATIVE AND GENERAL 19.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 0 19.0 0 0 0 19.0 0 0 0 0 19.0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
19.00 Nursing and allied health education (tuition, fees, books, etc.) 19.01 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines B -399 ADMINISTRATIVE AND GENERAL 10.00 0 0 19.00 0 1
19.01 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines 11.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory Nursing and allied health output of 19.00 on 1
books, etc.) 20.00 Vending machines B -399 ADMINISTRATIVE AND GENERAL 5.03 0 20.0 21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 0 RESPIRATORY THERAPY 65.00 23.00
20.00 Vending machines B -399 ADMINISTRATIVE AND GENERAL 5.03 0 20.0 21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 0 RESPIRATORY THERAPY 65.00 23.00
interest, finance or penal ty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.0
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 22.0 0.00 0.22.0 0.00 23.0
repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.0
23.00 Adjustment for respiratory A-8-3 0 RESPIRATORY THERAPY 65.00 23.0
Therapy costs in excess of
limitation (chapter 14)
24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.0 therapy costs in excess of
limitation (chapter 14)
25.00 Utilization review - 0 *** Cost Center Deleted *** 114.00 25.0 physicians' compensation (chapter 21)
(chapter 21) 26.00 Depreciation - CAP REL A -914, 343 CAP REL COSTS-BLDG & FIXT 1.00 9 26.0
COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL A 4,535,686 CAP REL COSTS-MVBLE EQUIP 2.00 9 27. 0
COSTS-MVBLE EQUIP
28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 28. 0 29. 00 Physicians' assistant 0 0 29. 0
30.00 Adjustment for occupational A-8-3 00CCUPATIONAL THERAPY 67.00 30.0 therapy costs in excess of
limitation (chapter 14) 30.99 Hospice (non-distinct) (see A -13,691ADULTS & PEDIATRICS 30.00 30.9
instructions)
31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.0
limitation (chapter 14)

Health Financial Systems			LUTHERAN DOWNT	OWN HOSPITAL	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES					Peri od:	Worksheet A-8	
					From 06/01/2021 To 05/31/2022	Date/Time Pre	pared:
						10/28/2022 2:	
				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	
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33. 00	PARKING GARAGE & MISC INCOME	В		ADMINISTRATIVE AND GENERAL	5. 03		33. 00
33. 01	MARKETING & RECRUITING EXPENSE			ADMINISTRATIVE AND GENERAL	5. 03	0	33. 01
33. 02	RENTAL INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00		33. 02
33. 03	FI TNESS REVENUE	В	-2, 016	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 03
33. 04	SENI OR CIRCLE	A	-9	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 04
33. 05	SI LVER RECOVERY	В	-1, 297	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 05
33. 06	PATIENT PHONE WAGE COSTS	A	-6, 211	ADMINISTRATIVE AND GENERAL	5. 03	0	33. 06
33. 07	PATIENT PHONES BENEFITS	A	-1, 722	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 07
33. 08	PATIENT PHONE DEPRECIATION	A	-93	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 08
33. 09	PATIENT TV DEPRECIATION	A	-290	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 09

1, 495, 836

3,897 ADMI NI STRATI VE AND GENERAL
-61,976 EMPLOYEE BENEFITS DEPARTMENT

-2, 804 ADMINISTRATIVE AND GENERAL

-5, 604 ADMINISTRATIVE AND GENERAL

-69, 595 ADMINI STRATI VE AND GENERAL

-87, 285 ADMINI STRATI VE AND GENERAL

5.03

4.00

5.03

5.03

5.03

5.03

33.11

33.12

33. 13

33. 14

33. 16

50.00

0 33. 10

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

Α

Α

Α

Α

(2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

INTEREST INCOME ADD BACK

LOBBYING EXPENSE IN DUES

(Transfer to Worksheet A,

PHYSICIAN RECRUITING

33.16 | NONALLOWABLE LEGAL EXPENSES

33. 13 CHARI TABLE CONTRIBUTIONS

33. 14 RECRUITING FEES

33. 10

33. 11

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

Provi der CCN: 15-0047

Peri od: Worksheet A-8-1 From 06/01/2021

				To 05/31/2022	Date/Time Pre 10/28/2022 2:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	32 piii
	Erric No.	GOST GOILE		Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		T			
1.00	1	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	1, 067, 721	0	1. 00
2.00	1	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	4, 015	0	2. 00
3.00	1	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	838	0	3. 00
4.00		REVENUE CYCLE	Capital-Related Interest	286, 736	0	4. 00
4.04		ADMINISTRATIVE AND GENERAL	Shared Service Center Alloca	1, 024, 482	826, 951	4. 04
4.05	1	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	48, 653	0	4. 05
4.06		CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm		0	4. 06
4. 07		ADMINISTRATIVE AND GENERAL	Non-Capital Home Office Cost	1, 901, 815	0	4. 07
4.08		ADMINISTRATIVE AND GENERAL	Malpractice Costs	138, 931	221, 502	4. 08
4. 09	1	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment	84, 870	83, 796	4. 09
4. 10		ADMINISTRATIVE AND GENERAL	Management Fees	0	1, 018, 396	4. 10
4. 11		ADMINISTRATIVE AND GENERAL	401K Fees	0	4, 609	4. 11
4. 12		ADMINISTRATIVE AND GENERAL	Audit Fees	0	34, 198	4. 12
4. 13	•	ADMINISTRATIVE AND GENERAL	Corporate Overhead Allocatio	0	709, 971	4. 13
4. 14		ADMINISTRATIVE AND GENERAL	HIIM Allocation	0	179, 441	4. 14
4. 15	5. 03	ADMINISTRATIVE AND GENERAL	Contract Management	0	26, 303	4. 15
4. 16	5. 03	ADMINISTRATIVE AND GENERAL	PASI Lien Unit Collection Fe	0	8, 471	4. 16
4. 17	5. 03	ADMINISTRATIVE AND GENERAL	PASI COLLECTION FEES	0	255, 312	4. 17
5.00	TOTALS (sum of lines 1-4).			4, 660, 238	3, 368, 950	5.00
	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.

 or book poored to not know or the or aller or 27 the amount arrowable officer a bo that outcourt or aller part					
			Related Organization(s) and/	or Home Office	
					-
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2.00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0. 00 CHS,	I NC 100. 00	6. 00
7.00	В	0. 00 PASI	100.00	7. 00
8.00	С	33. 00 SHARE	ED LAUNDRY 33.00	8. 00
9.00		0.00	0.00	9. 00
10.00		0.00	0.00	10.00
100.00	G. Other (financial or			100.00
	non-financial) specify:			

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

5.00 1, 291, 288 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

4 12

4. 13

4.15

4. 16

4. 17

	ated Organization(s) nd/or Home Office		
	Type of Business		
	6. 00		
B. INT	ERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	OWNER		6. 00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY		8.00
9.00			9.00
10.00			10.00
9. 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.
- Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

-34, 198

-709, 971

-179, 441

-26.303

-8, 471

-255, 312

0

0

0

0

4 12

4.13

4.14

4.15

4.16

4.17

						0 05/31/2022	2 Date/IIMe Pre 10/28/2022 2:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	5. 03	ADMINISTRATIVE AND GENERAL	100, 500	100, 500	0	0	0	1. 00
2.00	30. 00	ADULTS & PEDIATRICS	1, 278, 325	1, 278, 325	0	0	0	2. 00
3.00	50. 00	OPERATING ROOM	250, 000	250, 000	0	0	0	3. 00
4.00	59. 00	CARDIAC CATHETERIZATION	41, 610	41, 610	0	0	0	4. 00
5.00	91. 00	EMERGENCY	1, 173, 016	1, 173, 016	0	0	0	5. 00
6.00	0.00		0	C	0	0	0	6. 00
7. 00	0.00		0	l c	0	0	0	7. 00
8. 00	0. 00		0		0	0	0	8. 00
9. 00	0. 00		0	l c	0	0	0	9. 00
10. 00	0. 00		0	l c	0	0	0	10.00
200.00			2, 843, 451	2, 843, 451	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14.00	
1. 00		ADMINISTRATIVE AND GENERAL	0		_	-		
2. 00		ADULTS & PEDIATRICS	0		0	0	0	00
3. 00		OPERATING ROOM	0	0	0	0	0	0.00
4. 00		CARDIAC CATHETERIZATION	0	0	0	0	0	4. 00
5. 00		EMERGENCY	0	0	0	0	0	0.00
6. 00	0. 00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	C	0	0	0	1
200.00			0	C	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		ADMINISTRATIVE AND GENERAL	15.00			100, 500		1. 00
2. 00		ADULTS & PEDIATRICS		1	_	1, 278, 325	•	2.00
3. 00		OPERATING ROOM			_	250, 000	•	3. 00
4. 00		CARDIAC CATHETERIZATION				41, 610	•	4.00
5. 00		EMERGENCY			Ü	1, 173, 016		5.00
6. 00	0.00				9	1, 1/3, 010		6.00
7. 00	0.00							7.00
8. 00	0.00							8.00
9. 00	0.00							9.00
10. 00	0.00				0			10.00
200.00	0.00				· ·	2, 843, 451		200.00
200.00			1	1	.1	2,043,431	I	1 200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047 Peri od: Worksheet B From 06/01/2021 Part I Date/Time Prepared: 05/31/2022 10/28/2022 2:52 pm CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** REVENUE CYCLE Cost Center Description for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 11, 701, 082 1 00 00100 CAP REL COSTS-BLDG & FLXT 11, 701, 082 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 13, 615, 328 13, 615, 328 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 829, 653 82, 554 96,059 4, 008, 266 4.00 00590 REVENUE CYCLE 4, 919, 875 340, 801 5 01 292, 886 206, 546 5, 760, 108 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 74, 583 203, 404 236, 680 4,040 0 5.02 10, 816, 163 5.03 00591 ADMINISTRATIVE AND GENERAL 767, 844 893, 460 529, 167 0 5.03 7.00 00700 OPERATION OF PLANT 3,607,742 3, 386, 981 3, 941, 077 218, 715 7.00 0 00800 LAUNDRY & LINEN SERVICE 114, 403 64.834 75, 440 8 00 0 8 00 9.00 00900 HOUSEKEEPI NG 741, 201 981, 452 1, 142, 013 108, 569 0 9.00 01000 DI ETARY 669, 799 457, 994 532, 920 10.00 10.00 115 01100 CAFETERI A 634, 683 99, 308 115, 555 11.00 28 11.00 0 01300 NURSING ADMINISTRATION 13.00 1, 707, 959 112, 325 130, 701 365, 807 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 140, 374 45, 997 0 14.00 01500 PHARMACY 15.00 832, 158 72,770 84, 675 148, 900 15.00 01600 MEDICAL RECORDS & LIBRARY 213, 764 708 16, 00 16,00 202, 278 183, 710 0 17 00 01700 SOCIAL SERVICE 293.371 C 56,006 0 17 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 68,774 22.00 22.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDLATRICS 4, 437, 998 1, 610, 936 1, 874, 479 777, 855 517, 823 31.00 03100 INTENSIVE CARE UNIT 3, 011, 976 324, 043 377, 055 177, 709 266, 340 31.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 344, 743 727, 155 118, 567 50.00 846, 115 93.719 51.00 05100 RECOVERY ROOM 397, 927 101, 744 118, 389 36, 553 27, 232 51.00 05300 ANESTHESI OLOGY 912, 303 53.00 22, 553 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 275, 940 772, 421 898, 786 262, 937 1,540,642 54.00 54.01 03630 ULTRA SOUND 0 C 0 0 Ω 54.01 05600 RADI OI SOTOPE 56, 00 0 0 56.00 57.00 05700 CT SCAN 0 Ω 0 0 Ω 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 \cap Ω Λ 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 45, 988 32, 123 37, 378 10, 453 4, 473 59.00 06000 LABORATORY 379, 547 939, 723 60.00 2, 255, 187 326, 185 290, 806 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 15, 733 62.00 61, 050 13, 521 15, 207 62.00 06500 RESPIRATORY THERAPY 804, 731 124, 881 145, 311 161, 807 65.00 234, 644 65.00 66.00 06600 PHYSI CAL THERAPY 159, 419 130, 298 151, 614 33, 690 29, 327 66.00 67.00 06700 OCCUPATIONAL THERAPY 107, 710 49, 885 58,046 23, 113 25,002 67.00 22, 378 1, 993 06800 SPEECH PATHOLOGY 9.098 1.947 68 00 19, 232 68 00 69.00 06900 ELECTROCARDI OLOGY 170, 168 18, 266 21, 254 36, 590 59, 261 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 238, 255 93, 586 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 23, 987 0 10, 343 72.00 C 07300 DRUGS CHARGED TO PATIENTS 0 73 00 1, 012, 126 43, 209 50, 277 713, 675 73 00 76.00 03950 MISC ANCILLARY C 0 0 76.00 03951 SLEEP LAB 0 76.01 76.01 0 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.02 76.02 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 37, 204 43, 290 6, 323 90.00 09100 EMERGENCY 91.00 4, 124, 543 646, 197 751, 912 416, 489 1, 133, 394 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 74, 362, 575 11, 683, 362 13, 594, 709 4, 008, 266 5, 760, 108 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 17, 720 20, 619 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 194.00 07950 MEALS ON WHEELS 0 0 0 194. 00 0 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 74, 362, 575 11, 701, 082 13, 615, 328 4, 008, 266 5, 760, 108 202. 00

| Period: | Worksheet B | From 06/01/2021 | Part | To 05/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047

				Ť	o 05/31/2022		
	Cost Center Description	PURCHASI NG	Subtotal	ADMI NI STRATI VE	OPERATION OF	10/28/2022 2: LAUNDRY &	52 pm
	Cost Genter Bescription	RECEIVING AND	Subtotal	AND GENERAL	PLANT	LI NEN SERVI CE	
		STORES					
		5. 02	5A. 02	5. 03	7. 00	8. 00	
4 00	GENERAL SERVI CE COST CENTERS			ı		I	4 00
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			•			4. 00
5. 01	00590 REVENUE CYCLE						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	518, 707					5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	40, 295	13, 046, 929				5. 03
7.00	00700 OPERATION OF PLANT	2, 757	11, 157, 272				7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	14 655	254, 677 2, 987, 890	1			8. 00 9. 00
10.00	01000 DI ETARY	14, 655 104, 857	2, 967, 690 1, 765, 685		1		10.00
11. 00	01100 CAFETERI A	104,037	849, 574	1			11. 00
13.00	01300 NURSING ADMINISTRATION	766	2, 317, 558	1	1		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	17, 545	203, 916	43, 390		-	14. 00
15. 00	01500 PHARMACY	0	1, 138, 503				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	600, 460	1		0	16.00
17. 00 22. 00	01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	349, 377 68, 774	i .			17. 00 22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	ı o	00, 774	14,034		0	22.00
30. 00	03000 ADULTS & PEDI ATRI CS	30, 911	9, 250, 002	1, 968, 243	3, 128, 586	115, 464	30. 00
31.00	03100 INTENSIVE CARE UNIT	14, 017	4, 171, 140				31. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	(0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	0, 50,	0.4/4.005	1 (70 447	1 110 000		
50.00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	34, 506	3, 164, 805				50.00
51. 00 53. 00	05300 ANESTHESI OLOGY	485	682, 330 934, 856			0	51. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		4, 750, 726				54. 00
54. 01	03630 ULTRA SOUND	o	0,700,720	., 5.5, 5.	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	c	0	0	56. 00
57. 00	05700 CT SCAN	0	0	C	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	07.75	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	114 (22)	130, 415	1			59.00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	116, 633 12, 045	4, 308, 081 117, 556	1			60. 00 62. 00
65. 00	06500 RESPIRATORY THERAPY	10, 406	1, 481, 780	1			65. 00
66. 00	06600 PHYSI CAL THERAPY	464	504, 812	1			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	263, 756	56, 123	96, 881	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	54, 648	1			68. 00
69. 00	06900 ELECTROCARDI OLOGY	236	305, 775	1			69. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	46, 046	377, 887 34, 330			•	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		1, 819, 287			-	73.00
76. 00	03950 MISC ANCILLARY	o	0,017,207				76.00
76. 01	03951 SLEEP LAB	o	0	c	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS		0, 0, 0	10.470	70.050	1	
90.00	09000 CLINIC	72 002	86, 817				90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	72, 083	7, 144, 618 0	1	1, 254, 973	158, 686	91.00
72.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		1		L	72.00
118.00		518, 707	74, 324, 236	13, 038, 771	13, 496, 938	434, 730	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38, 339				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192. 00
194. 00 200. 00	07950 MEALS ON WHEELS Cross Foot Adjustments	0	0) c	0	0	194. 00 200. 00
200.00			0		0	0	200.00
202.00		518, 707	74, 362, 575	13, 046, 929	13, 531, 352		
				•	•	•	

Provider CCN: 15-0047

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 06/01/2021 | Part I | To 05/31/2022 | Date/Time Prepared: | 10/28/2022 2: 52 pm

						10/28/2022 2:	52 pm
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
					ADMI NI STRATI ON	SERVI CES & SUPPLY	
		9.00	10. 00	11. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 REVENUE CYCLE						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL						5. 03
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG	5, 529, 731					9. 00
10.00	01000 DI ETARY	427, 720	3, 458, 579				10.00
11.00	01100 CAFETERI A	92, 744	0	1, 315, 959			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	104, 901	0	126, 652		000 005	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	35, 079	l l	282, 385	14. 00
15. 00	1	67, 960	0	50, 138	l l	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	171, 566	U	522		0	16.00
17. 00	1 1	0	U	24, 286		0	17. 00
22. 00		0	0	C	ıj U	0	22. 00
30. 00	I NPATIENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDIATRI CS	1, 504, 450	2, 989, 814	342, 176	1, 621, 234	25, 838	30. 00
31. 00	+ I	302, 623	468, 765	63, 805		11, 716	31. 00
44. 00	1 1	302, 023	408, 703	03, 603	· · · · · · · · · · · · · · · · · · ·	0	44. 00
44.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		<u> </u>	0	44.00
50. 00		679, 089	O	32, 207	130, 691	28, 843	50. 00
51. 00	05100 RECOVERY ROOM	95, 018	o	14, 972		405	51. 00
53. 00	I I	0	o	, <u>.</u>	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	721, 363	o	132, 049	7, 666	0	54.00
54. 01	03630 ULTRA SOUND	0	o	C	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	O	o	C	o	0	56. 00
57. 00	05700 CT SCAN	o	o	C	o	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	О	C	o	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	30, 000	o	7, 312	el o	0	59. 00
60.00	06000 LABORATORY	304, 623	o	192, 981		97, 490	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12, 627	o	C	o	10, 068	62.00
65.00	06500 RESPIRATORY THERAPY	116, 626	0	79, 299	0	8, 698	65.00
66. 00	06600 PHYSI CAL THERAPY	121, 685	0	14, 537	0	388	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	46, 588	0	9, 314	. 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	17, 961	0	1, 132	1	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	17, 059	0	14, 101	0	197	69. 00
71. 00	1	0	0	C	0	38, 489	71. 00
72. 00		0	0	C	0	0	72. 00
73. 00		40, 352	0	C	0	0	73. 00
76. 00		0	0	C	0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	C	0	0	76. 01
76. 02		0	0	C	0	0	76. 02
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	34, 745	0	C	o	0	90. 00
	09100 EMERGENCY	603, 482	0			60, 253	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	003, 462	ď	175, 377	767,010	00, 255	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118. 00		5, 513, 182	3, 458, 579	1, 315, 959	3, 260, 394	282, 385	118. 00
	NONREI MBURSABLE COST CENTERS	5/2/2//	5, 155, 511	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5/ 200/ 01.1		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 549	0	C	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	O	0	C	0	0	192. 00
194.00	07950 MEALS ON WHEELS	o	o	C	o	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	C	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	5, 529, 731	3, 458, 579	1, 315, 959	3, 260, 394	282, 385	202. 00

| Peri od: | Worksheet B | From 06/01/2021 | Part | | To 05/31/2022 | Date/Time Prepared: | Provider CCN: 15-0047

				T	o 05/31/2022	Date/Time Pre 10/28/2022 2:	
					INTERNS &	10/20/2022 2.	JZ pili
					RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHER	Subtotal	
			RECORDS &		PRGM COSTS		
			LI BRARY		APPRV		
		15. 00	16.00	17.00	22.00	24.00	
GE	NERAL SERVICE COST CENTERS			'			
1.00 00	100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 00	200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00	400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00	590 REVENUE CYCLE						5. 01
5. 02 00	560 PURCHASING RECEIVING AND STORES						5. 02
5. 03 00	591 ADMINISTRATIVE AND GENERAL						5. 03
7. 00 00	700 OPERATION OF PLANT						7. 00
8.00 00	800 LAUNDRY & LINEN SERVICE						8. 00
	900 HOUSEKEEPI NG						9. 00
1	000 DI ETARY						10. 00
	100 CAFETERI A						11. 00
	300 NURSING ADMINISTRATION						13. 00
	400 CENTRAL SERVICES & SUPPLY						14. 00
	500 PHARMACY	1, 640, 181					15. 00
	600 MEDICAL RECORDS & LIBRARY	0	1, 257, 097				16. 00
1	700 SOCIAL SERVICE	0	C	448, 004			17. 00
	200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	C	0	83, 408		22. 00
	PATIENT ROUTINE SERVICE COST CENTERS						
1	000 ADULTS & PEDIATRICS	0	113, 014	1		21, 492, 975	1
	100 I NTENSI VE CARE UNI T	0	58, 128		I I	7, 190, 198	1
	400 SKILLED NURSING FACILITY	0	C	0	0	0	44. 00
	CILLARY SERVICE COST CENTERS		05.077			/ 4/7 5/0	
	000 OPERATING ROOM	0	25, 877			6, 167, 560	
1	100 RECOVERY ROOM	0	5, 943	•		1, 226, 162	1
	300 ANESTHESI OLOGY		4, 922			1, 138, 699	1
	400 RADI OLOGY-DI AGNOSTI C 630 ULTRA SOUND		336, 204 0			8, 527, 422 0	1
1	600 RADI OI SOTOPE			1		0	1
	700 CT SCAN					0	
1	800 MAGNETIC RESONANCE IMAGING (MRI)		C	i .		0	58.00
1	900 CARDI AC CATHETERI ZATI ON	o o	976			258, 839	1
	000 LABORATORY	o o	205, 093	1		6, 658, 435	1
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 319	1		194, 843	1
1	500 RESPIRATORY THERAPY	0	51, 211			2, 295, 442	1
1	600 PHYSI CAL THERAPY	o	6, 401	1		1, 008, 288	1
1	700 OCCUPATI ONAL THERAPY	o	5, 457			478, 119	1
	800 SPEECH PATHOLOGY	o	435			123, 154	1
	900 ELECTROCARDI OLOGY	0	12, 934		0	450, 918	1
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	20, 425	0	0	517, 209	71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 257	0	0	43, 892	72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	1, 640, 181	155, 759	0	0	4, 126, 607	73. 00
76. 00 03	950 MISC ANCILLARY	O	C	0	0	0	76. 00
76. 01 03	951 SLEEP LAB	O	C	0	0	0	76. 01
76. 02 03	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	0	0	0	76. 02
OU [*]	TPATIENT SERVICE COST CENTERS						
	000 CLI NI C	0	1, 380	0	0	213, 668	90. 00
	100 EMERGENCY	0	247, 362	2 0	0	12, 152, 634	
	200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	ECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 640, 181	1, 257, 097	448, 004	83, 408	74, 265, 064	118. 00
	NREI MBURSABLE COST CENTERS				T		
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C				190. 00
	200 PHYSI CLANS' PRI VATE OFFI CES	0	C	1	1		192. 00
	950 MEALS ON WHEELS	0	C	0	0		194. 00
200.00	Cross Foot Adjustments		-		0		200.00
201.00	Negative Cost Centers	1 (40 101	1 257 227	0	0 400		201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 640, 181	1, 257, 097	448, 004	83, 408	74, 362, 575	J2U2. UU

