This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1325 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/24/2024 6: 39 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 2/24/2024 6: 39 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(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 OSF SAINT LUKE MEDICAL CENTER (14-1325) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	40, 694	-304, 301	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-18, 710	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		96, 879		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	21, 984	-207, 422	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	Health Financial Systems OSF SAINT LUKE MEDICAL CENTER In Lieu of Form CMS-29 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1325 Period: From 10/01/2022 Part I									
						To 09/30/	2023	Date/Ti 2/24/20		
	1.00	2.00		3. 00			4. 00			
1. 00	Hospital and Hospital Health Care Co Street: 1051 WEST SOUTH STREET	PO Box: 747								1.00
2. 00	City: KEWANEE	State: IL	Zi p Cod			ty: HENRY	D		(D	2.00
		Component Name	CCN Number	CBSA Number	Provi der Type	Date Certified		nt Syst 0, or XVIII	N)	-
		1.00	2.00	3. 00	4.00	5. 00	6.00			
3. 00	Hospital and Hospital-Based Componer Hospital	nt Identification: OSF SAINT LUKE MEDICAL	141325	19340	1	07/01/1966	l N	0	0	3.00
3.00	nospi tai	CENTER CENTER	141323	19340	'	0770171900	I IN		0	3.00
4. 00 5. 00 6. 00 7. 00	Subprovi der - IPF Subprovi der - IRF Subprovi der - (Other) Swing Beds - SNF	OSF SAINT LUKE SWING	14Z325	19340		03/19/2003	N	0	N	4. 00 5. 00 6. 00 7. 00
8. 00	 Swing Beds - NF	OSF SAINT LUKE SWING	14Z325	19340		03/19/2003	N		l N	8.00
8.00	Swilly beus - NF	BED	142323	19340		03/ 19/ 2003	l IN		l IN	8.00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC	FAMILY HEALTH CLINIC	143445	19340		10/01/1998	N	0	N	9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
111.55	- Justice					From:		То		
20. 00	Cost Reporting Period (mm/dd/yyyy)					1.00		2. 0 09/30/		20.00
	Type of Control (see instructions)					1	022			21.00
					1. 00	2.00		3. () <u> </u>	-
	Inpatient PPS Information				1.00	2.00		0.0	,,,	
22. 00	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo	ustment, in accordance wi	ith 42 CF		N	N				22. 00
22. 01	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC	§412.106(c)(2)(Pickle ame or yes or "N" for no.	endment	for	N	N				22. 01
	this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on cost	n column 1, "Y" for yes on ng period occurring prion r "N" for no for the por	or "N" fo r to Octo	r no ber						
	instructions)	,								
22. 02	Is this a newly merged hospital that determined at cost report settlement	t? (see instructions) En	ter in co	lumn	N	N				22. 02
	1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in	•		no,						
22 03	for the portion of the cost reportir Did this hospital receive a geograph			0	N	N		N		22. 03
22.00	rural as a result of the OMB standar	rds for delineating stati	istical a	reas						22.00
	adopted by CMS in FY2015? Enter in conforthe portion of the cost reportion									
	in column 2, "Y" for yes or "N" for	no for the portion of the	ne cost							
	reporting period occurring on or aft Does this hospital contain at least	•	,							
	counted in accordance with 42 CFR 41									
22 04	yes or "N" for no. Did this hospital receive a geograph	nic reclassification from	m urhan t							22. 04
22.0.	rural as a result of the revised OME	delineations for statis	stical ar	eas						22.0.
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportir									
	in column 2, "Y" for yes or "N" for	no for the portion of the	ne cost							
	reporting period occurring on or aft Does this hospital contain at least	•								
	counted in accordance with 42 CFR 41									
23 00	yes or "N" for no. Which method is used to determine Me	edicaid davs on lines 24	and/or 2	5		0				23. 00
25.00	below? In column 1, enter 1 if date	of admission, 2 if censu	us days,	or 3						25.00
	if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost									
	reporting period? In column 2, enter									

	the direct own it aniwer gifted count.					
					1. 00	
	ACA Provisions Affecting the Health Resources and Se	ervices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting per	od for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instru					
62. 01	Enter the number of FTE residents that rotated from	a Teaching Health Cent	ter (THC) into	your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC pro	ogram. (see instruction	ns)			
	Teaching Hospitals that Claim Residents in Nonprovio	der Settings				
63.00	Has your facility trained residents in nonprovider s	settings during this co	ost reporting p	period? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, compl	ete lines 64 through 6	67. (see instr	uctions)		