Health Financial Systems

LUTHERAN DOWNTOWN HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0047

Period: Worksheet R

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0047 Peri od: Worksheet B From 06/01/2021 Part I Date/Time Prepared: 05/31/2022 10/28/2022 2:52 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00590 REVENUE CYCLE 5.01 5. 01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00591 ADMINISTRATIVE AND GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 01000 DI ETARY 10.00 10.00 11. 00 01100 CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 -83, 408 21, 409, 567 30.00 03100 INTENSIVE CARE UNIT 7, 190, 198 31.00 31 00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM Э 6, 167, 560 50.00 05100 RECOVERY ROOM 00000000000000000000 51.00 51.00 1, 226, 162 53.00 05300 ANESTHESI OLOGY 1, 138, 699 53.00 05400 RADI OLOGY-DI AGNOSTI C 8, 527, 422 54.00 54.00 03630 ULTRA SOUND 54.01 0 54.01 05600 RADI OI SOTOPE 56.00 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 258, 839 59.00 06000 LABORATORY 60 00 6, 658, 435 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 194, 843 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 2, 295, 442 65.00 06600 PHYSI CAL THERAPY 1,008,288 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 478, 119 67.00 68.00 06800 SPEECH PATHOLOGY 123, 154 68.00 69.00 06900 ELECTROCARDI OLOGY 450, 918 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 517, 209 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 892 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 126, 607 73.00 76.00 03950 MISC ANCILLARY 0 76.00 03951 SLEEP LAB 0 76.01 Ω 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 213, 668 91.00 09100 EMERGENCY 12, 152, 634 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -83, 408 74, 181, 656 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 97, 460 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192 00 51 194.00 07950 MEALS ON WHEELS 0 C 194.00 200.00 Cross Foot Adjustments 0 200.00 0 201.00 Negative Cost Centers 201.00 0 202.00 TOTAL (sum lines 118 through 201) -83, 408 74, 279, 167 202.00

Period: Worksheet B From 06/01/2021 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				To	05/31/2022	Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		10/28/2022 2:	52 pili
	Coot Conton Decemintion	Dimontly	DIDC 0 FLVT	MVDLE FOULD	Cubtatal	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZN	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	82, 554	96, 059	178, 613	178, 613	2. 00 4. 00
5. 01	00590 REVENUE CYCLE		292, 886	I	633, 687	9, 204	1
5.02	00560 PURCHASING RECEIVING AND STORES	o	203, 404	236, 680	440, 084	180	5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL	0	767, 844		1, 661, 304	23, 581	5. 03
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	3, 386, 981 64, 834		7, 328, 058 140, 274	9, 747 0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	981, 452	1	2, 123, 465	4, 838	1
10.00	01000 DI ETARY	O	457, 994	1	990, 914	5	10.00
11.00	01100 CAFETERIA	0	99, 308	1	214, 863	1 222	11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	112, 325 0		243, 026 0	16, 302 2, 050	1
15. 00	01500 PHARMACY		72, 770	_	157, 445	6, 635	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	183, 710		397, 474	32	1
17. 00	01700 SOCIAL SERVICE	0	0	- 1	0	2, 496	1
22. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	22. 00
30. 00	03000 ADULTS & PEDIATRICS	0	1, 610, 936	1, 874, 479	3, 485, 415	34, 656	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	324, 043	377, 055	701, 098	7, 919	1
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	727, 155	846, 115	1, 573, 270	4, 176	50.00
51. 00	05100 RECOVERY ROOM	O	101, 744	1	220, 133	1, 629	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	772, 421	898, 786	1, 671, 207	11, 717 0	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE	0	0		ol Ol	0	56.00
57. 00	05700 CT SCAN	0	0	Ō	ō	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	32, 123 326, 185		69, 501 705, 732	466 12, 959	59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	13, 521		29, 254	12, 959	62.00
65. 00	06500 RESPIRATORY THERAPY	l o	124, 881	1	270, 192	7, 211	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	130, 298	1	281, 912	1, 501	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	49, 885	1	107, 931	1, 030	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	19, 232 18, 266		41, 610 39, 520	87 1, 631	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	i o	0		0 7, 020	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	43, 209		93, 486	0	73.00
76. 00 76. 01	03950 MISC ANCILLARY 03951 SLEEP LAB	0	0		0	0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	Ö			Ö	0	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0		1	80, 494 1, 398, 109	0 18, 560	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		646, 197	/51, 912	1, 398, 109	18, 560	91.00
	SPECIAL PURPOSE COST CENTERS				-,		
118.00		0	11, 683, 362	13, 594, 709	25, 278, 071	178, 613	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 720	20, 619	38, 339	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		0	20, 017	0		192. 00
194.00	07950 MEALS ON WHEELS	0	0	0	О		194. 00
200.00	, ,		_		0	^	200.00
201. 00 202. 00		0	11, 701, 082	0 13, 615, 328	25, 316, 410	0 178, 613	201. 00 202. 00
202.00	1.5 (Sam 1.1	١	1, 701, 002		20, 510, 110	1,0,010	1-02.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				To	05/31/2022	Date/Time Pre	
	Cost Center Description	REVENUE CYCLE	PURCHASI NG	ADMI NI STRATI VE	OPERATION OF	10/28/2022 2: LAUNDRY &	52 piii
			RECEIVING AND		PLANT	LINEN SERVICE	
			STORES	5.00	7.00	0.00	
	GENERAL SERVICE COST CENTERS	5. 01	5. 02	5. 03	7. 00	8. 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. 01	00590 REVENUE CYCLE	642, 891					5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	0	440, 264				5. 02
5.03	00591 ADMINISTRATIVE AND GENERAL	0	34, 202				5. 03
7.00	00700 OPERATION OF PLANT	0	2, 340			040 407	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	12 420		71, 213	218, 627	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	12, 439 89, 000		1, 078, 018 503, 056	0	9. 00 10. 00
11. 00	01100 CAFETERI A	0	0 89,000	1		0	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	651		123, 377	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	14, 892		0	0	14. 00
15.00	01500 PHARMACY	0	0		79, 930	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	16, 835	201, 785	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	1, 928	0	0	22. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F7.70/	T 0/ 007	050.040	4 7/0 400	F0.0/0	00.00
30.00	03000 ADULTS & PEDIATRICS	57, 796	· ·		1, 769, 439	58, 060	1
31. 00 44. 00	03100 INTENSIVE CARE UNIT 04400 SKILLED NURSING FACILITY	29, 727		1	355, 926 0	35, 908 0	31. 00 44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS		0	<u> </u>	U	0	44.00
50. 00	05000 OPERATI NG ROOM	13, 234	29, 288	88, 732	798, 701	10, 273	50.00
51. 00	05100 RECOVERY ROOM	3, 039			111, 754	0	51. 00
53.00	05300 ANESTHESI OLOGY	2, 517	0	26, 211	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	171, 943	0	133, 196	848, 421	34, 408	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
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 MAGNETIC RESONANCE I MAGING (MRI)	499	0	_	0 25 204	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	104, 886		-,	35, 284 358, 278	0	59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 697			14, 851	0	62.00
65. 00	06500 RESPIRATORY THERAPY	26, 190			137, 168	0	65.00
66. 00	06600 PHYSI CAL THERAPY	3, 273			143, 118	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	2, 791	l e		54, 793	0	67. 00
68.00	06800 SPEECH PATHOLOGY	222	0	1, 532	21, 124	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 614			20, 063	158	•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 445			0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 154	l .		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 03950 MISC ANCILLARY	79, 656	l .		47, 460	0	73.00
76. 00 76. 01	03951 SLEEP LAB	0	0	_	0	0	76. 00 76. 01
76. 01	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES				0	0	76. 01
70.02	OUTPATIENT SERVICE COST CENTERS			1	0		70.02
90.00	09000 CLI NI C	706	0	2, 434	40, 864	0	90.00
91.00	09100 EMERGENCY	126, 502	61, 182	200, 314	709, 777	79, 794	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS		1				
118. 00		642, 891	440, 264	1, 718, 012	7, 633, 479	218, 601	J118. 00
100.00	NONREI MBURSABLE COST CENTERS			1 075	10 4/4	^	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		0		19, 464		190. 00 192. 00
	07950 MEALS ON WHEELS				0		194. 00
200.00					U		200. 00
201.00	1 1	0	0	0	0	0	201.00
202.00		642, 891	440, 264	1, 719, 087	7, 652, 943		
	· · · · · · · · · · · · · · · · · · ·	•	•			•	

| Peri od: | Worksheet B | From 06/01/2021 | Part II | To 05/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047

				Т	o 05/31/2022	Date/Time Pre	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	10/28/2022 2: CENTRAL	32 piii
	oost conten boscii pti on	11000EREEL TWO	DI E IANG	ON ETENIA	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		9.00	10.00	11. 00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 REVENUE CYCLE						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00591 ADMINISTRATIVE AND GENERAL						5. 03
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	2 202 521					8.00
10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 302, 531	1 007 020				9. 00 10. 00
11. 00	01100 CAFETERI A	255, 448 55, 390	1, 887, 928 0	403, 153			11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	62, 650	0	38, 801	1		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	02,030	0	10, 747		33, 406	1
15. 00	01500 PHARMACY	40, 588	0	15, 360	I I	0 33, 400	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	102, 465	0	160	I I	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	7, 440	1	0	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o	0	0	1	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,	-		,		
30.00	03000 ADULTS & PEDI ATRI CS	898, 503	1, 632, 044	104, 828	273, 380	3, 057	30.00
31.00	03100 INTENSIVE CARE UNIT	180, 736	255, 884	19, 547	72, 253	1, 386	31. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	405, 574	0	9, 867	,	3, 412	1
51. 00	05100 RECOVERY ROOM	56, 748	0	4, 587	I	48	1
53. 00	05300 ANESTHESI OLOGY	0	0	0		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	430, 821	0	40, 454	I	0	54. 00
54. 01	03630 ULTRA SOUND	0	0	C	- 1	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	O	- 1	0	56.00
57. 00	05700 CT SCAN	0	0	O	1	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	17 017	0	0	-	0	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	17, 917	0	2, 240 50, 131	l l	11 522	59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	181, 931 7, 541	0	59, 121 0	1	11, 533 1, 191	62.00
65. 00	06500 RESPIRATORY THERAPY	69, 653	0	24, 294	1	1, 191	1
66. 00	06600 PHYSI CAL THERAPY	72, 674	0	4, 453	1	1, 029	1
67. 00	06700 OCCUPATI ONAL THERAPY	27, 824	0	2, 853	1	0	67.00
68. 00	06800 SPEECH PATHOLOGY	10, 727	0	347	l l	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	10, 188	0	4, 320	I I	23	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	., 525	l	4, 553	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	C	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	24, 100	o	C	o	0	73. 00
76.00	03950 MISC ANCILLARY	0	0	C	0	0	76. 00
76. 01	03951 SLEEP LAB	O	0	C	o	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	20, 751	0		1 4	0	
	09100 EMERGENCY	360, 419	0	53, 734	166, 536	7, 128	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110 00	SPECIAL PURPOSE COST CENTERS	2 202 (42	1 007 000	400 450	E40 704	22.407	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 292, 648	1, 887, 928	403, 153	549, 784	33, 406	118. 00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 883	0	C	ol	^	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,003	0	C			190.00
	07950 MEALS ON WHEELS		0	0			194. 00
200.00		١	٩		1	U	200. 00
200.00			n	<u></u>		Λ	201. 00
201.00		3, 302, 531	1, 887, 928	403, 153	549, 784		202. 00
202.00	1.5 (Sum 111105 110 till ought 201)	0,002,001	1,007,720	100, 100	317,704	55, 400	1202.00

| Peri od: | Worksheet B | From 06/01/2021 | Part II | To 05/31/2022 | Date/Time Prepared: Provider CCN: 15-0047

				Т	o 05/31/2022	Date/Time Pre 10/28/2022 2:	
					INTERNS &	10/20/2022 2.	JZ piii
					RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHER	Subtotal	
			RECORDS &		PRGM COSTS		
		15.00	LI BRARY	17.00	APPRV	24.00	
CE	NERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00	22.00	24. 00	
	0100 CAP REL COSTS-BLDG & FLXT			Ι			1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2. 00
	0400 EMPLOYEE BENEFITS DEPARTMENT					•	4. 00
	0590 REVENUE CYCLE						5. 01
5. 02 00	0560 PURCHASING RECEIVING AND STORES						5. 02
5. 03 00	0591 ADMINISTRATIVE AND GENERAL						5. 03
1	0700 OPERATION OF PLANT						7. 00
1	0800 LAUNDRY & LINEN SERVICE						8. 00
	0900 HOUSEKEEPI NG						9. 00
	000 DI ETARY						10.00
	100 CAFETERIA						11.00
	300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY						13. 00 14. 00
	1500 PHARMACY	331, 878					15. 00
	1600 MEDICAL RECORDS & LIBRARY	331, 070	718, 751				16.00
	1700 SOCIAL SERVICE		710, 731				17. 00
	2200 I&R SERVICES-OTHER PRGM COSTS APPRV		0	1			22. 00
	IPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		,	1,720		1 22.00
	3000 ADULTS & PEDIATRICS	0	64, 605	15, 448		8, 682, 810	30. 00
31.00 03	3100 INTENSIVE CARE UNIT	0	33, 229	4, 283		1, 826, 739	31. 00
	1400 SKILLED NURSING FACILITY	0	0	0		0	44. 00
	ICI LLARY SERVI CE COST CENTERS			1 -	1		4
	5000 OPERATING ROOM	0	14, 793	•		2, 973, 358 435, 160	1
	5100 RECOVERY ROOM 5300 ANESTHESIOLOGY	0	3, 397 2, 814	1		31, 542	
1	5400 RADI OLOGY-DI AGNOSTI C		192, 321	1		3, 535, 781	
	8630 ULTRA SOUND		172, 321	1		0, 555, 761	1
	5600 RADI OI SOTOPE	l ol	0	1		Ö	1
	5700 CT SCAN	o	0	o		Ö	
1	5800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	0		0	58. 00
59. 00 05	5900 CARDI AC CATHETERI ZATI ON	o	558	0		130, 121	59. 00
	5000 LABORATORY	0	117, 242	2 0		1, 771, 461	60.00
1	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 897			69, 951	62. 00
	5500 RESPI RATORY THERAPY	0	29, 275			615, 389	1
	6600 PHYSI CAL THERAPY	0	3, 659			525, 183	1
	5700 OCCUPATI ONAL THERAPY	0	3, 119			207, 736	1
	5800 SPEECH PATHOLOGY	0	249	•		75, 898	1
	9900 ELECTROCARDIOLOGY 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 393 11, 676			98, 683 76, 351	1
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 290			3, 407	1
	7300 DRUGS CHARGED TO PATIENTS	331, 878	89, 040			716, 627	1
	3950 MISC ANCILLARY	0	07, 010	1		0	1
	3951 SLEEP LAB	l ol	0			Ö	1
	B550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	O	o		0	1
	ITPATIENT SERVICE COST CENTERS						
	POOO CLI NI C	0	789			146, 038	
	P100 EMERGENCY	0	141, 405	0		3, 323, 460	1
	0200 OBSERVATION BEDS (NON-DISTINCT PART			<u> </u>			92.00
118. 00	PECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	331, 878	718, 751	19, 731	0	25, 245, 695	110 00
	NREIMBURSABLE COST CENTERS	331,070	/10, /31	19, /31	0	25, 245, 695]116.00
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0		68, 761	190. 00
	2200 PHYSI CLANS' PRI VATE OFFI CES		0	1			192. 00
	7950 MEALS ON WHEELS	o	0	0			194. 00
200. 00	Cross Foot Adjustments			1	1, 928		200. 00
201.00	Negative Cost Centers	0	0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	331, 878	718, 751	19, 731	1, 928	25, 316, 410	J202. 00

Health Financial Systems LUTHERAN DOWNTOWN HOSPITAL In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0047 Peri od: Worksheet B From 06/01/2021 Part II 05/31/2022 Date/Time Prepared: 10/28/2022 2:52 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00590 REVENUE CYCLE 5.01 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00591 ADMINISTRATIVE AND GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 01000 DI ETARY 10.00 10.00 11. 00 01100 CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 8, 682, 810 30.00 03100 INTENSIVE CARE UNIT 0 1, 826, 739 31.00 31 00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 973, 358 50.00 05100 RECOVERY ROOM 0000000000000000000000 435, 160 51.00 51.00 53.00 05300 ANESTHESI OLOGY 31, 542 53.00 05400 RADI OLOGY-DI AGNOSTI C 3, 535, 781 54.00 54.00 03630 ULTRA SOUND 54.01 0 54.01 05600 RADI 01 S0T0PE 56.00 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 130, 121 59.00 06000 LABORATORY 60 00 1, 771, 461 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 69, 951 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 615, 389 65.00 06600 PHYSI CAL THERAPY 525, 183 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 207, 736 67.00 68.00 06800 SPEECH PATHOLOGY 75, 898 68.00 69.00 06900 ELECTROCARDI OLOGY 98, 683 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 76, 351 71.00 3, 407 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 716, 627 73.00 03950 MISC ANCILLARY 76.00 0 76.00 03951 SLEEP LAB 76.01 0 76.01 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 146, 038 91.00 09100 EMERGENCY 0 3, 323, 460 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 25, 245, 695 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 68, 761 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192 00 26 194.00 07950 MEALS ON WHEELS Ω 194.00 200.00 Cross Foot Adjustments 1, 928 200.00 0 201.00 Negative Cost Centers 201.00

25, 316, 410

202.00

TOTAL (sum lines 118 through 201)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0047 Peri od: Worksheet B-1 From 06/01/2021 05/31/2022 Date/Time Prepared: 10/28/2022 2:52 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** REVENUE CYCLE **PURCHASI NG** Cost Center Description (SQUARE FOO (GROSS CHAR RECEIVING AND (SQUARE FOO BENEFITS TAGE) TAGE) DEPARTMENT STORES. GES) (GROSS (COSTED REQUIS.) SALARI ES) 1.00 2.00 5. 01 4.00 5.02 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 278 658 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 278, 658 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,966 1, 966 17, 325, 044 4.00 00590 REVENUE CYCLE 6, 975 6 975 892, 758 218, 901, 752 5 01 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 4,844 4,844 17, 462 2, 625, 922 5.02 5.03 00591 ADMINISTRATIVE AND GENERAL 18, 286 18, 286 2, 287, 231 203, 992 5.03 945, 358 0 7.00 00700 OPERATION OF PLANT 80,660 80,660 13, 959 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 1.544 1.544 0 8 00 9.00 00900 HOUSEKEEPI NG 23, 373 23, 373 469, 269 0 74, 192 9.00 01000 DI ETARY 10, 907 o 10.00 10, 907 495 530, 831 10.00 0 01100 CAFETERI A 2, 365 2, 365 11.00 123 11.00 n 01300 NURSING ADMINISTRATION 13.00 2,675 2, 675 1, 581, 138 3.880 13.00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 198, 812 88, 821 14.00 01500 PHARMACY 1.733 15.00 1,733 643, 595 15.00 0 01600 MEDICAL RECORDS & LIBRARY 4, 375 16,00 4, 375 3.061 0 16,00 17 00 01700 SOCIAL SERVICE 242, 075 0 17 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 19, 678, 607 30.00 03000 ADULTS & PEDLATRICS 38, 364 38, 364 3, 362, 168 156, 487 30.00 31.00 03100 INTENSIVE CARE UNIT 7,717 7,717 768, 114 10, 121, 591 70, 960 31.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 17, 317 4, 505, 856 174. 683 50.00 17.317 405, 084 51.00 05100 RECOVERY ROOM 2, 423 2, 423 157, 994 1, 034, 876 2, 454 51.00 05300 ANESTHESI OLOGY 53.00 857, 065 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 18, 395 18, 395 1, 136, 498 58, 551, 173 54.00 0 54.01 03630 ULTRA SOUND C 0 0 54.01 0 05600 RADI OI SOTOPE 56.00 0 56.00 57.00 05700 CT SCAN 0 0 0 Ω 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 Ω Ω Ω 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 765 765 45, 181 169, 992 0 59.00 06000 LABORATORY 60.00 7,768 7, 768 1, 256, 956 35, 711, 893 590, 445 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 577, 905 60, 979 62.00 322 62.00 322 06500 RESPIRATORY THERAPY 699, 382 52, 678 65.00 2,974 2, 974 8, 917, 097 65.00 66.00 06600 PHYSI CAL THERAPY 3, 103 3, 103 145, 621 1, 114, 520 2, 347 66.00 67.00 06700 OCCUPATI ONAL THERAPY 1, 188 1, 188 99, 900 950, 126 67.00 06800 SPEECH PATHOLOGY 68 00 458 458 8 414 75 731 68 00 0 69.00 06900 ELECTROCARDI OLOGY 435 435 158, 153 2, 252, 056 1, 195 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 3, 556, 501 233, 103 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 393, 067 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1.029 1, 029 0 27, 121, 500 73 00 73 00 0 76.00 03950 MISC ANCILLARY 0 0 76.00 03951 SLEEP LAB 0 76.01 76.01 0 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.02 76.02 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 886 886 240, 297 0 90.00 09100 EMERGENCY 1, 800, 202 91.00 15, 389 15, 389 43, 071, 899 364, 916 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 278, 236 278, 236 17, 325, 044 218, 901, 752 2, 625, 922 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 422 422 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 194.00 07950 MEALS ON WHEELS 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 11, 701, 082 13, 615, 328 4,008,266 5, 760, 108 518, 707 202. 00 Cost to be allocated (per Wkst. B, Part I) 0. 197533 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 41. 990835 48.860352 0.231357 0.026314 204.00 Cost to be allocated (per Wkst. B, 642, 891 440, 264 204. 00 178, 613 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.010310 0.002937 0.167661 205.00 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207 00 NAHE unit cost multiplier (Wkst. D, 207 00 Parts III and IV)