	Financial Systems FAL AND HOSPITAL HEALTH CARE COMP			Provider CC	CN: 14-1325	Peri od: From 10/01/2022 To 09/30/2023		pared:
					Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Yea	ar FTE Residents in N	onprovi de	r Settings	1.00 This base ye	2.00 ar is your cost	3.00 reporting	
64. 00	period that begins on or after. Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column)	s yes, or your facili nber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained n-primary all nonpo d non-prio n column :	d residents care rovider mary care 3 the ratio	0.	0. 00	0. 000000	64.00
		Program Name	Progr	ram Code	Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
65 00	Enter in column 1 if line 42	1. 00	2	2. 00	3. 00	4.00	5.00	65.00
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 divided by (column 3 + column 4)). (see instructions)				O.			65.00
					Unwei ghted FTEs Nonprovi dei Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Vaar ETE Pasidants i	n Nonnroy	ider Settino	1.00	2.00	3.00	
	beginning on or after July 1, 20	010						
66.00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (col	occurring in all nonp unweighted non-prima tal. Enter in column	rovider so ry care ro 3 the rati	ettings. esident io of	0.	0. 00	0. 000000	66.00
		Program Name		ram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67 00	Enter in column 1, the program	1. 00	2	2. 00	3. 00	4. 00 00 0. 00	5. 00 0. 000000	67 00
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				J.		3. 365600	

97.00

0.00

0.00

applicable column.

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

umn 1 for title	Or WKSt. D,	N	N	98.06
unin i ioi titie	v, and in			
		Υ		105.00
II-inclusive met	hod of payment	Υ		106.00
		N		107.00
umn 1. (see ins	structions)			
do you train i&i	uni +(c)2			
	unit(S)?			
	edul e? See 42	N		108.00
Physi cal	Occupati onal	Speech	Respi ratory	
1.00	2. 00	3. 00	4. 00	
re N	N	N	N	109.00
			1.00	4
ital Domonstrati	on project (\$41	ΛΛ		110.00
			IN IN	110.00
Norksheet F-2	ines 200 throug	h 215 as		
MOTROTICOL E Z, T	11103 200 1111 049	11 210, 43		
		1 00	2.00	1
		1. 00	2.00	
n the Frontier (Communi ty	N 1.00	2.00	111.00
cost reporting	peri od? Enter		2.00	111.00
cost reporting column 1 is Y,	period? Enter enter the		2.00	111.00
cost reporting column 1 is Y, participating ir	period? Enter enter the column 2.		2.00	111.00
cost reporting column 1 is Y,	period? Enter enter the column 2.		2.00	111.00
cost reporting column 1 is Y, participating ir	period? Enter enter the column 2.		2.00	111.00
cost reporting column 1 is Y, participating ir	peri od? Enter enter the col umn 2. ; and/or "C"	N		111.00
cost reporting column 1 is Y, participating ir additional beds	peri od? Enter enter the col umn 2. s; and/or "C"		3.00	
cost reporting column 1 is Y, participating ir additional beds	peri od? Enter enter the col umn 2. ; and/or "C"	N		
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cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is	peri od? Enter enter the col umn 2. s; and/or "C"	N		
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cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is	peri od? Enter enter the col umn 2. s; and/or "C"	N		
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased	peri od? Enter enter the col umn 2. s; and/or "C"	N		
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no	peri od? Enter enter the col umn 2. s; and/or "C"	N	3.00	
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no B, or E only)	peri od? Enter enter the col umn 2. s; and/or "C"	N	3.00	112.00
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no , B, or E only) "93" percent	peri od? Enter enter the col umn 2. s; and/or "C"	N	3.00	112.00
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no , B, or E only) "93" percent e (includes	peri od? Enter enter the col umn 2. s; and/or "C"	N	3.00	112.00
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no , B, or E only) "93" percent	peri od? Enter enter the col umn 2. s; and/or "C"	N	3.00	112.00
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no , B, or E only) "93" percent e (includes ders) based on	peri od? Enter enter the col umn 2. s; and/or "C" 1.00 N	N	3.00	112.00
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no , B, or E only) "93" percent e (includes	peri od? Enter enter the col umn 2. s; and/or "C"	N	3.00	112.00
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no , B, or E only) "93" percent e (includes ders) based on Y" for yes or	peri od? Enter enter the col umn 2. s; and/or "C" 1.00 N	N	3.00	112. 00 115. 00
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cost reporting column 1 is Y, participating in additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no , B, or E only) "93" percent e (includes ders) based on Y" for yes or surance? Enter	peri od? Enter enter the col umn 2. s; and/or "C" 1.00 N	N	3.00	112. 00 115. 00
cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no , B, or E only) "93" percent e (includes ders) based on Y" for yes or	peri od? Enter enter the col umn 2. s; and/or "C" 1.00 N	N	3.00	112. 00 115. 00 116. 00 117. 00
	umn 1 for title I - inclusive met cost reimbursen umn 1. (see ins do you train I&F IPF and/or IRF ctions) ne CRNA fee sche Physical 1.00 re N	Physical Occupational 1.00 2.00	umn 1 for title V, and in Y II-inclusive method of payment Cost reimbursement for L&R umn 1. (see instructions) do you train L&Rs in an IPF and/or LRF unit(s)? ctions) ne CRNA fee schedule? See 42 Physical Occupational Speech 1.00 2.00 3.00	umn 1 for title V, and in II-inclusive method of payment Y cost reimbursement for I&R N umn 1. (see instructions) do you train I&Rs in an IPF and/or IRF unit(s)? ctions) ne CRNA fee schedule? See 42 N Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 ne N N N 1.00 tal Demonstration project (§410A N "Y" for yes or "N" for no. If yes,