Provider CCN: 15-0047

				1	0 05/31/2022	Date/Time Pre 10/28/2022 2:	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FOO TAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FOO TAGE)	OZ piii
		5A. 03	5. 03	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00590 REVENUE CYCLE						5. 01
5. 02 5. 03	00560 PURCHASING RECEIVING AND STORES 00591 ADMINISTRATIVE AND GENERAL	-13, 046, 929	61, 315, 646				5. 02 5. 03
7. 00	00700 OPERATION OF PLANT	-13,040,727	11, 157, 272				7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	254, 677				8.00
9. 00	00900 HOUSEKEEPI NG	0	2, 987, 890			141, 010	9. 00
10.00	01000 DI ETARY	0	1, 765, 685		0	10, 907	10.00
11. 00	01100 CAFETERI A	0	849, 574	2, 365	0	2, 365	11. 00
13.00	01300 NURSING ADMINISTRATION	0	2, 317, 558	2, 675	0	2, 675	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	203, 916		0	0	14. 00
15.00	01500 PHARMACY	0	1, 138, 503			1, 733	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	600, 460		0	4, 375	16.00
17. 00 22. 00	01700 SOCIAL SERVICE 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	349, 377 68. 774		0	0	17. 00 22. 00
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		00, 774	0	<u> </u>	0	22.00
30. 00	03000 ADULTS & PEDIATRICS	0	9, 250, 002	38, 364	38, 552	38, 364	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	4, 171, 140		23, 843	7, 717	31.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	. 0	0	. 0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	3, 164, 805			17, 317	50.00
51. 00	05100 RECOVERY ROOM	0	682, 330		0	2, 423	51.00
53. 00	05300 ANESTHESI OLOGY	0	934, 856		0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	4, 750, 726	18, 395	22, 847	18, 395	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56. 00 57. 00	05600	0	0	0	0	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	130, 415	765	0	765	59.00
60.00	06000 LABORATORY	0	4, 308, 081	•		7, 768	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	117, 556		0	322	62. 00
65.00	06500 RESPI RATORY THERAPY	0	1, 481, 780	2, 974	0	2, 974	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	504, 812	3, 103	0	3, 103	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	263, 756			1, 188	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	54, 648			458	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	305, 775		105	435 0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	377, 887 34, 330		0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 819, 287		0	1, 029	73.00
76. 00	03950 MISC ANCILLARY	0	0	0	0	0	76.00
76. 01	03951 SLEEP LAB	0	0	Ō	0	Ō	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0				886	
91. 00	09100 EMERGENCY	0	7, 144, 618	15, 389	52, 983	15, 389	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
118. 00	SPECIAL PURPOSE COST CENTERS	-13, 046, 929	41 277 207	145 505	1/5 151	140 500	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-13, 046, 929	61, 277, 307	165, 505	145, 151	140, 588	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38, 339	422	0	422	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		0			192. 00
	07950 MEALS ON WHEELS	0	0	Ō			
200.00							200. 00
201.00	Negative Cost Centers						201. 00
202.00			13, 046, 929	13, 531, 352	434, 781	5, 529, 731	202. 00
	Part I)			04 550004		00 0454/0	
203.00			0. 212783			39. 215169	
204.00			1, 719, 087	7, 652, 943	218, 627	3, 302, 531	204.00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part		0. 028037	46. 122349	1. 506027	23. 420545	205 00
∠∪3. ∪(0.020037	40. 122349	1. 500027	23. 420345	203.00
206.00							206. 00
_30.00	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)			l			1

	THAIRCIAN STATISTICAL PAGES	LUTHERAN DOWNTO		CN 15 0047 D		U OI FOIII CMS	
COST	ILLOCATION - STATISTICAL BASIS		Provi der C		eriod: rom 06/01/2021 o 05/31/2022	Worksheet B-1 Date/Time Pre 10/28/2022 2:	pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (GROSS SALARI ES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	J. J. J. J. J. J. J. J. J. J. J. J. J. J
		10.00	11. 00	13.00	14.00	15. 00	
	GENERAL SERVI CE COST CENTERS			1			
1.00 2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 22.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 REVENUE CYCLE 00560 PURCHASING RECEIVING AND STORES 00591 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFTERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	34, 035 0 0 0 0 0 0	15, 118 1, 453 403 576 6 279 0	5, 274, 929 0 0 0 0	1, 710, 247 0 0 0 0	1, 099, 662 0 0 0	16. 00 17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS	29, 422	3, 931		156, 487 70, 960	0	
	03100 INTENSIVE CARE UNIT 04400 SKILLED NURSING FACILITY	4, 613	733 0	1	70, 960	0	
	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1	<u> </u>		1 55
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0 0	370 172		174, 683 2, 454	0	
53.00	05300 ANESTHESI OLOGY	0	0		0	0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	1, 517	12, 403	0	0	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE		0	Ö	ol	0	1
57. 00	05700 CT SCAN	0	0	0	О	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	1 4	0	0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	84 2, 217		0 590, 445	0	59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		2, 217	0	60, 979	0	62.00
65. 00	06500 RESPI RATORY THERAPY	o	911		52, 678	0	1
66. 00	06600 PHYSI CAL THERAPY	0	167		2, 347	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	107	1	0	0	67. 00
68. 00 69. 00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY	0	13 162	1	0 1, 195	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		102	0	233, 103	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0	Ö	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	1, 099, 662	1
	03950 MI SC ANCI LLARY	0	0	0	0	0	1
	03951 SLEEP LAB 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		, o	<u>~</u>		70.02
90. 00		0	0		0	0	
91.00		0	2, 015	1, 597, 837	364, 916	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00		34, 035	15, 118	5, 274, 929	1, 710, 247	1, 099, 662	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
200.00	07950 MEALS ON WHEELS Cross Foot Adjustments		U	ı o	U	Ü	194. 00 200. 00
201.00							201. 00
202.00	Part I)	3, 458, 579	1, 315, 959		282, 385	1, 640, 181	
203. 00 204. 00	1 1	101. 618305 1, 887, 928	87. 045839 403, 153	1	0. 165114 33, 406	1. 491532 331, 878	1
205. 00		55. 470192	26. 667086	0. 104226	0. 019533	0. 301800	205. 00
206.00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	Parts III and IV)	l l					I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0047

Cost Center Description					10		Prepared: 2 2:52 pm
## CALL SERVICE PROVICE SAME ## COSTS (CORES CALLER COSTS) ## COSTS (CORES CALLER COSTS) ## COSTS (COSTS) COSTS) ## COSTS (COSTS) ## COSTS (COSTS (COSTS (COSTS (COSTS) ## COSTS (COSTS (COSTS (COSTS (COSTS) ## COSTS (COSTS					INTERNS &	, =	
NECROS CARR CONT CAPITES TRACTOR CONT CAPITES CONT CAP							
CEMBERAL SERVICE COST CENTERS 1.00 17.00 22.00 1	(Cost Center Description		SOCIAL SERVICE			
CEREBAL SERVICE COST CENTERS 19.00 17.00 22.00				/ /TOTAL PATIENT			
The REMERIA SERVICE CRIST CHATTERS 1.1.00 0.0000 CAP REL COSTS AVELE EQUIT 2.00 CAP REL COSTS CAP REL C			•				
1.00	OFNERA	L OFFILM OF COOT OFFITFING	16. 00	17. 00	22. 00		
2.00 00.000 CAP REL COSTS-MARLE EQUIP				I			1 00
4.00 00.000 DEPLOYER INFERTIS DEPARTMENT 5.00 5.	1 1						
5.01 00 0000 REVENUE CYCLE 5.02 00000 HORIZONIAN RETEL VIN NO AND STORES 5.03 00000 HORIZONIAN RETEL VIN NO AND STORES 5.04 00000 HORIZONIAN RETEL VIN NO AND STORES 6.05 00000 HORIZONIAN RETEL VIN NO AND STORES 6.06 00000 HORIZONIAN RETEL VIN NO AND STORES 6.07 00000 HORIZONIAN RETEL VIN NO AND STORES 6.08 00000 HORIZONIAN RETEL VIN NO AND STORES 6.09 00000 HORIZONIAN RETEL VIN NO AND STORES 6.00 000000 HORIZONIAN RETEL VIN NO AND STORES 6.00 00000 HORIZONIAN RETEL VIN NO AND S							l l
5 02 00000 PURCHAST NO RECEL YI NO AND STORES 5 03 000001 PURCHAST NO OF PLANT 7 00 00000 OPERAT TO NO FELANT 8 00 000000 CAPETRY I NO STORY 10 00 10000 DI FTANY 11 00 010000 CAPETRY I NO 10 10 10 10 10 10 10 10 10 10 10 10 10	1 1						
7.00 0.0700 DOPERATION OF PLANT	1 1						5. 02
8.00 00000 AUNIONY & LINENN SERVICE	5. 03 00591	ADMINISTRATIVE AND GENERAL					5. 03
9.00 0.0940 0.095EKEPI NS	1 1						
10.00 01000 DETARY	1 1						
11.00 01100 CAFETERIA							l l
13.00 1300 MURSING ADMINISTRATION 14.00 1400 1400 1400 1400 1400 1400 1400 1400 1400 1400 1400 1400 15.00 17.00							
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 01600 MEDICAL RECORDS & LIBRARY 218,901,752 1.00 1.	1 1						
16.00 10-00 MEDICAL RECORDS & LIBRARY 218, 901, 752	1 1						•
17.00 0.700 SOZIAL SERVICE OST CENTER PROJECTS APPRV 0 0 100 22.00 220.00 230.00 2	15. 00 01500 F	PHARMACY					15. 00
			218, 901, 752				16. 00
INPATI ENT ROUTINE SERVICE COST CENTERS 19, 678, 607 5, 817 100 30, 00 310 00 310 00 310 00 310 00 0			0				•
0.000 0.0000 0.0001 0.0001 0.0001 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.000000 0.00000000			0	0	100		22. 00
31.00 3100 INTENSIVE CARE UNIT 10.121.591 1.613 0 44.00 440.00 440.00 440.00 440.00 440.00 440.00 440.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 51.00			10 470 407	E 017	100		20.00
44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0							•
MAIL LIARY SERVICE COST CENTERS	1 1						
51.00			-	_	-1		
53.00 05300 ANESTHESI OLOGY 857, 065 0 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 56.00 57.	50. 00 05000 0	OPERATING ROOM	4, 505, 856	0	0		50. 00
54. 00 05400 RADIOLOGY-DIAGNOSTIC 58, 551, 173 0 0 54, 01							
54. 01 03630 LITRA SOUND 0 0 0 0 55. 00				1			
56.00 05600 ASDIO ISOTOPE 0 0 0 0 0 57.00 55.00 55.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 16.9 992 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1		58, 551, 173	0	1		I
57. 00 05700 CT SCAN 0 0 0 0 0 0 58.00 05800 05800 05800 05900			0	0	-		
58. 00 05800 MAGMETIC RESONANCE IMAGING (MRI) 0 0 0 59. 00 590 0 590 0 600 0 600 0 600	1 1		0	•	1		
60. 00 06000 LABORATORY 35, 711, 893 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 577, 905 0 0 0 065. 00 065. 00 06600 RSPI RATORY THERAPY 8, 917, 997 0 0 0 066. 00 06600 RSPI RATORY THERAPY 1, 114, 520 0 0 0 066. 00 06600 RSPI RATORY THERAPY 1, 114, 520 0 0 0 066. 00 06600 RSPI RATORY THERAPY 1, 114, 520 0 0 0 066. 00 06600 RSPI RATORY THERAPY 950, 126 0 0 0 0 067. 00 07. 0	1 1		0		-		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 577, 905 0 0 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 69.	1 1	, ,	169, 992	0	0		•
65.00 06500 RESPI RATORY THERAPY 8, 917, 097 0 0600 06600 06600 06600 06600 06600 06600 06700 0CCUPATI ONAL THERAPY 950, 126 0 0 0 06700 0CCUPATI ONAL THERAPY 950, 126 0 0 0 06700 0CCUPATI ONAL THERAPY 950, 126 0 0 0 06700 0CCUPATI ONAL THERAPY 950, 126 0 0 0 06700 0CCUPATI ONAL THERAPY 950, 126 0 0 0 0 0 0 0 0 0	60. 00 06000 L	LABORATORY	35, 711, 893	0	0		60.00
66 00 06600 06700 0CCUPATI ONAL THERAPY 950, 126 0 0 0 067.00 06700 0CCUPATI ONAL THERAPY 950, 126 0 0 0 0 0 068.00 069.00 05900 0ELECTROCARDI OLOGY 75, 731 0 0 0 0 0900 0.00 0.0	1 1				-		
67. 00 06700 06700 06700 06700 06800 06900 06900 06900 06900 06900 06900 06900 06900 06900 071.000 071.000 072.000 072.000 072.000 072.000 072.000 072.000 073.000 073000 073000 073000 07300 07300 07300 07300 07300 07300 07300 07300 07300				1			
68. 00 06900 SPEECH PATHOLOGY 75, 731 0 0 68. 00 69. 00 06900 LECTROCARDIOLOGY 2, 252, 056 0 0 0 07100	1 1			1	-		
69.00 06900 06900 06900 06900 0710			·		-		
71. 00	1 1		·	•			•
73. 00	1 1			0	0		
76. 00	72. 00 07200 I	IMPL. DEV. CHARGED TO PATIENTS		0	0		72. 00
76. 01 03951 SLEEP LAB			27, 121, 500				•
76. 02 03550 PSYCHIATRI C/PSYCHOLOGICAL SERVICES 0 0 0 0 0			0	-	· -		
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 240,297 0 0 0 90.00 91.00 09100 EMERGENCY 43,071,899 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS			0				
90. 00 990.00 CLINIC 240,297 0 0 0 990.00			0		U U		76.02
91. 00 09100 EMERGENCY 43,071,899 0 0 91.00 92.00 08SERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 118.00 119.00 119			240, 297	0	0		90.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 218,901,752 7,430 100 118.00 NONRE MBURSABLE COST CENTERS	91. 00 09100 E	EMERGENCY			0		91. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 218,901,752 7,430 100 100 118.00							92. 00
NONREI MBURSABLE COST CENTERS 190.00 19200 197000 19700 19							
190. 00			218, 901, 752	7, 430	100		118. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 194.00 07950 MEALS ON WHEELS 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Negative Cost to be allocated (per Wkst. B, Part I) 0.005743 60.296635 834.08000 203.00 Unit cost multiplier (Wkst. B, Part II) 0.005743 60.296635 834.08000 203.00 Unit cost multiplier (Wkst. B, Part II) 10.003283 2.655585 19.280000 205.00 Unit cost multiplier (Wkst. B, Part II) 0.003283 2.655585 19.280000 205.00 Unit cost multiplier (Wkst. B, Part II) 0.003283 2.655585 19.280000 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 206.00 NAHE unit cost multiplier (Wkst. D, 207.00			0				190 00
194.00 07950 MEALS ON WHEELS 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 0.005743 60.296635 834.080000 203.00 Unit cost multiplier (Wkst. B, Part II) 19,731 1,928 204.00 Cost to be allocated (per Wkst. B, Part II) 19,731 1,928 204.00 Unit cost multiplier (Wkst. B, Part II) 0.003283 2.655585 19.280000 205.00 Unit cost multiplier (Wkst. B, Part II) 0.003283 2.655585 19.280000 205.00 Unit cost multiplier (Wkst. B, Part II) 0.003283 2.655585 19.280000 205.00 Unit cost multiplier (Wkst. B, Part II) 0.003283 2.655585 19.280000 205.00 Unit cost multiplier (Wkst. B, Part II) 0.003283 2.655585 19.280000 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00		· ·	0		-		I
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 200.00 201.00 202.00 203.00 204.00 0.005743 0.00574			0	0	1		I
201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, 207.00	1 1		· ·				
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 Part I) 0.005743 60.296635 19,731 1,928 204.00 205.00 205.00 206.00 206.00 206.00 207.00	1 1						
203.00 Unit cost multiplier (Wkst. B, Part I) 0.005743 60.296635 834.080000 203.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00		**	1, 257, 097	448, 004	83, 408		202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) 19,731 1,928 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207			0.005742	(0.00//05	024 000000		202 00
Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00							
205.00 Unit cost multiplier (Wkst. B, Part 0.003283 2.655585 19.280000 205.00 II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00		**	/18, /51	19, /31	1, 928		204.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00			0. 003283	2. 655585	19. 280000		205. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00			2. 200200				[
207.00 NÄHE unit cost multiplier (Wkst. D, 207.00	206.00	NAHE adjustment amount to be allocated					206. 00
							207.00
							207.00
	1 1'			1	1		ı

Hool +b	Financial Systems	LUTHERAN DOWNT	TALIASOH MWO		In Lie	eu of Form CMS-2	DEE2 10
	ATION OF RATIO OF COSTS TO CHARGES	LOTHERAIN DOWNT	Provi der Co	1	Period: From 06/01/2021 To 05/31/2022	Worksheet C Part I	pared:
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDI ATRI CS	21, 409, 567		21, 409, 56	7 0	21, 409, 567	30. 00
31.00	03100 INTENSIVE CARE UNIT	7, 190, 198		7, 190, 198	0	7, 190, 198	31.00
44.00	04400 SKILLED NURSING FACILITY	0		(0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6, 167, 560		6, 167, 560	0	6, 167, 560	50. 00
51.00	05100 RECOVERY ROOM	1, 226, 162		1, 226, 162	2 0	1, 226, 162	51.00
53.00	05300 ANESTHESI OLOGY	1, 138, 699		1, 138, 699	9 0	1, 138, 699	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 527, 422		8, 527, 422	2 0	8, 527, 422	54. 00
54. 01	03630 ULTRA SOUND	0		(0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0		(0	0	56. 00
57.00	05700 CT SCAN	0		(0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		(0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	258, 839		258, 839	9 0	258, 839	59. 00
60.00	06000 LABORATORY	6, 658, 435		6, 658, 43	5 0	6, 658, 435	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	194, 843		194, 843	3 0	194, 843	62. 00
65.00	06500 RESPI RATORY THERAPY	2, 295, 442	0	2, 295, 442	2 0	2, 295, 442	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 008, 288	0	1, 008, 288	3 0	1, 008, 288	66.00
67.00	06700 OCCUPATI ONAL THERAPY	478, 119	0	478, 119	9 0	478, 119	67. 00
68. 00	06800 SPEECH PATHOLOGY	123, 154	0	123, 154	1 0	123, 154	68. 00
69.00	06900 ELECTROCARDI OLOGY	450, 918		450, 918	3 0	450, 918	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	517, 209		517, 209	9 0	517, 209	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	43, 892		43, 892		43, 892	72. 00
	07300 DRUGS CHARGED TO PATIENTS	4, 126, 607		4, 126, 60		4, 126, 607	73. 00
	03950 MISC ANCILLARY	0			o o	0	76. 00
	03951 SLEEP LAB	0			o o	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0	0	76. 02

213, 668

12, 152, 634

2, 514, 184

76, 695, 840

2, 514, 184

74, 181, 656

213, 668

12, 152, 634

0

2, 514, 184 76, 695, 840

2, 514, 184

74, 181, 656

90.00

213, 668

12, 152, 634 91. 00 2, 514, 184 92. 00

76, 695, 840 200. 00

2, 514, 184 201. 00

74, 181, 656 202. 00

0

0

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (see instructions)

Less Observation Beds

Subtotal (see instructions)

200.00

201.00

	LUTUEDAN DOMAT	OWN HOODI TAI			C.E. OHC (NEEO 40
Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0047	Peri od:	Worksheet C	
				From 06/01/2021	Part I	
				To 05/31/2022	Date/Time Pre	
					10/28/2022 2:	52 pm
		Title	xVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpati ent	