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Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			DI CAL CENTER	NI. 14 100	- D			Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DAT	Α	Provi der CC	N: 14-132		riod: om 10/01/2 09/30/2	022 Par 023 Dat	ksheet S- t I e/Time Pr 24/2024 6:	epared
								1. 00	-
147.00Was there a change in the statist	cal basis? Enter "Y"	' for v	es or "N" for	no				N N	147. 0
148.00 Was there a change in the order of								N	148. 0
149.00 Was there a change to the simplif					for n	Ο.		N	149.0
	-		Part A	Part	В	Title V	Т	itle XIX	
			1. 00	2.00		3. 00		4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or				and Part		see 42 CFR		3)	
55. 00 Hospi tal			Y	Y		N		N	155.0
156.00 Subprovi der - IPF			N	N		N		N	156. 0
57.00 Subprovi der - I RF 58.00 SUBPROVI DER			N	N N		N		N	157. C
59. 00 SNF			N	l N	-	N		N	159. 0
160.00HOME HEALTH AGENCY			N	N N		N		N	160.0
61. 00 CMHC				N N		N		N	161.0
		<u> </u>						1. 00	
Mul ti campus									
165.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no.	ampus hospital that h	nas one	or more camp	uses in d				N	165. C
	Name		County	State	Zip C			E/Campus	4
66.00 If line 165 is yes, for each	0		1. 00	2. 00	3. 0	0 4.0	0	5. 00	00 166. 0
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)									
								1. 00	
Health Information Technology (HI						Act			
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	05 is "Y") and is a m	neani ng	ful user (lin	"N" for n e 167 is	o. "Y"), (enter the		Y	167. 0 168. 0
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user ? Enter "Y" for yes o	n, does	this provide for no. (see	instructi	ons)	·			168.0
69.00 f this provider is a meaningful transition factor. (see instruction		') and	is not a CAH	(line 105	is "N				00169. 0
						Begi nni n	g	Endi ng	4
70 00 5-1			C 11 ·			1. 00		2. 00	170 0
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and er	nding d	ate for the r	eporting					170. C
						1. 00		2. 00	
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3 umn 1. If column 1 is	3, Pt.	I, line 2, co	I. 6? Ent		N			0171.0