			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'		'	+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6, 00	7. 00	8. 00	9. 00	10.00	
INF	PATIENT ROUTINE SERVICE COST CENTERS						
30. 00 030	000 ADULTS & PEDIATRICS	17, 009, 364		17, 009, 364			30.00
31, 00 031	100 INTENSIVE CARE UNIT	10, 121, 591		10, 121, 591			31.00
44. 00 044	400 SKILLED NURSING FACILITY	0		0			44.00
ANC	CILLARY SERVICE COST CENTERS	'					1
50.00 050	000 OPERATING ROOM	1, 941, 717	2, 564, 139	4, 505, 856	1. 368788	0.000000	50. 00
51. 00 051	100 RECOVERY ROOM	291, 533	743, 343	1, 034, 876	1. 184840	0.000000	51.00
53. 00 053	300 ANESTHESI OLOGY	342, 419	514, 646	857, 065	1. 328603	0.000000	53. 00
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	10, 095, 758	48, 455, 415	58, 551, 173	0. 145640	0.000000	54.00
54. 01 036	630 ULTRA SOUND	0	0	0	0.000000	0.000000	54. 01
56. 00 056	600 RADI OI SOTOPE	o	0	0	0.000000	0.000000	56.00
57. 00 057	700 CT SCAN	0	0	0	0.000000	0.000000	57. 00
58. 00 058	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58. 00
59. 00 059	900 CARDI AC CATHETERI ZATI ON	18, 403	151, 589	169, 992	1. 522654	0.000000	59. 00
60.00 060	000 LABORATORY	11, 009, 052	24, 702, 841	35, 711, 893	0. 186449	0.000000	60.00
62. 00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELL	411, 063	166, 842	577, 905	0. 337154	0.000000	62. 00
65. 00 065	500 RESPI RATORY THERAPY	7, 208, 739	1, 708, 358	8, 917, 097	0. 257420	0.000000	65. 00
66. 00 066	600 PHYSI CAL THERAPY	1, 041, 430	73, 090	1, 114, 520	0. 904684	0.000000	66. 00
67. 00 067	700 OCCUPATIONAL THERAPY	899, 614	50, 512	950, 126	0. 503216	0.000000	67. 00
68. 00 068	800 SPEECH PATHOLOGY	71, 567	4, 164	75, 731	1. 626203	0.000000	68. 00
69. 00 069	900 ELECTROCARDI OLOGY	519, 639	1, 732, 417	2, 252, 056	0. 200225	0.000000	69. 00
71. 00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 667, 826	1, 888, 675	3, 556, 501	0. 145426	0.000000	71. 00
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENTS	231, 200	161, 867	393, 067	0. 111665	0.000000	72. 00
73. 00 073	300 DRUGS CHARGED TO PATIENTS	17, 756, 817	9, 364, 683	27, 121, 500	0. 152153	0.000000	73. 00
76. 00 039	950 MISC ANCILLARY	0	0	0	0.000000	0.000000	76. 00
76. 01 039	951 SLEEP LAB	0	0	0	0.000000	0.000000	76. 01
76. 02 035	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0.000000	0.000000	76. 02
TUO	TPATIENT SERVICE COST CENTERS						1
90.00 090	000 CLI NI C	18, 062	222, 235	240, 297	0. 889183	0.000000	90. 00
91. 00 091	100 EMERGENCY	4, 520, 536	38, 551, 363	43, 071, 899	0. 282148	0.000000	91.00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART	417, 916	2, 251, 327	2, 669, 243	0. 941909	0.000000	92. 00
200.00	Subtotal (see instructions)	85, 594, 246	133, 307, 506				200.00
201.00	Less Observation Beds						201.00
202. 00	Total (see instructions)	85, 594, 246	133, 307, 506	218, 901, 752			202. 00
•				•			•

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0047		Worksheet C Part I Date/Time Prepared: 10/28/2022 2:52 pm

					10/28/2022 2:52 pm
			Title XVIII	Hospi tal	PPS
Cost Center D	escri pti on	PPS Inpatient			
		Ratio			
		11. 00			
	SERVICE COST CENTERS				
0.00 03000 ADULTS & PEDI					30.0
31.00 03100 INTENSIVE CAR	E UNIT				31. 0
4.00 04400 SKILLED NURSI					44. 0
ANCILLARY SERVICE (COST CENTERS				
05000 OPERATING ROC	M	1. 368788			50. 0
61.00 05100 RECOVERY ROOM		1. 184840			51. 0
3. 00 05300 ANESTHESI OLOG	Υ	1. 328603			53.0
64. 00 05400 RADI OLOGY-DI A	GNOSTI C	0. 145640			54. 0
4. 01 03630 ULTRA SOUND		0. 000000			54.0
66. 00 05600 RADI 0I SOTOPE		0. 000000			56.0
7.00 05700 CT SCAN		0. 000000			57.0
8.00 05800 MAGNETIC RESC	NANCE IMAGING (MRI)	0. 000000			58. 0
9. 00 05900 CARDI AC CATHE	TERI ZATI ON	1. 522654			59. 0
0. 00 06000 LABORATORY		0. 186449			60.0
2.00 06200 WHOLE BLOOD 8	PACKED RED BLOOD CELL	0. 337154			62.0
5. 00 06500 RESPI RATORY T	HERAPY	0. 257420			65.0
6. 00 06600 PHYSI CAL THER	APY	0. 904684			66.0
7. 00 06700 OCCUPATI ONAL	THERAPY	0. 503216			67. 0
8. 00 06800 SPEECH PATHOL	.OGY	1. 626203			68.0
9. 00 06900 ELECTROCARDI 0	LOGY	0. 200225			69.0
1.00 07100 MEDICAL SUPPL	IES CHARGED TO PATIENT	0. 145426			71. 0
2.00 07200 IMPL. DEV. CH	ARGED TO PATIENTS	0. 111665			72.0
3.00 07300 DRUGS CHARGED	TO PATIENTS	0. 152153			73. 0
6.00 03950 MISC ANCILLAR	Υ	0. 000000			76. 0
6. 01 03951 SLEEP LAB		0. 000000			76. 0
6. 02 03550 PSYCHI ATRI C/F	SYCHOLOGI CAL SERVI CES	0. 000000			76. 0
OUTPATIENT SERVICE	COST CENTERS				
0. 00 09000 CLINIC		0. 889183			90.0
1.00 09100 EMERGENCY		0. 282148			91. 0
2.00 09200 OBSERVATION E	EDS (NON-DISTINCT PART	0. 941909			92. 0
	instructions)				200. 0
201.00 Less Observat					201. 0
202.00 Total (see in					202. 0

Heal th	Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In lie	u of Form CMS-:	2552-10
	ATTION OF RATIO OF COSTS TO CHARGES	EOTHERAN BONNT	Provi der CO		Period: From 06/01/2021 To 05/31/2022	Worksheet C Part I	pared:
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	21, 409, 567		21, 409, 56	7 0	21, 409, 567	30. 00
	03100 INTENSIVE CARE UNIT	7, 190, 198		7, 190, 19	0 8	7, 190, 198	31.00
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	-					
	05000 OPERATI NG ROOM	6, 167, 560		6, 167, 56		6, 167, 560	
	05100 RECOVERY ROOM	1, 226, 162		1, 226, 16	2 0	1, 226, 162	
	05300 ANESTHESI OLOGY	1, 138, 699	l e	1, 138, 69		1, 138, 699	
	05400 RADI OLOGY-DI AGNOSTI C	8, 527, 422		8, 527, 42	2 0	8, 527, 422	
	03630 ULTRA SOUND	0			0	0	0 0 .
	05600 RADI 01 SOTOPE	0			0	0	56. 00
	05700 CT SCAN	0			0	0	07.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	00.00
	05900 CARDI AC CATHETERI ZATI ON	258, 839	l	258, 83		258, 839	
	06000 LABORATORY	6, 658, 435		6, 658, 43		6, 658, 435	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	194, 843	l .	194, 84		194, 843	
	06500 RESPI RATORY THERAPY	2, 295, 442		2, 295, 44		2, 295, 442	
66.00	06600 PHYSI CAL THERAPY	1, 008, 288	0	1, 008, 28	8 0	1, 008, 288	66.00

478, 119

123, 154

450, 918

517, 209

213, 668

12, 152, 634

2, 514, 184

76, 695, 840

2, 514, 184

74, 181, 656

4, 126, 607

43, 892

0

0

0

0

478, 119

123, 154

450, 918

517, 209

43, 892

213, 668

76, 695, 840 200. 00

2, 514, 184 201. 00

74, 181, 656 202. 00

12, 152, 634

2, 514, 184

0 76.00

0 76.01

0 76.02

4, 126, 607

67.00

68. 00

69.00

71.00

72.00

73.00

90.00

91.00

92.00

478, 119

123, 154

450, 918

517, 209

43, 892

213, 668

12, 152, 634

2, 514, 184

76, 695, 840

2, 514, 184

74, 181, 656

0

0

0

4, 126, 607

MCRI F32 - 17. 12. 175. 1

67. 00 06700 OCCUPATIONAL THERAPY

06900 ELECTROCARDI OLOGY

72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (see instructions)

Less Observation Beds

Subtotal (see instructions)

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

68. 00 06800 SPEECH PATHOLOGY

76.00 03950 MISC ANCILLARY

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

03951 SLEEP LAB

69.00

71.00

73.00

76.01

76.02

200.00

201.00

Health Financial Systems	LUTHERAN DOWNTO	NWN HOSPITAI		Inlie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	ZOTTIZIUM DOMITIC	Provi der Co	CN: 15-0047	Peri od: From 06/01/2021	Worksheet C	
					Date/Time Prep 10/28/2022 2:	
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	

					.0 00,01,2022	10/28/2022 2:	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	17, 009, 364		17, 009, 36	4		30.00
31.00 0	3100 INTENSIVE CARE UNIT	10, 121, 591		10, 121, 59 ⁻	1		31.00
44.00 0	14400 SKILLED NURSING FACILITY	0		(O		44. 00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	1, 941, 717	2, 564, 139			0.000000	
	5100 RECOVERY ROOM	291, 533	743, 343			0. 000000	
53.00 0	5300 ANESTHESI OLOGY	342, 419	514, 646	857, 06	1. 328603	0. 000000	53. 00
	5400 RADI OLOGY-DI AGNOSTI C	10, 095, 758	48, 455, 415	58, 551, 17		0. 000000	
	3630 ULTRA SOUND	0	0		0. 000000	0. 000000	
	15600 RADI 01 SOTOPE	0	0	(0.000000	0.000000	56. 00
57.00 0	5700 CT SCAN	0	0	(0. 000000	0.000000	57. 00
58.00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0.000000	0.000000	58. 00
	5900 CARDI AC CATHETERI ZATI ON	18, 403	151, 589			0. 000000	59. 00
60.00 0	6000 LABORATORY	11, 009, 052	24, 702, 841	35, 711, 89	0. 186449	0. 000000	60.00
62.00 0	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	411, 063	166, 842	577, 90	0. 337154	0. 000000	62. 00
65.00 0	6500 RESPI RATORY THERAPY	7, 208, 739	1, 708, 358	8, 917, 09 ⁻	0. 257420	0.000000	65. 00
66.00 0	6600 PHYSI CAL THERAPY	1, 041, 430	73, 090	1, 114, 520	0. 904684	0.000000	66. 00
67.00 0	6700 OCCUPATI ONAL THERAPY	899, 614	50, 512	950, 12	0. 503216	0. 000000	67. 00
68.00 0	6800 SPEECH PATHOLOGY	71, 567	4, 164	75, 73 ⁻	1 1. 626203	0. 000000	68. 00
69.00 0	6900 ELECTROCARDI OLOGY	519, 639	1, 732, 417	2, 252, 05	6 0. 200225	0.000000	69. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 667, 826	1, 888, 675	3, 556, 50°	0. 145426	0. 000000	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	231, 200	161, 867	393, 06		0. 000000	
	7300 DRUGS CHARGED TO PATIENTS	17, 756, 817	9, 364, 683	27, 121, 50	0. 152153	0. 000000	
	3950 MISC ANCILLARY	0	0	(0. 000000	0. 000000	
	3951 SLEEP LAB	0	0	(0. 000000	0. 000000	76. 01
76. 02 0	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0. 000000	0. 000000	76. 02
	UTPAȚIENT SERVICE COST CENTERS						
	99000 CLI NI C	18, 062	222, 235			0. 000000	
	9100 EMERGENCY	4, 520, 536	38, 551, 363	43, 071, 89		0.000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	417, 916	2, 251, 327	2, 669, 24	0. 941909	0.000000	
200.00	Subtotal (see instructions)	85, 594, 246	133, 307, 506	218, 901, 75	2		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	85, 594, 246	133, 307, 506	218, 901, 75	2		202. 00

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0047		Worksheet C Part I Date/Time Prepared: 10/28/2022 2:52 pm

					10/28/2022 2:52 pm
•			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11. 00			
1.1	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00 0	3000 ADULTS & PEDIATRICS				30. 00
31. 00 0	3100 INTENSIVE CARE UNIT				31.00
44.00 0	4400 SKILLED NURSING FACILITY				44. 00
1A	NCILLARY SERVICE COST CENTERS				
50.00 0	5000 OPERATING ROOM	1. 368788			50.00
51.00 0	5100 RECOVERY ROOM	1. 184840			51.00
53.00 0	5300 ANESTHESI OLOGY	1. 328603			53.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0. 145640			54.00
54. 01 0	3630 ULTRA SOUND	0. 000000			54. 01
56. 00 0	5600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 0	5700 CT SCAN	0. 000000			57. 00
58. 00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 0	5900 CARDI AC CATHETERI ZATI ON	1. 522654			59.00
60.00 0	6000 LABORATORY	0. 186449			60.00
62. 00 0	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 337154			62.00
65.00 0	6500 RESPI RATORY THERAPY	0. 257420			65. 00
66.00 0	6600 PHYSI CAL THERAPY	0. 904684			66. 00
67.00 0	6700 OCCUPATIONAL THERAPY	0. 503216			67. 00
68. 00 0	6800 SPEECH PATHOLOGY	1. 626203			68. 00
	6900 ELECTROCARDI OLOGY	0. 200225			69. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 145426			71.00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 111665			72. 00
73. 00 0	7300 DRUGS CHARGED TO PATIENTS	0. 152153			73. 00
	3950 MISC ANCILLARY	0. 000000			76. 00
76. 01 0	3951 SLEEP LAB	0. 000000			76. 01
76. 02 0	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 02
Ol	UTPATIENT SERVICE COST CENTERS				
90.00 0	9000 CLI NI C	0. 889183			90.00
91.00 0	9100 EMERGENCY	0. 282148			91.00
92. 00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 941909			92.00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems	LUTHERAN DOWNTOWN	I HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-0047	From 06/01/2021	Worksheet C Part II Date/Time Prepared:

Title XIX Hospital PPS
Cost Cost
Note
1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 6, 167, 560 2, 973, 358 3, 194, 202 0 0 50. 00 51. 00 O5100 RECOVERY ROOM 1, 226, 162 435, 160 791, 002 0 0 51. 00 53. 00 O5300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 8, 527, 422 3, 535, 781 4, 991, 641 0 0 54. 00 54. 01 O3630 ULTRA SOUND 0 0 0 0 0 0 0 0 0 0 0
51.00 05100 RECOVERY ROOM 1, 226, 162 435, 160 791, 002 0 51.00 53.00 05300 ANESTHESI OLOGY 1, 138, 699 31, 542 1, 107, 157 0 0 53.00 54.01 05400 RADI OLOGY-DI AGNOSTI C 8, 527, 422 3, 535, 781 4, 991, 641 0 0 54.00 54.01 03630 ULTRA SOUND 0 0 0 0 0 0 0 0 54.01 56.00 05600 RADI OL SOTOPE 0 0 0 0 0 0 55.00 0 0 0 0 0 57.00 0 0 0 0 0 57.00 0 0 0 0 57.00 0 0 0 0 0 57.00 0 0 0 0 57.00 0 0 0 0 0 57.00 0 0 0 0 58.00 0 57.00 0
53. 00 05300 ANESTHESI OLOGY 1, 138, 699 31, 542 1, 107, 157 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 8, 527, 422 3, 535, 781 4, 991, 641 0 0 54. 00 56. 01 03630 ULTRA SOUND 0 0 0 0 0 0 0 0 0 0 0 54. 00 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 258, 839 130, 121 128, 718 0 0 59. 00 60. 00 06000 LABORATORY 6, 658, 435 1, 771, 461 4, 886, 974 0 0 0 60. 00 65. 00 06500 RE
54. 00
54. 01 03630 ULTRA SOUND 0 0 0 0 0 0 54. 01 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 258, 839 130, 121 128, 718 0 0 58. 00 06. 00 06. 00 0 0 0 0 0 0 0 0 0 0 0
56. 00
57. 00
58. 00
59. 00
60. 00 06000 LABORATORY
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 194, 843 69, 951 124, 892 0 0 65. 00 65. 00 65. 00 66. 00 06500 RESPIRATORY THERAPY 2, 295, 442 615, 389 1, 680, 053 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 008, 288 525, 183 483, 105 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 478, 119 207, 736 270, 383 0 0 67. 00 680. 00 6800 SPEECH PATHOLOGY 123, 154 75, 898 47, 256 0 0 68. 00 6900 ELECTROCARDI OLOGY 450, 918 98, 683 352, 235 0 0 69. 00 69. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 517, 209 76, 351 440, 858 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 43, 892 3, 407 40, 485 0 0 72. 00
65. 00 06500 RESPIRATORY THERAPY 2, 295, 442 615, 389 1, 680, 053 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 008, 288 525, 183 483, 105 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 478, 119 207, 736 270, 383 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 123, 154 75, 898 47, 256 0 0 68. 00 06900 ELECTROCARDI OLOGY 450, 918 98, 683 352, 235 0 0 69. 00 69. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 517, 209 76, 351 440, 858 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 43, 892 3, 407 40, 485 0 0 72. 00
66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 478, 119 207, 736 270, 383 0 0 67. 00 68. 00 69. 00 06900 ELECTROCARDI OLOGY 450, 918 98, 683 352, 235 0 0 69. 00 69. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 517, 209 76, 351 440, 858 0 0 71. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 43, 892 3, 407 40, 485 0 0 72. 00 072. 00
68. 00 06800 SPEECH PATHOLOGY 123, 154 75, 898 47, 256 0 0 68. 00 69. 00
69. 00 06900 ELECTROCARDI OLOGY 450, 918 98, 683 352, 235 0 69. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 43, 892 3, 407 40, 485 0 0 72. 00 072. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 517, 209 76, 351 440, 858 0 0 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 43, 892 3, 407 40, 485 0 0 72. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 892 3, 407 40, 485 0 0 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 126, 607 716, 627 3, 409, 980 0 73. 00
76. 00 03950 MISC ANCILLARY 0 0 0 0 76. 00
76. 01 03951 SLEEP LAB 0 0 0 0 76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 02
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 213, 668 146, 038 67, 630 0 90. 00
91. 00 09100 EMERGENCY 12, 152, 634 3, 323, 460 8, 829, 174 0 0 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 2,514,184 1,019,645 1,494,539 0 0 92.00
200.00 Subtotal (sum of lines 50 thru 199) 48,096,075 15,755,791 32,340,284 0 0 200.00
201.00 Less Observation Beds 2,514,184 1,019,645 1,494,539 0 0 201.00
202.00 Total (line 200 minus line 201) 45,581,891 14,736,146 30,845,745 0 0 202.00

Health Financial Systems	LUTHERAN DOWNTOWN	I HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST T REDUCTIONS FOR MEDICALD ONLY	O CHARGE RATIOS NET OF	Provider CCN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet C Part II Date/Time Prepared:

						10/28/2022 2	:52 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and		Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reducti on	8)	/ col . 7)			
		6.00	7. 00	8. 00			
AN	NCILLARY SERVICE COST CENTERS						
50. 00 05	5000 OPERATING ROOM	6, 167, 560	4, 505, 856	1. 368788			50. 00
51.00 05	5100 RECOVERY ROOM	1, 226, 162	1, 034, 876	1. 184840			51.00
53. 00 05	5300 ANESTHESI OLOGY	1, 138, 699	857, 065	1. 328603			53. 00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	8, 527, 422	58, 551, 173	0. 145640			54. 00
54. 01 03	3630 ULTRA SOUND	0	0	0.000000			54. 01
56. 00 05	5600 RADI 0I SOTOPE	0	0	0. 000000			56. 00
57. 00 05	5700 CT SCAN	0	0	0.000000			57. 00
58. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000			58. 00
59. 00 05	5900 CARDI AC CATHETERI ZATI ON	258, 839	169, 992	1. 522654			59. 00
60.00 06	6000 LABORATORY	6, 658, 435	35, 711, 893	0. 186449			60.00
62. 00 06	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	194, 843	577, 905	0. 337154			62. 00
65. 00 06	6500 RESPIRATORY THERAPY	2, 295, 442	8, 917, 097				65. 00
66. 00 06	6600 PHYSI CAL THERAPY	1, 008, 288	1, 114, 520	0. 904684			66. 00
67. 00 06	6700 OCCUPATIONAL THERAPY	478, 119	950, 126	0. 503216			67. 00
	6800 SPEECH PATHOLOGY	123, 154					68. 00
	6900 ELECTROCARDI OLOGY	450, 918					69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	517, 209					71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	43, 892					72. 00
	7300 DRUGS CHARGED TO PATIENTS	4, 126, 607					73. 00
	3950 MISC ANCILLARY	0	0	0. 000000			76. 00
	3951 SLEEP LAB	0	0	0. 000000			76, 01
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0. 000000			76. 02
	JTPATIENT SERVICE COST CENTERS			0.00000			7 7 0 2
	9000 CLINI C	213, 668	240, 297	0. 889183			90.00
	9100 EMERGENCY	12, 152, 634					91.00
4	9200 OBSERVATION BEDS (NON-DISTINCT PART	2, 514, 184					92.00
200.00	Subtotal (sum of lines 50 thru 199)	48, 096, 075					200.00
201.00	Less Observation Beds	2, 514, 184					201. 00
202.00	Total (line 200 minus line 201)	45, 581, 891	l e				202. 00
202.00	Trotal (Trito 200 millias Trito 201)	10,001,071	1 , 1 , 1 , 1 , 0 , 1 , 1	l	I .		1202.00

Health Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Peri od:	Worksheet D	
				From 06/01/2021 To 05/31/2022		narad.
				10 03/31/2022	10/28/2022 2:	
		Title	xVIII	Hospi tal	PPS	<u></u>
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	8, 682, 810	0	8, 682, 81	0 6, 591	1, 317. 37	30. 00
31.00 INTENSIVE CARE UNIT	1, 826, 739		1, 826, 73	9 1, 613	1, 132. 51	31.00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	10, 509, 549		10, 509, 54	9 8, 204		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	892	1, 175, 094				30. 00
31.00 INTENSIVE CARE UNIT	196	221, 972				31. 00
44.00 SKILLED NURSING FACILITY	0	0			ļ	44. 00
200.00 Total (lines 30 through 199)	1, 088	1, 397, 066				200. 00

Heal th	Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Period: From 06/01/2021 To 05/31/2022	Worksheet D Part II Date/Time Pre 10/28/2022 2:	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS					0.00	
50.00	05000 OPERATING ROOM	2, 973, 358	4, 505, 856	0. 65988	7 304, 031	200, 626	50.00
51.00	05100 RECOVERY ROOM	435, 160			5 25, 435	10, 695	51.00
53.00	05300 ANESTHESI OLOGY	31, 542	857, 065	0. 03680	2 51, 631	1, 900	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 535, 781	58, 551, 173	0. 06038	8 1, 739, 846	105, 066	54.00
54. 01	03630 ULTRA SOUND	0	0	0. 00000	0 0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	0	0.00000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.00000	0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	130, 121	169, 992	0. 76545	4 0	0	59. 00
60.00	06000 LABORATORY	1, 771, 461	35, 711, 893	0. 04960	4 1, 646, 745	81, 685	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	69, 951	577, 905	0. 12104	2 44, 485	5, 385	62.00
65.00	06500 RESPI RATORY THERAPY	615, 389	8, 917, 097	0. 06901	2 1, 015, 088	70, 053	65.00
66.00	06600 PHYSI CAL THERAPY	525, 183	1, 114, 520	0. 47121	9 172, 216	81, 151	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	207, 736	950, 126	0. 21864	0 154, 362	33, 750	67.00
68. 00	06800 SPEECH PATHOLOGY	75, 898	75, 731	1. 00220	5 18, 922	18, 964	68. 00
69. 00	06900 ELECTROCARDI OLOGY	98, 683	2, 252, 056	0. 04381	9 78, 215	3, 427	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 351	3, 556, 501	0. 02146	8 233, 468	5, 012	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 407	393, 067	0. 00866	8 71, 950	624	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	716, 627	27, 121, 500	0. 02642	3 2, 362, 267	62, 418	73. 00
76.00	03950 MISC ANCILLARY	0	0	0. 00000	0 0	0	76. 00
76. 01	03951 SLEEP LAB	0	0	0. 00000	0 0	0	76. 01
7/ 02	DOSEED DEVOUE ATDLE OPENCION OCLONE. SERVECES	1 ^		0 00000	ما م	ا م'	74 00

146, 038

3, 323, 460

1, 019, 645 15, 755, 791

240, 297 43, 071, 899

2, 669, 243 191, 770, 797

0.000000

0.607740

0.077161

0. 381998

594, 196

89, 737 8, 602, 594

0 76. 02

0

34, 279 92. 00 760, 884 200. 00

45, 849

90.00

91.00

03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)

76.02

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

44.00 04400 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 0 0 0	Health Financial Systems	LUTHERAN DOWNTO	OWN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
Nursing Program Post-Stepdown Adjustments Nursing Post-Stepdown Adjustments Nursing Program Post-Stepdown Adjustments Nursing Program Post-Stepdown Adjustments Nursing Program Post-Stepdown Adjustments Nursing Program Post-Stepdown Adjustments Nursing Program Post-Stepdown Adjustments Nursing Post-Stepdow	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST			From 06/01/2021 To 05/31/2022	Part III Date/Time Pre 10/28/2022 2:	
Program Post-Stepdown Adj ustments			Title	e XVIII	Hospi tal	PPS	
NPATIENT ROUTINE SERVICE COST CENTERS 1	Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2A 2.00 3.00		Program	Program	Post-Stepdowr	Cost	Medi cal	
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2A 2.00 3.		Post-Stepdown	· ·	Adjustments		Education Cost	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30000 ADULTS & PEDI ATRI CS 0 0 0 0 0 0 31.00		Adjustments					
30. 00		1A	1.00	2A	2. 00	3. 00	
NPATI ENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0	INPATIENT ROUTINE SERVICE COST CENTERS						
Additional Control of Control o	30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
Additional Cost Center Description Swing-Bed Adjustment Amount (see instructions) Advised Adjustment Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustment Amount (see instructions) Advised Adjustmen	31.00 03100 INTENSIVE CARE UNIT	l ol	0		ol o	0	31.00
Cost Center Description	44.00 04400 SKILLED NURSING FACILITY	l ol	0	,	ol o		44.00
Cost Center Description	200.00 Total (lines 30 through 199)	l ol	0	,	o o	0	200.00
Amount (see instructions) minus col. 4) INPATIENT ROUTINE SERVICE COST CENTERS		Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
Amount (see instructions) minus col. 4) INPATIENT ROUTINE SERVICE COST CENTERS		Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS		Amount (see	1 through 3,				
NPATIENT ROUTINE SERVICE COST CENTERS		instructions)					
30. 00		4.00	5. 00	6.00	7. 00	8. 00	
31. 00 03100 INTENSIVE CARE UNIT 0 1,613 0.00 196 31. 00 44. 00 04400 SKILLED NURSING FACILITY 0 0 0.00 0 44. 00 200. 00 Total (lines 30 through 199) 0 8,204 1,088 200. 00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8)	INPATIENT ROUTINE SERVICE COST CENTERS						
44.00 04400 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 0 0 0	30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 59	1 0.00	892	30. 00
Total (lines 30 through 199) 0 8, 204 1, 088 200.00	31.00 03100 INTENSIVE CARE UNIT		0	1, 61	0.00	196	31.00
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8)	44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44.00
Program Pass-Through Cost (col. 7 x col. 8)	200.00 Total (lines 30 through 199)		0	8, 20	4	1, 088	200.00
Pass-Through Cost (col. 7 x col. 8)	Cost Center Description	I npati ent			•		
Cost (col. 7 x col. 8)		Program					
col . 8)		Pass-Through					
		Cost (col. 7 x					
		col . 8)					
9.00		9. 00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00	30. 00 03000 ADULTS & PEDI ATRI CS	O					30.00
31.00 03100 INTENSIVE CARE UNIT 0 31.00	31.00 03100 INTENSIVE CARE UNIT	0					31.00
44.00 04400 SKILLED NURSING FACILITY 0 44.00	44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199) 0 200.00	200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	LUTHERAN DOWNTOWN	N HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047	Peri od:	Worksheet D
THROUGH COSTS			From 06/01/2021	

11111000				1	Го 05/31/2022	Date/Time Pre 10/28/2022 2:	
			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	ANOLILABLE OFFICE OFFICE	1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1	J				F0 00
	05000 OPERATING ROOM	0			0	0	50.00
	05100 RECOVERY ROOM	0			0	0	51.00
	05300 ANESTHESI OLOGY	0			0	0	53. 00 54. 00
	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND					0	54.00
	05600 RADI OI SOTOPE					0	56.00
	05700 CT SCAN					0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)					0	58. 00
	05900 CARDI AC CATHETERI ZATI ON					o n	59.00
	06000 LABORATORY					o n	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL					, O	62. 00
	06500 RESPIRATORY THERAPY	0			0	,	65. 00
	06600 PHYSI CAL THERAPY				0	o o	66. 00
	06700 OCCUPATI ONAL THERAPY	0			0	Ō	67. 00
	06800 SPEECH PATHOLOGY	0			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) (0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) (0	0	73. 00
76.00	03950 MISC ANCILLARY	0	0) (0	0	76. 00
76. 01	03951 SLEEP LAB	0	0) (0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0)	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0)	0	0	90. 00
	09100 EMERGENCY	0	0) (0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0)			0	92. 00
200.00	Total (lines 50 through 199)	0	0) (0	0	200. 00

Heal th	Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS			Period: From 06/01/2021 To 05/31/2022	Date/Time Pre 10/28/2022 2:	pared: 52 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
					7.00	instructions)	
	ANOLULARY OFRICAS COOT OFFITTED	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			ı			
50.00	05000 OPERATI NG ROOM	0	0		0 4, 505, 856		
51.00	05100 RECOVERY ROOM	0	0		0 1, 034, 876	l	1
53. 00	05300 ANESTHESI OLOGY	0	0		0 857, 065	l	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 58, 551, 173		
54. 01	03630 ULTRA SOUND	0	0		0	0.000000	
56.00	05600 RADI OI SOTOPE	0	0		0	0.000000	
57. 00	05700 CT SCAN	0	0		0	0.000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 169, 992		
60.00	06000 LABORATORY	0	0		0 35, 711, 893		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 577, 905		
65.00	06500 RESPIRATORY THERAPY	0	0		0 8, 917, 097	l e	
66.00	06600 PHYSI CAL THERAPY	0	0		0 1, 114, 520	l e	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 950, 126		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 75, 731	0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 2, 252, 056		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 3, 556, 501		
	07300 DRUGS CHARGED TO PATIENTS		0		0 393, 067 0 27 121 500		1
	03950 MISC ANCILLARY		0		0 27, 121, 500	0. 000000 0. 000000	
76. 00 76. 01	03951 SLEEP LAB		0			0.000000	
76. 01 76. 02			0		0 0	0.00000	
70. UZ	OUTDATI ENT. SERVICES COST. SERVICES	0	0	L	<u>U</u>	<u>U. 000000</u>	/ O. UZ

0 0 0

90.00

91.00

92.00 200.00

0.000000

0.000000

0.000000

240, 297 43, 071, 899 2, 669, 243 191, 770, 797

0 0 0

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES
OUTPATI ENT SERVI CE COST CENTERS

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

Health Financial Systems	LUTHERAN DOWNTO	OWN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der CO		Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2021	Part IV	
				Γο 05/31/2022	Date/Time Prep 10/28/2022 2:	
		Title	XVIII	Hospi tal	PPS	02 piii
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	304, 031		165, 260		50.00
51.00 05100 RECOVERY ROOM	0. 000000	25, 435		70, 072	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	51, 631		41, 189	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 739, 846		4, 534, 310	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	0		0	0	54. 01
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

0.000000

0.000000

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0.000000

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0.000000

0.000000

1, 646, 745

1, 015, 088

44, 485

172, 216

154, 362

18, 922

78, 215

233, 468

2, 362, 267

71, 950

594, 196

89, 737

8, 602, 594

58.00

59.00

65.00

68.00

71.00

72.00

73.00

90.00

92. 00

0 200. 00

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0 60.00

0 62.00

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0 66.00

0 67.00

0 69.00

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0 76.00

0 76.01

0 76.02

0

0 91.00

0

15, 986

28, 128

2, 932

491

0

0

0

201, 869

155, 556

63, 383

695, 417

43, 772

2, 105, 260

9, 275, 699

174, 644

2, 289

975, 141

0

0

0

0

0

0

0

05800 MAGNETIC RESONANCE I MAGING (MRI)

06200 WHOLE BLOOD & PACKED RED BLOOD CELL

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

05900 CARDIAC CATHETERIZATION

06500 RESPIRATORY THERAPY

06700 OCCUPATIONAL THERAPY

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

03950 MISC ANCILLARY

03951 SLEEP LAB

09100 EMERGENCY

09000 CLI NI C

06000 LABORATORY

58.00

59.00

62.00

65.00

66.00

67.00

68 00

69.00

72.00

73.00

76.00

76. 01

76.02

90.00

Health Financial Systems	LUTHERAN DOWNTOWN	I HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTH	HER HEALTH SERVICES AND VACCINE COST		From 06/01/2021 To 05/31/2022	Worksheet D Part V Date/Time Prepared:

					To 05/31/2022	Date/Time Pre 10/28/2022 2:	pared: 52 pm
			Ti tl e	XVIII	Hospi tal	PPS	
				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	Subj ect To		
				Ded. & Coins.	Ded. & Coi ns.		
		1.00		(see inst.)	(see inst.)		
1000	ALLARY OFRITAE AGOT OFFITERS	1.00	2.00	3. 00	4. 00	5. 00	
	ILLARY SERVICE COST CENTERS	1 0/0700	1.50.0	1	J al	201 201	
	OOO OPERATING ROOM	1. 368788		1	1	226, 206	1
	OO RECOVERY ROOM	1. 184840			0	83, 024	51.00
	ANESTHESI OLOGY	1. 328603			0	54, 724	53.00
	00 RADI OLOGY-DI AGNOSTI C	0. 145640			0	660, 377	54.00
	30 ULTRA SOUND	0. 000000	l .	(0	0	54. 01
	000 RADI OI SOTOPE	0. 000000			0	0	56. 00
	OO CT SCAN	0. 000000			0	0	57. 00
	MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0	0	58. 00
	OOO CARDI AC CATHETERI ZATI ON	1. 522654			0	24, 341	59. 00
	000 LABORATORY	0. 186449				181, 814	60.00
	000 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 337154			0	9, 483	ł
	000 RESPI RATORY THERAPY	0. 257420			0	51, 965	
	000 PHYSI CAL THERAPY	0. 904684			0	2, 653	
	OO OCCUPATIONAL THERAPY	0. 503216	l .	1	1 1	247	67. 00
	SPEECH PATHOLOGY	1. 626203		1	이	0	68. 00
	OOO ELECTROCARDI OLOGY	0. 200225		1	이	31, 146	1
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 145426			이	9, 218	
	OO IMPL. DEV. CHARGED TO PATIENTS	0. 111665		1	0	256	
	DRUGS CHARGED TO PATIENTS	0. 152153			17, 399	105, 810	1
	50 MISC ANCILLARY	0. 000000		(이	0	76. 00
	SLEEP LAB	0. 000000		(0	76. 01
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	<u>C</u>	() 0	0	76. 02
	PATIENT SERVICE COST CENTERS		T	1			
90. 00 090		0. 889183		1		38, 921	
	00 EMERGENCY	0. 282148		1	0	593, 995	1
	OO OBSERVATION BEDS (NON-DISTINCT PART	0. 941909		1	0	164, 499	
200. 00	Subtotal (see instructions)		9, 275, 699	2, 750	17, 399	2, 238, 679	
201. 00	Less PBP Clinic Lab. Services-Program				이		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		9, 275, 699	2, 750	17, 399	2, 238, 679	202. 00

Health Financial Systems	LUTHERAN DOWN	TOWN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	AND VACCINE COST	Provi der C	CN: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet D Part V Date/Time Pre 10/28/2022 2:	pared: 52 pm
		Ti tl e	e XVIII	Hospi tal	PPS	
·	Co	sts				
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(coo inct)	(coo inct)				

	Rei mbursed	Reimbursed		
	Servi ces	Services Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS	0.00	7.00		
50. 00 05000 OPERATING ROOM	T C	0		50.00
51. 00 05100 RECOVERY ROOM		o o		51. 00
53. 00 05300 ANESTHESI OLOGY				53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C				54. 00
54. 01 03630 ULTRA SOUND				54. 01
56. 00 05600 RADI OI SOTOPE				56. 00
57. 00 05700 CT SCAN				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		59. 00
60. 00 06000 LABORATORY	513	0	-	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	313	0	-	62.00
65. 00 06500 RESPIRATORY THERAPY		0	-	65.00
66. 00 06600 PHYSI CAL THERAPY		0	-	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0	-	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		68.00
69. 00 06900 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
	0	0		71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		71.00
	0	2 (47		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 647		
76. 00 03950 MI SC ANCI LLARY	0	0		76.00
76. 01 03951 SLEEP LAB	0	0		76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		76. 02
OUTPATIENT SERVICE COST CENTERS	T			00.00
90. 00 09000 CLINIC	0	0		90.00
91. 00 09100 EMERGENCY	0	0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	[0	2 (47		92.00
200.00 Subtotal (see instructions)	513	2, 647		200. 00
201.00 Less PBP Clinic Lab. Services-Program			 	201. 00
Only Charges	F40	2 (47		202 00
202.00 Net Charges (line 200 - line 201)	513	2, 647	-	202. 00

Health Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 06/01/2021 To 05/31/2022		narad.
				10 03/31/2022	10/28/2022 2:	
		Ti tl	e XIX	Hospi tal	PPS	<u></u>
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	8, 682, 810	0	8, 682, 81	0 6, 591	1, 317. 37	30. 00
31.00 INTENSIVE CARE UNIT	1, 826, 739		1, 826, 73	9 1, 613	1, 132. 51	31.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44. 00
200.00 Total (lines 30 through 199)	10, 509, 549		10, 509, 54	9 8, 204		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	467	615, 212				30. 00
31.00 INTENSIVE CARE UNIT	80	90, 601			ļ	31.00
44.00 SKILLED NURSING FACILITY	0	0			ļ	44. 00
200.00 Total (lines 30 through 199)	547	705, 813				200. 00

Health Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet D Part II Date/Time Pre 10/28/2022 2:	pared: 52 pm
		Ti 1	le XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost		Ratio of Cos		Capital Costs (column 3 x	
	(from Wkst. B, Part II, col.		(col . 1 ÷ co		column 4)	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	

			CAIA	поэрт сат	113	
Cost Center Description	Capi tal		Ratio of Cost	Inpati ent	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	·	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS					T	
50.00 05000 OPERATING ROOM	2, 973, 358			174, 999		
51.00 05100 RECOVERY ROOM	435, 160			22, 740		
53. 00 05300 ANESTHESI OLOGY	31, 542			32, 742		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 535, 781	58, 551, 173		707, 507	42, 725	
54. 01 03630 ULTRA SOUND	0	0	0.000000	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0.000000	0	0	56. 00
57.00 05700 CT SCAN	0	0	0.000000	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	130, 121	169, 992	0. 765454	0	0	59. 00
60. 00 06000 LABORATORY	1, 771, 461	35, 711, 893	0. 049604	824, 789	40, 913	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	69, 951	577, 905	0. 121042	48, 618	5, 885	62.00
65. 00 06500 RESPIRATORY THERAPY	615, 389	8, 917, 097	0. 069012	430, 114	29, 683	65.00
66. 00 06600 PHYSI CAL THERAPY	525, 183	1, 114, 520	0. 471219	51, 784	24, 402	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	207, 736	950, 126	0. 218640	47, 136	10, 306	67. 00
68. 00 06800 SPEECH PATHOLOGY	75, 898	75, 731	1. 002205	3, 579	3, 587	68. 00
69. 00 06900 ELECTROCARDI OLOGY	98, 683	2, 252, 056	0. 043819	37, 431	1, 640	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 351	3, 556, 501	0. 021468	132, 480	2, 844	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 407			0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	716, 627	27, 121, 500	0. 026423	1, 546, 094	40, 852	73. 00
76. 00 03950 MISC ANCILLARY	0	0	0. 000000	0	0	76. 00
76. 01 03951 SLEEP LAB	0	0	0. 000000	0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0. 000000	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	146, 038	240, 297	0.607740	1, 055	641	90.00
91. 00 09100 EMERGENCY	3, 323, 460			352, 394	l e	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 019, 645			29, 768		
200.00 Total (lines 50 through 199)	15, 755, 791			4, 443, 230		
, , ,	1					'

Health Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COST	S Provider C		Period: From 06/01/2021 Fo 05/31/2022	Worksheet D Part III Date/Time Pre 10/28/2022 2:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
· ·	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments		'			
	1A	1. 00	2A	2, 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	,	0	0	31.00
44.00 04400 SKILLED NURSING FACILITY	o	0		0		44. 00
200.00 Total (lines 30 through 199)	0	0	,	0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
, , , , , , , , , , , , , , , , , , ,	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				<u>'</u>		
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 59	0.00	467	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 61	0.00	80	31.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	8, 20	4	547	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
31.00 03100 INTENSIVE CARE UNIT	o					31. 00
44.00 04400 SKILLED NURSING FACILITY	o					44. 00
200.00 Total (lines 30 through 199)	O					200. 00
	. '					•

Health Financial Systems	LUTHERAN DOWNTOW	N HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0047	Peri od:	Worksheet D
THROUGH COSTS			From 06/01/2021	Part IV

			-	To 05/31/2022	Date/Time Pre 10/28/2022 2:	
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	(0 0	0	50. 00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0) (0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0) (0	0	54.00
54. 01 03630 ULTRA SOUND	0	0	(0 0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	(0	0	56. 00
57. 00 05700 CT SCAN	0	0)	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0		0	0	73.00
75. 00 07500 DROGS CHARGED TO PATTENTS 76. 00 03950 MISC ANCILLARY				0	0	76.00
76. 00 03951 SLEEP LAB					0	76. 00
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES)		0	76. 01
OUTPATIENT SERVICE COST CENTERS		0	1	<u>J</u>	0	70.02
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	Ō		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			o	0	92.00
200.00 Total (lines 50 through 199)	0	0)	0 (c	0	200. 00

Hool +b	Financial Systems	LUTHERAN DOWNT	OWN HOSDITAL		In Lie	eu of Form CMS-2	DEE2 10
APPORT	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER OF COSTS		S Provider C		Period: From 06/01/2021 To 05/31/2022	Worksheet D Part IV Date/Time Pre 10/28/2022 2:	pared:
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	T	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCI LLARY SERVI CE COST CENTERS	_	_	T			
50.00	05000 OPERATING ROOM	0	0		0 4, 505, 856		
51.00	05100 RECOVERY ROOM	0	0		0 1, 034, 876	l	
53. 00	05300 ANESTHESI OLOGY	0	0		0 857, 065		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 58, 551, 173		
54. 01	03630 ULTRA SOUND	0	0		0	0. 000000	
56.00	05600 RADI OI SOTOPE	0	0		0 0	0. 000000	
57. 00	05700 CT SCAN	0	0		0 0	0. 000000	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 169, 992	l	1
60.00	06000 LABORATORY	0	0		0 35, 711, 893	l e	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 577, 905		
65.00	06500 RESPI RATORY THERAPY	0	0		0 8, 917, 097	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 1, 114, 520		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 950, 126		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 75, 731	0.000000	
	06900 ELECTROCARDI OLOGY	0	0		0 2, 252, 056		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 3, 556, 501		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 393, 067	l e	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 27, 121, 500		
	03950 MISC ANCILLARY	0	0		0	0.000000	
76. 01	03951 SLEEP LAB	0	0		0	0.000000	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0. 000000	76. 02

0 0 0

240, 297 43, 071, 899 2, 669, 243

191, 770, 797

0.000000

0.000000

0.000000

90.00

91.00

92.00

200.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES
OUTPATIENT SERVI CE COST CENTERS

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	/ SERVICE OTHER PASS	Provider Co		Period: From 06/01/2021 To 05/31/2022	Worksheet D Part IV Date/Time Pre 10/28/2022 2:		
		Ti tl	e XIX	Hospi tal	PPS		
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through		