Proceedings Proceedings Procedure	Heal th	Financial Systems OSF SAINT LUKE I	MEDICAL CENTER		In Lie	u of Form CMS-	2552-10	
DART II NOSHITAL AND JOSPITAL HEATHCARE COMPLEX RETURNISHMENT OURSTLOWARD RECORD AND COMPLETED BY ALL HOSPITAL HEATHCARE COMPLEX RETURNISHMENT OURSTLOWARD RECORD AND COMPLETED BY ALL HOSPITALS PROVIDED BY ALL HOSPITALS PRO	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		From 10/01/2022	Date/Time Pro	epared:	
PART 11 - HOSPITAL AND HOSPITAL HEATHCASE COMPLEX RETURNISHENT OURSTIONANA BE				<u> </u>		Date		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the middly Myryy Yoring. DOWN ITED by ALL HOSPITA'S COMPLETED by ALL HOSPITA'S CO		PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX RELMBURS	EMENT OUESTLON	NΔIRF	1.00	2. 00		
Provider Organization and Operation Provider Changed ownership Immediately prior to the beginning of the cost N		General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format.			er all dates in	the		
reporting period? If yes, enter the date of the change in column 2. (see instructions) Part		Provider Organization and Operation						
2.00 Has the provider terminated participation in the Medicare Program? F 1.00 2.00 3.00	1. 00						1.00	
Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		reporting period: 11 yes, enter the date of the change in	corumir z. (see			V/I		
yes, enter in column 2 the date of termination and in column 3. "Y for voluntary or "I" for involuntary or "I" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) in "I" for see instructions. 5.00 Are the cost report total expenses and total revenues different from Nountary or "I" for involuntary or "I"					2. 00	3. 00	2.00	
contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see Instructions) Financial bota and Reports		yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.						
Financial Data and Reports	3. 00	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth		3.00				
Financial Data and Reports				Y/N	Type	Date		
Accountant? Column 1: Were the financial statements prepared by a Certified Public Y A A Caccuntant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions.) If no, see instructions in those on the filed financial statements? If yes, submit reconciliation. Approved Educational Activities		Cinconsint Data and Day		1.00	2. 00	3. 00		
those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper.		4.00 Column 1: Were the financial statements prepared by a Certified Public Y Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in						
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29.00 bid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 10.01 instructions. 11.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 11.01 No. 1.02 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 12.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 12.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. osee instructions. 13.00 If line 34 is yes, were the requirements or amended existing agreements with the provider-based physicians? Y if yes, see instructions. 13.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Y if yes, see instructions. 13.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Y if yes, see instructions. 13.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Y if yes, see instructions. 13.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider ly fiyes, enter in column 2 the fiscal year end of the home office. 13.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 13.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 14.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 15.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 16.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 17.00 Enter the employer/company name of the cost	28. 00		ntered into du	ring the cost	reporting	N	28. 00		
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.01 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.02 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N no. see instructions. 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Y 36.00 If line 36 is yes, were there new agreements or amended existing agreements with the provider-based Y 36.00 Were home office costs	29. 00	11	bond funds (D	ebt Service F	Reserve Fund)	N	29. 00		
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 11.00 N	30. 00		s, see	N	30.00				
Purchased Services Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N N N N N N N N N N	31. 00	1.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see							
Blave changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 No. see instructions. No. see instructions No.									
33.00 If line 32 is yes, we're the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N N N N N N N N N	32.00		rvi ces furni sh	ed through co	ontractual	Υ	32.00		
Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.0 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Y 35.00 Physicians during the cost reporting period? If yes, see instructions. N/N Date	33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If	N	33.00		
34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.0 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Y 35.0 physicians during the cost reporting period? If yes, see instructions. No									
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Y 35.0	34 00		arrangement wi	th provider-h	nased physicians?	Y	34.00		
physicians during the cost reporting period? If yes, see instructions. Y/N Date	01.00	i i	arrangement wi	tii provider k	asca priysi ci aris.	,	01.00		
Home Office Costs 86.00 Were home office costs claimed on the cost report? 97.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 98.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 99.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 99.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 100 2.00 Cost Report Preparer Contact Information 1.00 2.00 Cost Report Preparer Contact Information 1.00 2.00 Cost Report Preparer Contact Information 1.00 2.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. 90.00 Enter the telephone number and email address of the cost 314-231-5544 PATTY. RACHELL@FORVIS. COM 43.00	35. 00			nts with the	provi der-based	Y	35.00		
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Instructions. 41.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 314-231-5544 PATTY. RACHELL@FORVIS. COM 43.00									
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.01 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 41.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 314-231-5544 PATTY. RACHELL@FORVIS. COM 43.00		Home Office Costs			1. 00	2.00			
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 314-231-5544 PATTY. RACHELL@FORVIS. COM 43.00	36 00				V		36.00		
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report FORIVS PATTY. RACHELL@FORVIS. COM 43.00 Enter the telephone number and email address of the cost 1.00 PATRICIA PATTY. RACHELL@FORVIS. COM 43.00 PATTY. RACHELL@FORVIS. COM 43.00		If line 36 is yes, has a home office cost statement been p	repared by the	home office?			37.00		
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 314-231-5544 PATTY. RACHELL@FORVIS. COM 43.00	38. 00	If line 36 is yes , was the fiscal year end of the home of			n N		38.00		
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 314-231-5544 PATTY. RACHELL@FORVIS. COM 43.00	39. 00	If line 36 is yes, did the provider render services to other			s, N		39. 00		
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42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 314-231-5544 PATTY. RACHELL@FORVIS. COM 43.00	41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	PATRI CI A		41.00				
43.00 Enter the telephone number and email address of the cost 314-231-5544 PATTY. RACHELL@FORVIS. COM 43.00	42. 00	Enter the employer/company name of the cost report	FORI VS				42.00		
proport propard in corumna ranaz, respectivery.	43. 00		314-231-5544		PATTY. RACHELL@	FORVIS. COM	43.00		