T' II VIV	20
Title XIX Hospital PF	<u> </u>
Cost Center Description Outpatient Inpatient Inpatient Outpatient Outpatient Outpatient	it
Ratio of Cost Program Program Program Program Program	
to Charges Charges Pass-Through Charges Pass-Throu	ıgh
(col . 6 ÷ col .	. 9
7) x col. 10) x col. 12	2)
9.00 10.00 11.00 12.00 13.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0. 000000 174, 999 0 0	0 50.00
51. 00 05100 RECOVERY ROOM 0.000000 22, 740 0 0	0 51.00
53. 00 05300 ANESTHESI OLOGY 0. 000000 32, 742 0 0 0	0 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 707, 507 0 0	0 54.00
54. 01 03630 ULTRA SOUND 0. 000000 0 0	0 54.01
56. 00 05600 RADI 01 SOTOPE 0. 000000 0 0 0	0 56.00
57. 00 05700 CT SCAN 0. 000000 0 0 0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 0	0 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0	0 59.00
60. 00 06000 LABORATORY 0. 000000 824, 789 0 0	0 60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 000000 48, 618 0 0	0 62.00
65. 00 06500 RESPI RATORY THERAPY 0. 000000 430, 114 0 0	0 65.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 51, 784 0 0	0 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 47, 136 0 0	0 67.00
68. 00 06800 SPEECH PATHOLOGY 0.000000 3,579 0 0	0 68.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 37, 431 0 0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 132,480 0 0	0 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 000000 0 0	0 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 1, 546, 094 0	0 73.00
76. 00 03950 MI SC ANCI LLARY 0. 000000 0 0	0 76.00
76. 01 03951 SLEEP LAB 0. 000000 0 0	0 76.01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0 0 0	0 76.02
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0. 000000 1, 055 0 0	0 90.00
91. 00 09100 EMERGENCY 0.000000 352, 394 0 0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 29,768 0 0	0 92.00
200.00 Total (lines 50 through 199) 4,443,230 0	0 200. 00

Health Financial Systems	LUTHERAN DOWNTO	OWN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der CC			Worksheet D Part V Date/Time Prep 10/28/2022 2:	
		Title	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge Ratio From Worksheet C,	PPS Reimbursed Services (see inst.)		Cost Reimbursed Services Not	PPS Services (see inst.)	

			litle XIX Hospital			L PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	1. 368788	0	0	60, 992	0	50. 00
51.00 051	100 RECOVERY ROOM	1. 184840	0	0	6, 592	0	51.00
53.00 053	BOO ANESTHESI OLOGY	1. 328603	0	0	11, 096	0	53. 00
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	0. 145640	0	0	2, 992, 731	0	54. 00
54. 01 036	530 ULTRA SOUND	0. 000000	0	0	0	0	54. 01
56. 00 056	600 RADI OI SOTOPE	0. 000000		0	0	0	56. 00
57. 00 057	700 CT SCAN	0. 000000	0	0	0	0	57. 00
	BOO MAGNETIC RESONANCE IMAGING (MRI)	0. 000000		0	0	0	58. 00
	900 CARDI AC CATHETERI ZATI ON	1, 522654		0	2, 588	0	59.00
	DOO LABORATORY	0. 186449	0	0	1, 085, 171	0	60.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 337154	0	0	16, 448	0	62.00
	500 RESPIRATORY THERAPY	0. 257420	0	0	220, 940	0	65. 00
	500 PHYSI CAL THERAPY	0. 904684	0	0	5, 895	0	66. 00
	700 OCCUPATIONAL THERAPY	0. 503216	0	0	2, 640	0	67. 00
	BOO SPEECH PATHOLOGY	1. 626203	0	0	0	0	68. 00
	900 ELECTROCARDI OLOGY	0. 200225	0	0	83, 149	0	69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 145426	l e	0	54, 262	0	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 111665	0	0	832	0	72. 00
	BOO DRUGS CHARGED TO PATIENTS	0. 152153	0	0	504, 920	0	73. 00
	950 MISC ANCILLARY	0. 000000		0	0	0	76. 00
	951 SLEEP LAB	0. 000000		0	0	0	76. 01
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000		0	0	0	76. 02
	TPATIENT SERVICE COST CENTERS			_			
	DOO CLINIC	0. 889183	0	0	6, 748	0	90.00
	100 EMERGENCY	0. 282148		0	2, 065, 024	0	91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 941909		l o	130, 385	0	1
200.00	Subtotal (see instructions)		ا م	l o	7, 250, 413	_	200. 00
201.00	Less PBP Clinic Lab. Services-Program]	l o	0		201. 00
	Only Charges			Ĭ			
202.00	Net Charges (line 200 - line 201)		0	0	7, 250, 413	0	202. 00
	1 1 1 2 2 3 2 4 1 1 1 2 2 3 1 1 1 1 2 3 1 7	I	1	ı	., ===,		

Health Financial Systems	LUTHERAN DOWNTOWN	I HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SE	ERVICES AND VACCINE COST	Provider CCN: 15-0047	From 06/01/2021	Worksheet D Part V Date/Time Prepared: 10/28/2022 2:52 pm
		Title YIY	Hospi tal	DDS

				To 05/31/2022	Date/Time Pr 10/28/2022 2	epared: :52 pm
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6.00	7. 00	l			
50. 00 05000 OPERATING ROOM		83. 485				50.00
51. 00 05100 RECOVERY ROOM	0	7, 810	1			51.00
53. 00 05300 ANESTHESI OLOGY	0	14, 742				53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	435, 861				54.00
54. 01 03630 ULTRA SOUND	0	0				54. 01
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	3, 941				59. 00
60. 00 06000 LABORATORY	o	202, 329				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	5, 546				62. 00
65. 00 06500 RESPIRATORY THERAPY	o	56, 874				65. 00
66. 00 06600 PHYSI CAL THERAPY	o	5, 333				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 328				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	16, 649				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 891				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	93				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	76, 825				73. 00
76.00 03950 MISC ANCILLARY	0	0	ł			76. 00
76. 01 03951 SLEEP LAB	0	0	1			76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76. 02
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC		/ 000	I			1 00 00
91. 00 09100 ELI NI C 91. 00 09100 EMERGENCY	0	6, 000	•			90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	582, 642				91. 00 92. 00
	0	122, 811				200.00
200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Progra	am 0	1, 630, 160				200.00
Only Charges	aiii 0					201.00
202.00 Net Charges (line 200 - line 201)	o	1, 630, 160				202. 00

Heal th	Financial Systems LUTHE	RAN DOWNTOWN HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPU	TATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet D-1 Date/Time Prep 10/28/2022 2:5	
		Title XVIII	Hospi tal	PPS	JZ PIII
	Cost Center Description				
	<u>'</u>			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and sw			6, 865	1. 00
2.00	Inpatient days (including private room days, exclu	uding swing-bed and newborn days)		6, 591	2.00
3. 00	Private room days (excluding swing-bed and observation do not complete this line.	ation bed days). If you have only	private room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and ob	oservation bed days)		5, 817	4.00
5. 00	Total swing-bed SNF type inpatient days (including reporting period	g private room days) through Decem	nber 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including reporting period (if calendar year, enter 0 on thi		er 31 of the cost	274	6. 00
7 00	Total swing-bed NE type inpatient days (including		er 31 of the cost	0	7 00

	Cost Center Description		
	DADT I ALL DOOW DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6, 865	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6, 591	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0, 371	3.00
0.00	do not complete this line.	Ĭ	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5, 817	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	274	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period	ا	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	000	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	892	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	٥	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	89	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0,1	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	21, 409, 567	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting 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 period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	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
27.00	x line 20)		27 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)	21, 409, 567	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29.00
30. 00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35. 00	Average per diem private room cost differential (The 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	21, 409, 567	37. 00
	27 minus line 36)	=:, :07,007	55
	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)	3, 248. 30	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 897, 484	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 897, 484	41.00

	Financial Systems	LUTHERAN DOWNT				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0047	Peri od: From 06/01/2021	Worksheet D-1	
					To 05/31/2022	Date/Time Pre 10/28/2022 2:	
				XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	inpatient bays	col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT	7, 190, 198	1, 613	4, 457. 6	56 196	873, 701	43. 00
44.00	CORONARY CARE UNIT		,				44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
17.00	Cost Center Description						17.00
40.00	10		1. 200)			1.00	40.00
48.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ine)		2, 285, 111 6, 056, 296	
47.00	PASS THROUGH COST ADJUSTMENTS	+1 till ough +0) (see mstraetre	113)		0,030,270	77.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sun	n of Parts I and	1, 397, 066	50. 00
51. 00		atient ancillar	v services (fr	om Wkst D s	cum of Parts II	760, 884	51.00
01.00	and IV)	atront unorrran	<i>y</i> 301 11 003 (11	om with b, c	Jam of Tarts II	700,001	01.00
52.00	Total Program excludable cost (sum of lines					2, 157, 950	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anestr	netist, and	3, 898, 346	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program discharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	, ,	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	Ü			ŕ	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996, u	pdated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	er of 50% of		0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	riisti deti olis)				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of the	cost reporti	ng period (See	0	64. 00
01.00	instructions)(title XVIII only)	rts till odgir beee		cost reperti	ng perred (see		01.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 d	f the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
(0.00	(line 13 x line 20)			(0)			(0.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil				l		70.00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		SSC TIME COLL OIL	(11110 70 11111	11110 77)		81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82. 00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
	Total Program inpatient operating costs (sum						86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			774 3, 248. 30	
	Observation bed cost (line 87 x line 88) (se					2, 514, 184	
		,				•	

Health Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 06/01/2021 To 05/31/2022	Date/Time Pre 10/28/2022 2:	pared: 52 pm
		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	8, 682, 810	21, 409, 567	0. 40555	7 2, 514, 184	1, 019, 645	90.00
91.00 Nursing Program cost	0	21, 409, 567	0.00000	2, 514, 184	0	91.00
92.00 Allied health cost	0	21, 409, 567	0.00000	2, 514, 184	0	92.00
93.00 All other Medical Education	0	21, 409, 567	0. 00000	2, 514, 184	0	93. 00

Heal th	Financial Systems	LUTHERAN DOWNTOWN	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0047	Peri od:	Worksheet D-1	
				From 06/01/2021 To 05/31/2022	Date/Time Pre 10/28/2022 2:	
			Title XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description					
	·				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					ļ
1.00	Inpatient days (including private room days				6, 865	
2.00	Inpatient days (including private room days				6, 591	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	d and observation be	d days)		5, 817	4. 00
5.00	Total swing-bed SNF type inpatient days (ir	ncluding private roc	m days) through Decembe	r 31 of the cost	0	5. 00
	reporting period					
6.00	Total swing-bed SNF type inpatient days (ir	ncluding private roc	m days) after December	31 of the cost	274	6.00
	reporting period (if calendar year, enter 0	on this line)				
7.00	Total swing-bed NF type inpatient days (inc	luding private room	days) through December	31 of the cost	0	7. 00
	reporting period					
8.00	Total swing-bed NF type inpatient days (inc	luding private room	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0	on this line)				
9.00	Total inpatient days including private room	n days applicable to	the Program (excluding	swi ng-bed and	467	9. 00
	newborn days) (see instructions)			-		
10.00	Swing-bed SNF type inpatient days applicabl	e to title XVIII on	ly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting p	eriod (see instruct	i ons)	•		
11.00	Swing-bed SNF type inpatient days applicabl	e to title XVIII on	ly (including private r	oom days) after	0	11. 00
	December 31 of the cost reporting period (i					
12.00	Swing-bed NF type inpatient days applicable		only (including privat	e room days)	0	12. 00
	through December 31 of the cost reporting p					
13. 00	Swing-bed NF type inpatient days applicable				0	13. 00
	after December 31 of the cost reporting per					
14.00	Medically necessary private room days appli	cable to the Progra	m (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)				0	15. 00
16. 00	Nursery days (title V or XIX only)				0	16. 00
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services ap	oplicable to service	s through December 31 o	f the cost	0.00	17. 00
	reporting period					
18. 00	Medicare rate for swing-bed SNF services ap	pplicable to service	s after December 31 of	the cost	0.00	18. 00
	reporting period					
19. 00	Medicaid rate for swing-bed NF services app	olicable to services	through December 31 of	the cost	0. 00	19. 00
	reporting period					
20. 00	Medicaid rate for swing-bed NF services app	olicable to services	after December 31 of t	he cost	0.00	20. 00
	reporting period					
21. 00	Total general inpatient routine service cos				21, 409, 567	
22. 00	Swing-bed cost applicable to SNF type servi	ces through Decembe	r 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)					
23. 00	Swing-bed cost applicable to SNF type servi	ces after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)					
24. 00	Swing-bed cost applicable to NF type service	es through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)					
25. 00	Swing-bed cost applicable to NF type service	es after December 3	1 of the cost reporting	period (line 8	0	25. 00
	x line 20)					l
26. 00	Total swing-bed cost (see instructions)				0	
27. 00	General inpatient routine service cost net	of swing-bed cost (line 21 minus line 26)		21, 409, 567	27.00

Private room days (excluding selfing-bed and observation bed days). If you have only private room days, 0 3 0 0 0 0 0 0 0 0	2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6, 591	
Semi-private room days (excluding swing-bed and observation bed days) through Becember 31 of the cost reporting period (it called your swing-bed SMF type inpartient days (including private room days) after December 31 of the cost reporting period (it called your swing-net of the cost reporting period (it called your swing-net of this line) 7.00	3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 7.00 Medicard patient patient days applicable to 11 tle XVIII only (including private room days) 8.00 Total patient days including private room days) 8.00 Total inpatient days applicable to 11 tle XVIII only (including private room days) 8.00 Total patient days applicable to 11 tle XVIII only (including private room days) 8.00 Total patient days applicable to 11 tle XVIII only (including private room days) 9.00 Total proper 31 of the cost reporting period (including private room days) 9.00 Total proper 31 of the cost reporting period (including private room days) 9.00 Total proper 31 of the cost reporting period (including private room days) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total nursery days (title V or XIX only) 9.00 Total general inpatient routine services applicable to services after December 31 of the cost reporting period 9.00 Total general	4 00		E 047	4 00
reporting period (if callendar year, enter 0 on this line) 7. 00 Total saing-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) 8. 00 Total inpatient days including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days aprice December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. 00 Swing-bed SNF type inpatient days applicable to this line) 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) after through December 31 of the cost reporting period (see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) after December 31 of the cost reporting period (see instructions) 12. 00 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to titles Vor XIX only (including private room days) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Intra on the propries of the cost reporting period (see the Program (excluding swing-bed days) 16. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of the Program (excluding swing-bed base) 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of the Program (excluding swing-bed base) 18. 00 Medicare rate for swing-bed SNF services applicable to servi				
Total sain_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)	5.00		0	5.00
reporting period (if Callendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 7.00 Total swing-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) 9.00 Swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Callendar) year end days applicable to the Program (excluding swing-bed and neborn days) (see Instructions) 10.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to XVIII only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to Titles V or XIX only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to Titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to Titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to Titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to Titles V or XIX only (including private room days) 14.00 Nedically increases your private room days applicable to XIX only (including private room days) 15.00 Nedically increases your private room days applicable to the Program (excluding swing-bed days) 16.00 Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost 17.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services a	/ 00		274	/ 00
7.00 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) 10.00 Total swing-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) 10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Swing-bed SMF type inpatient days applicable to the trough December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to the trough December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding Swing-bed days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding Swing-bed days) 13.00 Swing-bed DAUJSWIND (it it of Swing-bed Swing-be	6.00		2/4	6.00
reporting period 8. 00 Total swing-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. 03 wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 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 (see instructions) 12. 00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this line) 12. 00 Swing-bed SNF type Inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 16. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 17. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including period seed of the period	7 00		0	7 00
Total swing 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)	7.00		U	7.00
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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 21, 409, 567) 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) 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) 0.00 34.00 35.00 36.00 37.00 21, 409, 567				
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 21, 409, 567 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) 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) 0.00 35.00 36.00 36.00 36.00 36.00 36.00 37.00 27 minus line 36 37.00 27 minus line 36 37.00 37				
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 21, 409, 567 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) 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) 36.00 21, 409, 567 37.00 37				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 21, 409, 567 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) 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) 37.00 21, 409, 567 37.00 37.				
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) 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) 0 40.00			-	
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) 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) 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) 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)	57.00	, , ,	2., 107, 007	000
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 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 private room cost applicable to the Program (line 14 x line 35) 38.00 1,516,956 39.00 40.00				
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 private room cost applicable to the Program (line 14 x line 35) 38.00 1,516,956 39.00 40.00				
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) 1,516,956 39.00 40.00	38 00		3 248 30	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
1,310,730 41.00				
	11.00	1. cta	1, 510, 750	1 00

	Financial Systems	LUTHERAN DOWNT				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0047	Peri od: From 06/01/2021	Worksheet D-1	
					To 05/31/2022	Date/Time Prep 10/28/2022 2:	
				e XIX	Hospi tal	PPS	PIII
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
		Impatrent cost	inpatrent bays	col . 2)	-	4)	
12.00	NUDGEDY (4: +1 - V o VIV1)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT	7, 190, 198	1, 613	4, 457. 6	66 80	356, 613	•
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					1, 160, 711	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ins)		3, 034, 280	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sun	of Parts I and	705, 813	50.00
51. 00		ationt ancillar	v sorvicos (fr	com Wkst D s	um of Darte II	368, 287	51.00
31.00	and IV)	atrent ancirrai	y services (II	OIII WKSt. D, S	Sum Of Parts II	300, 207	31.00
52.00	Total Program excludable cost (sum of lines					1, 074, 100	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anestr	ietist, and	1, 960, 180	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	- ,					
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	portina period	endi na 1996. u	pdated and co	mpounded by the	0.00	
	market basket		-				
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	ı
000	which operating costs (line 53) are less tha	n expected cost					000
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			Ö	
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +b	21 -6 +1				
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bece	iliber 31 of the	cost reporti	ng period (see	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportino	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
	CAH (see instructions)					_	
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	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	routine costs (line 67 + line	. 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		, ,			70. 00 71. 00
72.00	, ,		THE 70 + TIME	2)			72.00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II. column		74. 00 75. 00
	26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
	Inpatient routine service cost (line 74 minu	,					78. 00
79.00	Aggregate charges to beneficiaries for exces				uo lino 70)		79.00
80.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iiiiii tätion	i (iine /8 Mir	ius IIIle /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		s)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL observation bed days (see instructions					774	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			3, 248. 30	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				2, 514, 184	89. 00

Health Financial Systems	LUTHERAN DOWNT	OWN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 06/01/2021 To 05/31/2022	Date/Time Pre 10/28/2022 2:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	8, 682, 810	21, 409, 567	0. 40555	7 2, 514, 184	1, 019, 645	90.00
91.00 Nursing Program cost	0	21, 409, 567	0.00000	2, 514, 184	0	91.00
92.00 Allied health cost	0	21, 409, 567	0.00000	2, 514, 184	0	92.00
93.00 All other Medical Education	0	21, 409, 567	0.00000	2, 514, 184	0	93.00

	Provider C	CN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet D-3 Date/Time Pre 10/28/2022 2:	pared
	Ti tl e	e 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			2, 670, 906		30.0
1.00 03100 INTENSIVE CARE UNIT			1, 094, 040		31.0
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM		1. 36878		416, 154	50.0
1.00 05100 RECOVERY ROOM		1. 1848	40 25, 435	30, 136	
3. 00 05300 ANESTHESI OLOGY		1. 32860		68, 597	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1456		253, 391	
4. 01 03630 ULTRA SOUND		0.00000		0	
6. 00 05600 RADI OI SOTOPE		0.00000		0	
7. 00 05700 CT SCAN		0.00000		0	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		0	1
9.00 05900 CARDIAC CATHETERIZATION		1. 5226!		0	
0. 00 06000 LABORATORY		0. 1864		307, 034	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 3371!		14, 998	
5. 00 06500 RESPI RATORY THERAPY		0. 25742		261, 304	
6. 00 06600 PHYSI CAL THERAPY		0. 90468		155, 801	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 5032		77, 677	
8. 00 06800 SPEECH PATHOLOGY		1. 62620		30, 771	
9. 00 06900 ELECTROCARDI OLOGY		0. 2002		15, 661	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 14542		33, 952	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1116		8, 034	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1521!		359, 426	
6. 00 03950 MI SC ANCI LLARY		0. 00000		0	
6. 01 03951 SLEEP LAB		0.00000		0	1
6. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000	00 0	0	76.0
OUTPATIENT SERVICE COST CENTERS 10. 00 09000 CLINIC		0. 88918	83 0	0	90.0
0. 00 09000 CLINI C 11. 00 09100 EMERGENCY		0. 88918		-	1
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		•		167, 651	
	1	0. 94190		84, 524	
Total (sum of lines 50 through 94 and 96 through 98 O1.00 Less PBP Clinic Laboratory Services-Program only ch			8, 602, 594	2, 285, 111	
ULLUUL - LESS PBP CLINIC LADOCATORY SERVICES-PROGRAM ONLY CR	arues (TINE 61)	1	0		201. (

NPATI I	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0047	Peri od:	Worksheet D-3	3
		Component	CCN: 15-U047	From 06/01/2021 To 05/31/2022		
		Ti tl e	e XVIII	Swing Beds - SN		JZ PIII
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
				· ·	2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.0
	03100 INTENSIVE CARE UNIT					31. C
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		1. 3687			
1	05100 RECOVERY ROOM		1. 1848		1	
	05300 ANESTHESI OLOGY		1. 3286		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 1456		1	
	03630 ULTRA SOUND		0.0000		-	
	05600 RADI OI SOTOPE		0.0000		0	
	05700 CT SCAN		0.0000		0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		1	
	05900 CARDI AC CATHETERI ZATI ON		1. 5226		1	1
	06000 LABORATORY		0. 1864			1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 3371		-	1
	06500 RESPI RATORY THERAPY		0. 2574		1	
	06600 PHYSI CAL THERAPY		0. 9046	·	•	
	06700 OCCUPATI ONAL THERAPY		0. 5032			
	06800 SPEECH PATHOLOGY		1. 6262			
	06900 ELECTROCARDI OLOGY		0. 2002		-	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1454		0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1116		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 1521	·		
	03950 MISC ANCILLARY		0.0000		1	
	03951 SLEEP LAB		0.0000		1	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000	00	0	76.
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0. 8891			
	09100 EMERGENCY		0. 2821		1	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 9419		0	
00.00	Total (sum of lines 50 through 94 and 96 through 98)			211, 011	100, 981	
01.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)			P	201.
02.00	Net charges (line 200 minus line 201)			211, 011		202.

I NPATI ENT	F ANCILLARY SERVICE COST APPORTIONMENT Pr	rovider C	CN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet D-3 Date/Time Pre 10/28/2022 2:	pared
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS					
	000 ADULTS & PEDIATRICS			1, 362, 840		30.0
	100 INTENSIVE CARE UNIT			664, 905		31.0
	CILLARY SERVICE COST CENTERS		,			
	OOO OPERATING ROOM		1. 36878			
	100 RECOVERY ROOM		1. 1848			
	300 ANESTHESI OLOGY		1. 32860			
	400 RADI OLOGY-DI AGNOSTI C		0. 1456			
	630 ULTRA SOUND		0. 00000		1	
	600 RADI OI SOTOPE		0. 00000		0	
4	700 CT SCAN		0. 00000		0	1 0 /
	800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		0	
	900 CARDI AC CATHETERI ZATI ON		1. 5226!			
	000 LABORATORY		0. 1864			60.
	200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 3371			
	500 RESPI RATORY THERAPY		0. 25742			
	600 PHYSI CAL THERAPY		0. 90468			
	700 OCCUPATI ONAL THERAPY		0. 5032			
	800 SPEECH PATHOLOGY		1. 62620			
	900 ELECTROCARDI OLOGY		0. 2002	·		1
	100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 1454:	·		1
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 1116			
	300 DRUGS CHARGED TO PATIENTS		0. 1521!			1
	950 MI SC ANCI LLARY		0.0000		1	
	951 SLEEP LAB		0.00000		1	
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000	00 0	0	76.
	TPATIENT SERVICE COST CENTERS 000 CLINIC		0.0001	1 055	020	-00
			0. 88918			
	100 EMERGENCY		0. 2821			
- 1	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 94190	·		
00.00	Total (sum of lines 50 through 94 and 96 through 98)	ino (1)	[4, 443, 230		
201.00	Less PBP Clinic Laboratory Services-Program only charges (I	rne 61)		4 442 222		201.
202. 00	Net charges (line 200 minus line 201)		1	4, 443, 230	1	202.

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0047	Peri od:		Worksheet D-3	
			From 06/0			
	Component	CCN: 15-U047	To 05/3	1/2022	Date/Time Pre 10/28/2022 2:	
	Ti tl	e XIX	Swing Beds	- SNF		OZ PIII
Cost Center Description	<u> </u>	Ratio of Cos	st Inpati	ent	I npati ent	
		To Charges			Program Costs	
			Charg	ges	(col. 1 x col.	
				_	2)	
LADATI FAIT DOUTLAG OFFICE OF CONT. OFFITFED		1.00	2. 0	0 [3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1 20 0
D. 00 03000 ADULTS & PEDIATRICS . 00 03100 NTENSIVE CARE UNIT						30.0
ANCI LLARY SERVI CE COST CENTERS		1				31.0
D. OO O5000 OPERATI NG ROOM		1. 3687	88	ol	0	50.0
I. OO 05100 RECOVERY ROOM		1. 1848		o	0	
B. 00 05300 ANESTHESI OLOGY		1. 3286		o	0	
1. OO 05400 RADI OLOGY-DI AGNOSTI C		0. 1456		o	0	
4. 01 03630 ULTRA SOUND		0.0000	00	o	0	54.0
5. 00 05600 RADI 0I SOTOPE		0.0000	00	О	0	56.0
7.00 05700 CT SCAN		0.0000	00	O	0	57. C
3.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	0	1
P. 00 05900 CARDI AC CATHETERI ZATI ON		1. 5226		0	0	59. C
0. 00 06000 LABORATORY		0. 1864		0	0	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 3371		0	0	62.0
5. 00 06500 RESPIRATORY THERAPY		0. 2574		0	0	
5. 00 06600 PHYSI CAL THERAPY		0. 9046		0	0	
7. 00 06700 0CCUPATIONAL THERAPY 3. 00 06800 SPEECH PATHOLOGY		0. 5032 1. 6262		0	0	
2. 00 06900 SPEECH PATHOLOGY		0. 2002		0	0	
1. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 2002		0	0	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1116		0	0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1521		0	0	1
5. 00 03950 MI SC ANCI LLARY		0.0000		o	0	
5. 01 03951 SLEEP LAB		0.0000		0	0	76. (
5. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000	00	0	0	76.0
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLI NI C		0. 8891		0	0	
I. 00 09100 EMERGENCY		0. 2821		0	0	1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 9419	09	0	0	
700.00 Total (sum of lines 50 through 94 and 96 through 98)	(1)			0	0	200.0
01.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)	1	1	Ol		201. C

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL	-	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet E Part A Date/Time Prepared: 10/28/2022 2:52 pm

			03/31/2022	10/28/2022 2:	
		Title XVIII	Hospi tal	PPS	
				1 00	
	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 occurri	ng prior to October 1 (see	537, 463	1. 00
	instructions)	g p c. to to to to (0077 100	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see			1, 158, 674	1. 02
	instructions)				
1. 03	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions)	or discharges escurring	on or ofter	0	1. 04
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring to	on or arter	U	1. 04
2.00	Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1	(see instructions)		1, 728	2. 03
2.04	Outlier payments for discharges occurring on or after October			373, 629	2. 04
3.00	Managed Care Simulated Payments			2, 617, 404	3. 00
4.00	Bed days available divided by number of days in the cost repo	rting period (see instru	ctions)	57. 55	4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting p	period ending on	8. 95	5. 00
	or before 12/31/1996. (see instructions)	6		0.00	, 00
6. 00	FTE count for allopathic and osteopathic programs that meet the	ne criteria for an add-oi	n to the cap for	0. 00	6. 00
7. 00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u	indor 42 CEP 8412 105(f)	(1) (i, v) (P) (1)	0. 00	7. 00
7. 00	ACA § 5503 reduction amount to the IME cap as specified under			1. 89	7. 00
7.01	cost report straddles July 1, 2011 then see instructions.	42 CIR 3412. 103(1)(1)(1)	V)(b)(2) 11 the	1.07	7.01
8. 00	Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic prod	grams for	-6. 37	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.07	0.00
	1998), and 67 FR 50069 (August 1, 2002).		,		
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the A	ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0. 00	8. 02
	under § 5506 of ACA. (see instructions)				
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (s	see	0. 69	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the curre	ont year from your record	de	0. 85	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	erit year from your record	us		11. 00
12. 00	Current year allowable FTE (see instructions)			0. 69	
13. 00	Total allowable FTE count for the prior year.			0. 69	
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sen	tember 30 1997		14. 00
11.00	otherwise enter zero.	ar crided on or arter sep	tember 60, 1777,	0. 12	11.00
15.00	Sum of lines 12 through 14 divided by 3.			0. 60	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17.00	Adjustment for residents displaced by program or hospital clos	sure		0.00	17. 00
18.00	Adjusted rolling average FTE count			0. 60	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4)).		0. 010426	19.00
20.00	Prior year resident to bed ratio (see instructions)			0. 011577	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 010426	21.00
22.00	IME payment adjustment (see instructions)			9, 641	
22. 01	IME payment adjustment - Managed Care (see instructions)			14, 877	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422				
23. 00	Number of additional allopathic and osteopathic IME FTE reside	ent cap slots under 42 Cl	FR 412. 105	4. 00	23. 00
	(f)(1)(iv)(C).				
24. 00	IME FTE Resident Count Over Cap (see instructions)	6.1.		0. 16	
25. 00	If the amount on line 24 is greater than -0-, then enter the	ower of line 23 or line	24 (see	0. 16	25. 00
27 00	instructions)			0 002700	24 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.002780	
27. 00	IME payments adjustment factor. (see instructions)			0.000743	27. 00
28. 00 28. 01	IME add-on adjustment amount (see instructions)			1, 260 1, 945	
29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)	,		10, 901	29. 00
29. 00	Total IME payment - Managed Care (sum of lines 22.01 and 28.0)	1)		16, 822	29. 00
27.01	Disproportionate Share Adjustment			10, 022	27.01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	18. 01	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	21. 2.1. 44.5 (365 11151146		46. 04	
32. 00	Sum of lines 30 and 31			64. 05	
	Allowable disproportionate share percentage (see instructions))		12. 00	
	Disproportionate share adjustment (see instructions)			50, 884	
			'		

ALCUL	Financial Systems LUTHERAN DOWNTO ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Peri od:	u of Form CMS-2 Worksheet E	∠UOZ-
			From 06/01/2021 To 05/31/2022	Part A	pare
		Title XVIII	Hospi tal	10/28/2022 2: PPS	52 p
		THE AVIII	Pri or to 10/1		
			1. 00	2. 00	
	Uncompensated Care Adjustment				
5. 00 5. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000000000	0. 000000000	35. 35.
5. 02	1	ter zero on this line) (se			
5. 03	Pro rata share of the hospital uncompensated care payment am		254, 808 1, 053, 660		35. 36.
	Additional payment for high percentage of ESRD beneficiary d	lischarges (lines 40 throu			
0. 00	Total Medicare discharges (see instructions)		0		40.
			Before 1/1 1.00	0n/After 1/1 1.01	
1. 00	Total ESRD Medicare discharges (see instructions)		0	0	41.
I. 01	Total ESRD Medicare covered and paid discharges (see instruc	*	0	0	
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42.
3. 00 4. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided days)	d by line 41 divided by 7	0. 000000		43. 44.
5. 00	Average weekly cost for dialysis treatments (see instruction	ns)	0.00	0. 00	45.
6. 00	Total additional payment (line 45 times line 44 times line 4	11. 01)	0		46.
. 00	Subtotal (see instructions)		3, 186, 939		47.
. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural nospitals	0		48.
	1. (555 Thist: 45t. 6hb)			Amount	
				1.00	
0.00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I a	•		3, 203, 761 262, 667	1
. 00	Exception payment for inpatient program capital (Wkst. L, Pt	• • • • • •		0	1
. 00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		22, 506	
. 00	Nursing and Allied Health Managed Care payment			121 042	53
. 00	Special add-on payments for new technologies Islet isolation add-on payment			131, 862 0	54 54
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	
00	Cost of physicians' services in a teaching hospital (see int	*		0	56
. 00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.		hrough 35).	0	
00	Total (sum of amounts on lines 49 through 58)	1V, Col. 11 1111e 200)		3, 620, 796	
00	Pri mary payer payments			0	60
. 00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		3, 620, 796	
00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			178, 784 12, 614	
00	Allowable bad debts (see instructions)			86, 235	
00	Adjusted reimbursable bad debts (see instructions)			56, 053	65
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		19, 607	1
00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	annlicable to MS_DPGs (s	ea instructions)	3, 485, 451 0	67
00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	69
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	,	0	70
. 50	Rural Community Hospital Demonstration Project (§410A Demons		instructions)	0	70
. 87 . 88	Demonstration payment adjustment amount before sequestration	1		0	1
. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	structions)		U	70
. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70
	Bundled Model 1 discount amount (see instructions)			0	70
). 92	· · · · · · · · · · · · · · · · · · ·			4 /74	70
). 92). 93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-1, 671 -129	

Hoal th	Financial Systems LUTHERAN DOWNTOW	IAT IDZOLI IAU		India	u of Form CMS-:	2552 10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet E Part A Date/Time Pre 10/28/2022 2:	pared:
		Titl∈	e XVIII	Hospi tal	PPS	
			FF\	′ (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3	ŕ			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			3, 483, 651	71. 00
71. 01	Sequestration adjustment (see instructions)				5, 922	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				2, 756, 994	
72. 01	Interim payments-PARHM					72. 01
73. 00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	02, 72, and			720, 735	
74. 01 75. 00	Balance due provider/program-PARHM (see instructions)				1 100 710	74. 01
75.00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ance with			1, 133, 712	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			1
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2 03			0	90.00
70.00	plus 2.04 (see instructions)	01 2.00			Ü	70.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92. 00	· ·	ructions)			0	1
93. 00					0	1
94.00	The rate used to calculate the time value of money (see instr				0.00	94.00
95.00	Time value of money for operating expenses (see instructions))			0	95. 00
96.00	Time value of money for capital related expenses (see instruc	ctions)			0	96.00
					On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions)	20)		0. 0000000000	0.000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	15)		U	U	102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions	=)		0.0000		104.00
104.00	Rural Community Hospital Demonstration Project (§410A Demonst		istment	<u> </u>		104.00
200.00	Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.					200. 00
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir	ne 49)				201. 00
	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)	61 .	6 11			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in period)	n first year	of the curre	nt 5-year demonst	ration	
	Medicare target amount					204. 00
205.00	Case-mix adjusted target amount (line 203 times line 204)					205. 00

peri od)	_
204.00 Medicare target amount	204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)	205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)	206. 00
Adjustment to Medicare Part A Inpatient Reimbursement	
207.00 Program reimbursement under the §410A Demonstration (see instructions)	207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)	208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)	209. 00
210.00 Reserved for future use	210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)	211. 00
Comparision of PPS versus Cost Reimbursement	
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)	212. 00
213.00 Low-volume adjustment (see instructions)	213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)	218. 00
(line 212 minus line 213) (see instructions)	

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet E Part B Date/Time Prepared: 10/28/2022 2:52 pm

			10 03/31/2022	10/28/2022 2:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			3, 160	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		2, 238, 679	2. 00
3.00					3. 00
4.00					4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructi	ions)		0. 000	4. 01 5. 00
6. 00	Line 2 times line 5	i oris)		0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 160	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			20, 149	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	ŕ		20, 149	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pay			0	15. 00
16. 00	Amounts that would have been realized from patients liable for patients with 42 CFD 6412 12(2)	payment for services on	a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			20, 149	18.00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	e 11) (see	16, 989	19.00
	instructions)		, `		
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	e 18) (see	0	20. 00
21 00	instructions)			2.1/0	21 00
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			3, 160 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		793, 941	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			951	
26. 00	Deductibles and Coinsurance amounts relating to amount on line 2	•		137, 105	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	us the sum of lines 22	and 23] (see	659, 045	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	· 50)		8, 242	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	3 33)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			667, 287	30.00
31. 00	Primary payer payments			784	
32. 00	Subtotal (line 30 minus line 31)	2)		666, 503	32. 00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		0	33. 00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			56, 809	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			36, 926	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		30, 449	36.00
37.00	Subtotal (see instructions)			703, 429	37. 00
	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Prioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	d devices (see instruct	ions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see instruct	10113)	0	39. 99
40. 00	Subtotal (see instructions)			703, 429	40.00
40. 01	Sequestration adjustment (see instructions)			1, 196	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00	Interim payments			734, 226	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 00	Tentative settlement (for contractors use only)			U	42.00
43. 00	Balance due provider/program (see instructions)			-31, 993	
43. 01	Balance due provider/program-PARHM (see instructions)			.,.,0	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, c	hapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR		-		00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0.00	93. 00
	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	LUTHERAN DOWNTOWN	I HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 06/01/2021		
			To 05/31/2022	Date/Time Pr	epared:
				10/28/2022 2	:52 pm_
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Health Financial Systems LUTH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0047

					10/28/2022 2: 5	52 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		2, 756, 99	4	734, 226	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER			0		3. 01
3. 02				0		3. 02
3. 04				0		3. 04
3. 05				0		3. 05
3.03	Provider to Program			<u> </u>	0	3. 03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	l ol	3. 51
3. 52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 756, 99	4	734, 226	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	o	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		720, 73	5	0	6. 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	31, 993	6. 01
6. 02 7. 00	Total Medicare program liability (see instructions)		3, 477, 72	-	702, 233	6. 02 7. 00
7.00	Trotal modicale program trability (see Histructions)		5,411,12	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•			•		

Title XVIII Swing Beds - SNF PPS Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		2 0111
Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,	0	
1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,	- 1	
1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,	- 1	
1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,	- 1	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,	- 1	
submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,	0	1.00
services rendered in the cost reporting period. If none,		2. 00
write "NONE" or enter a zero		
3.00 List separately each retroactive lump sum adjustment		3. 00
amount based on subsequent revision of the interim rate		
for the cost reporting period. Also show date of each		
payment. If none, write "NONE" or enter a zero. (1)		
Program to Provider		
3.01 ADJUSTMENTS TO PROVIDER 0	0	3. 01
3.02	0	3. 02
3. 03	0	3. 03
3.04	0	3. 04
3. 05 Dravit day, to Draway	0	3. 05
Provi der to Program 3.50 ADJUSTMENTS TO PROGRAM 0	0	3. 50
3.51 0 ADDUST WEINTS TO PROGRAW 0	0	3. 51
3.52	0	3. 52
3. 53	0	3. 53
3.54	o	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0	0	3. 99
3. 50-3. 98)		
4.00 Total interim payments (sum of lines 1, 2, and 3.99) 63,129	0	4. 00
(transfer to Wkst. E or Wkst. E-3, line and column as		
appropri ate)		
TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after		5. 00
desk review. Also show date of each payment. If none,		5.00
write "NONE" or enter a zero. (1)		
Program to Provider		
5. 01 TENTATI VE TO PROVI DER 0	0	5. 01
5. 02	0	5. 02
5. 03	0	5. 03
Provider to Program		
5.50 TENTATI VE TO PROGRAM 0	0	5. 50
5. 51	0	5. 51
5. 52 0 0 Cultural (cum of lines 5.01.5.40 minus cum of lines	0	5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.50-5.98)	ال	5. 99
6.00 Determined net settlement amount (balance due) based on		6. 00
the cost report. (1)		0.00
6.01 SETTLEMENT TO PROVIDER 129	0	6. 01
6.02 SETTLEMENT TO PROGRAM	0	6. 02
7.00 Total Medicare program Liability (see instructions) 63,258	0	7. 00
Contractor NPR Date		
Number (Mo/Day/Yr)	
0 1.00 2.00		
8.00 Name of Contractor	- 1	8. 00

Health Financial Systems LUTHERAN DOWNTOWN HOSPITAL In Lieu of Form CMS-2552-1					
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0047	Peri od:	Worksheet E-1	
	From 06/01/2021 To 05/31/2022 I				
				10/28/2022 2:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	The state of the s			1. 00
2.00	2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost				2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost				
	reporting periods beginning on or after 10/01/2013, line 32)				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HII technology	WKSt. S-2, Pt. I		7. 00
0.00	line 168				0.00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00 9. 00
	9.00 Sequestration adjustment amount (see instructions)				
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
00.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)	! 21)	-)		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 DOWNTOWN	I HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-0047	Peri od:	Worksheet E-2
		Component CCN: 15-U047	From 06/01/2021	Date/Time Prepared:
		Component CCN. 15-0047	10 03/31/2022	10/28/2022 2: 52 pm

		Component CCN: 15-U047	To 05/31/2022	Date/Time Pre 10/28/2022 2:	
		Title XVIII	Swing Beds - SNF		<u> </u>
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPTED OFFICE		1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		42 AE2	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		63, 452	U	1. 00 2. 00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· A and sum of Wkst D	0	0	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir			Ĭ	0.00
	instructions)	J			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4. 00
F 00	instructions)		00		F 00
5.00	Program days	ustrusti ons)	89	0	5. 00 6. 00
6. 00 7. 00	Interns and residents not in approved teaching program (see ir Utilization review - physician compensation - SNF optional met	had only	0	0	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	riod only	63, 452	0	1
9. 00	Primary payer payments (see instructions)		0	Ö	
10.00	Subtotal (line 8 minus line 9)		63, 452	0	
11.00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11. 00
	professional services)				
12. 00	Subtotal (line 10 minus line 11)		63, 452	0	12.00
13. 00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	194	0	13. 00
14. 00	for physician professional services) 80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (see instructions)		63, 258		
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		03, 230	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	•	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)	weti enel	0	0	1
18. 00 19. 00	Allowable bad debts for dual eligible beneficiaries (see instr Total (see instructions)	uctions)	63, 258	0	18. 00 19. 00
19. 00	Sequestration adjustment (see instructions)		03, 230	0	19. 00
19. 02	Demonstration payment adjustment amount after sequestration)		0	Ö	
19. 03	Sequestration adjustment-PARHM pass-throughs		_		19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20.00	Interim payments		63, 129	0	20. 00
20. 01	Interim payments-PARHM				20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	
21. 01	Tentative settlement-PARHM (for contractor use only)	10.05.00 1.01)	100		21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	r, 19.25, 20, and 21)	129	0	22. 00 22. 01
22. 01 23. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordar	uce with CMS Pub 15-2	0	0	1
23.00	chapter 1, §115. 2	ice with clast ub. 13-2,	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
004 00	Cost Reimbursement				004 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	KST. D-I, PT. II, IINE			201. 00
202 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	wkst D-3 col 3 lin	Α.		202. 00
202.00	200 (title XVIII swing-bed SNF))	1 WK31. D-3, COI. 3, 111			202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	tration	
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	•	1		208.00
200.00	and 3)	., cor. 1, sum of fines	'		200.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 00
	Reserved for future use	-/			210.00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
	instructions)		I	l	I

Health Financial Systems	LUTHERAN DOWNTOWN	I HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-0047	Peri od: From 06/01/2021	Worksheet E-2
		Component CCN: 15-U047		Date/Time Prepared: 10/28/2022 2:52 pm

		Component CCN: 15-U047	To 05/31/2022	Date/Time Pr 10/28/2022 2	
		Title XIX	Swing Beds - SNF		2. 32 piii
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
	Inpatient routine services - swing bed-NF (see instructions)	A D	0		2.0
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		0		3. 0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing instructions)	g-bed pass-through, see			
3. 01	instructions) Nursing and allied health payment DADUM (see instructions)				3. 0
1	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teachi	ng program (coo	0.00		4.0
1.00	instructions)	ng program (see	0.00		4.0
5. 00	Program days		0		5. C
	Interns and residents not in approved teaching program (see in	structions)	o		6.0
7.00	Utilization review - physician compensation - SNF optional met	hod onl v	o		7. 0
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	, , ,	o		8.0
	Primary payer payments (see instructions)		o		9.0
10. 00	Subtotal (line 8 minus line 9)		o		10. C
11.00	Deductibles billed to program patients (exclude amounts applic	able to physician	o		11. 0
	professional services)				
12. 00	Subtotal (line 10 minus line 11)		0		12. 0
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0		13.0
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		0		14.0
	Subtotal (see instructions)		0		15. C
- 1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.0
	Pioneer ACO demonstration payment adjustment (see instructions	,			16. 5
16. 55	Rural community hospital demonstration project (§410A Demonstra	ation) payment			16. 5
17 00	adjustment (see instructions)				1,,
	Demonstration payment adjustment amount before sequestration		0		16. 9
	Allowable bad debts (see instructions)		0		17.0
	Adjusted reimbursable bad debts (see instructions)	uati ana)	0		17. 0 18. 0
	Allowable bad debts for dual eligible beneficiaries (see instr Total (see instructions)	uctions)	0		19. 0
	Sequestration adjustment (see instructions)		0		19.0
	Demonstration payment adjustment amount after sequestration)				19.0
1	Sequestration adjustment-PARHM pass-throughs		- I		19.0
1	Sequestration for non-claims based amounts (see instructions)		o		19. 2
1	Interim payments				20.0
	Interim payments-PARHM		ď		20.0
- 1	Tentative settlement (for contractor use only)		0		21. 0
- 1	Tentative settlement-PARHM (for contractor use only)				21. 0
- 1	Balance due provider/program (line 19 minus lines 19.01, 19.02	. 19. 25. 20. and 21)	o		22. 0
	Balance due provider/program-PARHM (see instructions)	,			22. 0
	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	o		23.0
	chapter 1, §115.2				
J	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment			
200. 00	Is this the first year of the current 5-year demonstration per	iod under the 21st			200. C
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201. 00	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201. 0
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	WKST. D-3, col. 3, line	9		202. 0
202 00	200 (title XVIII swing-bed SNF))				202 0
	Total (sum of lines 201 and 202)				203. 0
	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the surrer	at E year demonst	ration	204. 0
	period)	irrst year or the curren	it 5-year demonst	1 4 1 1 0 1 1	
	Medicare swing-bed SNF target amount				205. 0
- 1	Medicare swing bed SNF inpatient routine cost cap (line 205 til	mes line 204)			206. 0
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				
	Program reimbursement under the §410A Demonstration (see instr				207. 0
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2		1		208. 0
55	and 3)	,,			[
l	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 0
209. 00		*			210.0
1	Reserved for future use				
210. 00	Reserved for future use Comparision of PPS versus Cost Reimbursement				
10. 00		09 plus line 210) (see			215. (

Health Financial Systems	LUTHERAN DOWNTOWN HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022 Worksheet E-3 Part VII Date/Time Prepared: 10/28/2022 2:52 pm

			0 05/31/2022	Date/lime Pre 10/28/2022 2:	
		Title XIX	Hospi tal	PPS	02 piii
		THE SALK	Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	Wide fall filled t all Mi	02.00		
1.00	Inpatient hospital/SNF/NF services		O		1.00
2. 00	Medical and other services			1, 630, 160	2. 00
3. 00	Organ acquisition (certified transplant centers only)		0	1,000,100	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		ol	1, 630, 160	
5. 00	Inpatient primary payer payments		o	1,000,100	5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		o	1, 630, 160	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		-1	.,,,	
	Reasonable Charges				
8.00	Routine service charges		2, 027, 745		8. 00
9. 00	Ancillary service charges		4, 443, 230	7, 250, 413	9. 00
10. 00	Organ acquisition charges, net of revenue		0	7,200,110	10. 00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		6, 470, 975	7, 250, 413	
	CUSTOMARY CHARGES			.,,	
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s	g-			
14.00	Amounts that would have been realized from patients liable for	payment for services on	o	0	14. 00
	a charge basis had such payment been made in accordance with 4				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		6, 470, 975	7, 250, 413	16. 00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	6, 470, 975	5, 620, 253	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	1, 630, 160	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	0	
	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00 29. 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		0	1 (20 1(0	28. 00 29. 00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		l ol	1, 630, 160	29.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	1, 630, 160	
32. 00	Deductibles		0	1, 630, 160	
33. 00	Coinsurance		0	0	33.00
34. 00			0	0	34. 00
	Utilization review		0	Ü	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 22)	0	1, 630, 160	36.00
	ELIMINATE SETTLEMENT	1 33)		-1, 630, 160	
	Subtotal (line 36 ± line 37)		Ö	1, 030, 100	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	U	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41. 00	Interim payments			0	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2	Ö	0	43. 00
	chapter 1, §115.2	2,		· ·	10.00
			'		

	Financial Systems LUTHERAN DOWNTO GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	OWN HOSPITAL Provider C	CN: 15-0047	<u> </u>	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS	Provider C		From 06/01/2021 To 05/31/2022	Date/Time Prep 10/28/2022 2:	pared:
		Title	XVIII	Hospi tal	PPS	02 piii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	c programs for	cost reporti	ng periods	7. 63	1.0
. 00	Unweighted FTE resident cap add-on for new programs per 42		1) (see instr	uctions)	0. 00	2. 0
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of Direct GME cap reduction amount under ACA §5503 in accordange		8413 79 (m)	(see	0. 00 0. 00	3. 0 3. 0
. 01	instructions for cost reporting periods straddling 7/1/2011)		·	0.00	3.0
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (programs due	to a Medicare	-6. 94	4.0
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see in:		cost reporti	ng periods	0. 00	4.0
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap sl	ots (soo inst	ructions for	cost roporting	0. 00	4.0
. 02	periods straddling 7/1/2011)	ots (see mst	ructions for	cost reporting	0.00	4.0
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 4.02 plus applicable subscripts	plus or minus	line 4 plus l	ines 4.01 and	0. 69	5. 0
. 00	Unweighted resident FTE count for allopathic and osteopathic	c programs for	the current	year from your	0. 85	6. 0
. 00	records (see instructions) Enter the lesser of line 5 or line 6			-	0.40	7.0
. 00	Eliter the resser of fille 5 of fille 6		Primary Care	0ther	0. 69 Total	7. 0
	lw : 11 LETE		1.00	2. 00	3. 00	0.0
. 00	Weighted FTE count for physicians in an allopathic and oster program for the current year.	opatni c	0.8	5 0.00	0. 85	8. 0
. 00	If line 6 is less than 5 enter the amount from line 8, othe		0.6	9 0.00	0. 69	9. 0
	multiply line 8 times the result of line 5 divided by the al 6.	mount on line				
0. 00	Weighted dental and podiatric resident FTE count for the cu			0.00		10.0
0. 01 1. 00	Unweighted dental and podiatric resident FTE count for the Total weighted FTE count	current year	0.6	0. 00 9 0. 00		10. C
2. 00	Total weighted resident FTE count for the prior cost report	ing year (see	0.6			12.0
3. 00	instructions) Total weighted resident FTE count for the penultimate cost	renorti na	0. 4	2 0.00		13. 0
	year (see instructions)					
4. 00 5. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	ed by 3).	0.6			14. 0 15. 0
5. 01	Unweighted adjustment for residents in initial years of new		0.0			15. C
6. 00 6. 01	Adjustment for residents displaced by program or hospital c Unweighted adjustment for residents displaced by program or		0. 0 0. 0			16. C
0. 01	closure	поѕрг тат	0.0	0.00		16.0
7.00	Adjusted rolling average FTE count		0.6			17. 0 18. 0
	Per resident amount Approved amount for resident costs		112, 988. 9 67, 79		67, 793	
					1 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME	FTE resident	cap slots rec	eived under 42	1. 00	20. 0
	Sec. 413.79(c)(4)					
1. 00 2. 00	Direct GME FTE unweighted resident count over cap (see inst Allowable additional direct GME FTE Resident Count (see ins				0. 16 0. 16	
3. 00	Enter the locality adjustment national average per resident		nstructions)		112, 364. 43	
4. 00 5. 00	Multiply line 22 time line 23 Total direct CME amount (sum of lines 19 and 24)				17, 978 85, 771	1
3. 00	Total direct GME amount (sum of lines 19 and 24)	Inpatient Part			Total	25. 0
		Α	Prior to 1/1	On or after 1/1		
		1.00	2.00	2. 01	3. 00	
6 00	COMPUTATION OF PROGRAM PATIENT LOAD	1 000	27	g 1 2F0		26.0
6. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	1, 088	37	8 1, 250		26. 0
7.00	Total Inpatient Days (see instructions)	7, 430				27. 0
8. 00	Ratio of inpatient days to total inpatient days Program direct GME amount	0. 146433 12, 560			31, 354	28. 0 29. 0
9. 01	Percent reduction for MA DGME	, 500	3. 2	2 3. 22		29. 0
30.00	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount		14	1 465	606 30, 748	
, i. UU	INCL FLOGIAII ULLECT GWE AIIIOUITE		I	1	30, 748	J 31. U

RECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT EDICAL EDUCATION COSTS	Provider CCN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet E-4 Date/Time Pre 10/28/2022 2:	pared:
	Title XVIII	Hospi tal	PPS	
PLEET MEDICAL EDWATION COOTS FOR FORD COMPOSITE DATE. THE	5 MALL ON V (MUDOLNO D		1. 00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	LE XVIII ONLY (NURSING P	ROGRAM AND PARAMED	ICAL	
EDUCATION COSTS) 2.00 Renal dialysis direct medical education costs (from Wkst. B,	Pt I sum of col 20 a	nd 23 lines 74	0	32.00
and 94)	1 t. 1, 3am 01 cor. 20 a	na 25, 1111c3 74	O	32.00
3.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I. col. 8. sum of lines	74 and 94)	0	33.00
1.00 Ratio of direct medical education costs to total charges (lir	,	0.000000	34.00	
5.00 Medicare outpatient ESRD charges (see instructions)		0	35.00	
6.00 Medicare outpatient ESRD direct medical education costs (line			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
Part A Reasonable Cost				
7.00 Reasonable cost (see instructions)			6, 119, 748	
0.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	1
Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
0.00 Primary payer payments (see instructions) .00 Total Part A reasonable cost (sum of lines 37 through 39 minu	us Line 40)		0 6, 119, 748	1
Part B Reasonable Cost	as Title 40)		0, 119, 740	41.0
2.00 Reasonable cost (see instructions)			2, 241, 839	42 0
3.00 Primary payer payments (see instructions)			784	1
1.00 Total Part B reasonable cost (line 42 minus line 43)			2, 241, 055	
5.00 Total reasonable cost (sum of lines 41 and 44)			8, 360, 803	
5.00 Ratio of Part A reasonable cost to total reasonable cost (lir	ne 41 ÷ line 45)		0. 731957	46.0
7.00 Ratio of Part B reasonable cost to total reasonable cost (lir	ne 44 ÷ line 45)		0. 268043	47.0
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	ART B			
3.00 Total program GME payment (line 31)			30, 748	1
Part A Medicare GME payment (line 46 x 48) (title XVIII only)			22, 506	
0.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only)		0.1	8, 242	50.0
_	Y/N Primary Ca 0 1.00		Total	
E-4 Calculation - In accordance with the FY 2023 IPPS Final R		2. 00	3. 00	_
19.00 Enter in column 0, "Y" or "N" to calculate line 9 in		. 00	0.00	109. 0
accordance the Federal Fiscal Year 2023 Final Rule for	N	. 00	0.00	107.0
cost reporting periods beginning prior to 10/1/2021. (see				
instructions)				
line 109 column 0 is Y, you MUST open up the PY and Penultimate of			"Y" and cal cul	ate,
en input amounts from line 11 columns 1 & 2 to the CY lines 12 & 1				
22.00 Override of line 22 for cost reporting periods beginning		. 00		122. 0

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: 15-0047 Pe

Peri od: Worksheet G From 06/01/2021 To 05/31/2022 Date/Time Prepared: 10/28/2022 2:52 pm

——————————————————————————————————————					10/28/2022 2:	52 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS	1	,	.		
1.00	Cash on hand in banks	-308, 341		_		
2.00	Temporary investments	0	0	_		1
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	8, 401, 082	0	_	0	
5. 00	Other receivable	8, 401, 082	0	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	-4, 130, 990	1	0	0	
7. 00	Inventory	2, 096, 534		0	0	
8. 00	Prepai d expenses	758, 707		0	Ō	
9.00	Other current assets	825, 476	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10)	7, 642, 468	0	0	0	11. 00
	FI XED ASSETS			_	_	
12.00	Land	1, 010, 000		_	1	
13. 00 14. 00	Land improvements	395, 750 -316, 600	1	_		
15. 00	Accumulated depreciation Buildings	87, 011, 356		_	l	1
16. 00	Accumul ated depreciation	-3, 232, 479	1	0	0	
17. 00	Leasehold improvements	282, 623	1	Ö	Ö	
18. 00	Accumul ated depreciation	-69, 622	1	0	0	
19. 00	Fi xed equipment	1, 098, 238	0	0	0	19. 00
20. 00	Accumulated depreciation	-104, 536	0	0	0	
21. 00	Automobiles and trucks	0	0	_	0	
22. 00	Accumulated depreciation	0	0	0	0	
23. 00	Maj or movable equipment	22, 198, 367		0	0	1
24. 00 25. 00	Accumulated depreciation	-4, 313, 349		0	0	
26. 00	Minor equipment depreciable Accumulated depreciation	3, 401, 404 -610, 884		_	0	
27. 00	HIT designated Assets	-010, 004	0	0	0	
28. 00	Accumul ated depreciation	0	o o	Ö	Ö	
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	l	
30.00	Total fixed assets (sum of lines 12-29)	106, 750, 268	0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	0	0	_	_	
32.00	Deposits on Leases	0	0	_	_	1
33.00	Due from owners/officers	14 504 541	0	_	0	
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	14, 504, 541 14, 504, 541		_	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	128, 897, 277	1	_		
00.00	CURRENT LIABILITIES	120,077,277				00.00
37.00	Accounts payable	2, 705, 876	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 402, 059	0	0	0	38. 00
39. 00	Payroll taxes payable	-1, 844		0	0	
40. 00	Notes and Loans payable (short term)	332, 995	0	0	0	1
41.00	Deferred income	0	0	0	0	
42.00	Accel erated payments	172 174 405)	0	0	42.00
43. 00 44. 00	Due to other funds Other current liabilities	172, 174, 495 4, 074, 676		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	180, 688, 257	1	_	l .	1
10.00	LONG TERM LIABILITIES	100,000,207				10.00
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	1, 233, 643	0	0	0	47. 00
48. 00	Unsecured Loans	0	0	0		
49. 00	Other long term liabilities	783, 142		_	1	
50. 00	Total long term liabilities (sum of lines 46 thru 49)	2, 016, 785			1	
51. 00	Total liabilities (sum of lines 45 and 50)	182, 705, 042	! 0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	-53, 807, 765				52.00
53. 00	Specific purpose fund	-55, 607, 765	'l o			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted		1	o o		55.00
56. 00	Governing body created - endowment fund balance		1	Ō		56. 00
57. 00	Plant fund balance - invested in plant		1		0	
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
-a -:	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	-53, 807, 765		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	128, 897, 277	0		0	60.00
	l~'/	I	1	I	I	I

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0047

0

19.00

Peri od: Worksheet G-1 From 06/01/2021

05/31/2022 Date/Time Prepared: 10/28/2022 2:52 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period -31, 603, 517 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -22, 204, 248 2.00 3.00 Total (sum of line 1 and line 2) -53, 807, 765 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 -53, 807, 765 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance -53, 807, 765 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Health Financial Systems L STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0047

			0 05/31/2022	Date/IIme Pre 10/28/2022 2:	
	Cost Center Description	Inpati ent	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	17, 009, 36	1	17, 009, 364	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	ĺ			3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	1		0	5.00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY			0	7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	17, 009, 36	1	17, 009, 364	10.00
	Intensive Care Type Inpatient Hospital Services	1.7,007,00	'	1770077001	
11. 00	INTENSIVE CARE UNIT	10, 121, 59		10, 121, 591	11. 00
12. 00	CORONARY CARE UNIT	10,121,07		10/ 121/071	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT	ı			14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	10, 121, 59		10, 121, 591	16. 00
10.00	11-15)	10, 121, 37	'	10, 121, 371	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	27, 130, 95		27, 130, 955	17. 00
18. 00	Ancillary services	53, 506, 778		145, 789, 359	18. 00
19. 00	Outpatient services	4, 956, 51		45, 981, 439	19. 00
20. 00	RURAL HEALTH CLINIC	4, 750, 51	1	45, 761, 437	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		1 1	0	21. 00
22. 00	HOME HEALTH AGENCY	'	1 4	U	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
					25. 00
25. 00 26. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE				26. 00
26.00	IP CONTRACTED HOSPICE	122, 53:		100 500	26.00
			1	122, 532	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	85, 716, 77	133, 307, 506	219, 024, 285	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		72, 866, 739		29. 00
30.00	ADD (SPECIFY)	1) 72, 800, 739		30.00
31. 00	ADD (SPECIFI)		1		31. 00
32. 00					32.00
		· · · · · · · · · · · · · · · · · · ·			
33.00					33.00
34. 00			-		34. 00
35. 00	T + 1 + 11111 (C + 11 + 20 + 25)	·			35.00
36.00	Total additions (sum of lines 30-35)		J 9		36.00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00			1 1		39. 00
40.00					40.00
41. 00	T + 1 + 1 + 1	'			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)(trans	ster	72, 866, 739		43.00
	to Wkst. G-3, line 4)	1	1 I		

	Financial Systems LUTHERAN DOWNTO			u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0047	Peri od:	Worksheet G-3	
			From 06/01/2021 To 05/31/2022	Date/Time Pre	narod:
			10 03/31/2022	10/28/2022 2:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		219, 024, 285	1. 00
2.00	Less contractual allowances and discounts on patients' accou	nts		173, 334, 998	2.00
3.00	Net patient revenues (line 1 minus line 2)			45, 689, 287	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		72, 866, 739	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-27, 177, 452	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communicatio	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12. 00
13. 00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00 21. 00
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER MISC GAIN/LOSS			4, 648, 134	
24. 50 25. 00	COVID-19 PHE Funding Total other income (sum of lines 6-24)			325, 070 4, 973, 204	
	,				
26.00	Total (line 5 plus line 25) OTHER EXPENSES (SPECIFY)			-22, 204, 248 0	26.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
	Net income (or loss) for the period (line 26 minus line 28)			-22, 204, 248	
27.00	The tricome (or 1033) for the period (trine 20 millius frie 20)		ı	22, 204, 240	27.00

CALCIII	Financial Systems LUTHERAN DOW			u of Form CMS-2	2552-10
CALCUI	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0047	Peri od: From 06/01/2021 To 05/31/2022	Worksheet L Parts I-III Date/Time Pre 10/28/2022 2:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			126, 704	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			134, 620	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cos Number of interns & residents (see instructions)	st reporting period (see inst	ructions)	20. 43 0. 76	3. 00 4. 00
4. 00 5. 00	Indirect medical education percentage (see instructions)			0. 76 1. 06	5. 00
6. 00	Indirect medical education percentage (see instructions)	the sum of lines 1 and 1 01	columns 1 and	1, 343	6. 00
0.00	1. 01) (see instructions)	, the sam of fines f and f. of	, corumns r and	1, 010	0. 00
7.00	Percentage of SSI recipient patient days to Medicare Part	t A patient days (Worksheet E	, part A line	0.00	7. 00
	30) (see instructions)				
8. 00	Percentage of Medicaid patient days to total days (see in	nstructions)		0. 00	8. 00
9.00	Sum of lines 7 and 8			0.00	9. 00
10. 00 11. 00	Allowable disproportionate share percentage (see instruct Disproportionate share adjustment (see instructions)	(ions)		0. 00 0	10. 00 11. 00
12. 00				262, 667	
12.00	Total prospective capital payments (see mistructions)			202, 007	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instruction			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0	3.00
4.00				0	4 00
5 00				0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)				
	Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	5. 00
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)	etances (see instructions)		1.00	1.00
1. 00 2. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	,		1.00	1. 00 2. 00
1. 00 2. 00 3. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	,		1.00	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	, , , , , , , , , , , , , , , , , , ,		1.00	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)			0 1.00 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	ee instructions)	cline 6)	0 1.00 0 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7)	ee instructions) nary circumstances (line 2 x	cline 6)	0 1.00 0 0 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a	ee instructions) nary circumstances (line 2 x	ŕ	0 1.00 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level	pe instructions) nary circumstances (line 2 x applicable) to capital payments (line 8	less line 9)	0 1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14)	pee instructions) nary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri	less line 9) or year	0 1.00 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	pee instructions) nary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri	less line 9) or year ne 11)	0 1.00 0 0 0.00 0 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, exception)	pee instructions) nary circumstances (line 2 x applicable) to capital payments (line 8 yer capital payment (from pri al payments (line 10 plus lirenter the amount on this line	less line 9) or year ne 11)	0 1.00 0 0 0.00 0.00 0 0.00 0	1. 00 2. 00 3. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (Sedjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level on	pee instructions) nary circumstances (line 2 x applicable) to capital payments (line 8 yer capital payment (from pri al payments (line 10 plus lirenter the amount on this line	less line 9) or year ne 11)	0 1.00 0 0 0.00 0 0.00 0 0 0	1. 00 2. 00 3. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a current year comparison of capital minimum payment level carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, excarryover of accumulated capital minimum payment level on (if line 12 is negative, enter the amount on this line)	pe instructions) nary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus line enter the amount on this line ver capital payment for the f	less line 9) or year ne 11)	0 1.00 0 0 0.00 0 0.00 0 0 0	1. 000 2. 000 3. 000 4. 000 5. 000 6. 000 7. 000 8. 000 10. 000 11. 000 12. 000 14. 000
3. 00 4. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a current year comparison of capital minimum payment level carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level on (if line 12 is negative, enter the amount on this line) current year allowable operating and capital payment (see	pee instructions) nary circumstances (line 2 x applicable) to capital payments (line 8 ever capital payment (from pri al payments (line 10 plus line enter the amount on this line ever capital payment for the f e instructions)	less line 9) or year ne 11)	0 1.00 0 0 0.00 0.00 0 0.00 0	4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00