Heal th	Financial Systems OSF SAINT	Γ LUKE !	MEDICAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA	I RE	Provider CCN:		Peri od:	Worksheet S-2	
					From 10/01/2022 To 09/30/2023		pared: 9 pm
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/positi	i on	MANAGING DIRECTO	2			41.00
	held by the cost report preparer in columns 1, 2, ar	nd 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the	cost					43.00
	report preparer in columns 1 and 2, respectively.						

33.00

33.01

0 34.00

Health Financial Systems OSF SAINT LUKE MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1325 Peri od: Worksheet S-3 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm I/P Days / 0/P Visits / Tri ps Bed Days CAH/REH Hours Component Worksheet A No. of Beds Title V Li ne No. Avai I abl e 1.00 2.00 3.00 4.00 5.00 PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 22 8, 030 20, 311. 20 1.00 0 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 HMO IRF Subprovider 3.00 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 22 8,030 20, 311. 20 7.00 0 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1,095 396.44 0 8.00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 25 9.125 20, 707, 64 0 14.00 15.00 CAH visits 15.00 15. 10 REH hours and visits 15.10

30.00

33.00

LTCH non-covered days

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

Heal th Financial SystemsOSF SAINTHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Peri od: Worksheet S-3
From 10/01/2022 Part I
To 09/30/2023 Date/Time Prepared: 2/24/2024 6: 39 pm Provider CCN: 14-1325

		1 (5.5	(0 (0) ())	,		9 pm	
		I/P Days	/ O/P Visits	/ Irips	Full Time I		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II tie will	II LIE AIA	Patients	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	388	9	833			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)	287	69				2.00
3.00	HMO IPF Subprovider	o	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	246	0	454			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	43			6.00
7.00	Total Adults and Peds. (exclude observation	634	9	1, 330			7.00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	12	0	16			8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		_				13.00
14.00	Total (see instructions)	646	9	1, 346	0. 00	126. 07	14.00
15.00	CAH visits	0	0	0			15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - I PF						16.00
17.00	SUBPROVIDER - IRF						17.00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY						18. 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	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC			Ĭ			25. 00
26. 00	RHC (CONSOLI DATED)	6, 083	11, 196	35, 311	0.00	54. 63	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0			l e	1
27. 00	Total (sum of lines 14-26)	_	_	_	0.00	180. 70	
28. 00	Observation Bed Days		72	425			28. 00
29. 00	Ambul ance Trips	o					29.00
30. 00	Employee discount days (see instruction)			О			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	o					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

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 MEDICAL CENTER

 HOSPITAL
 AND
 HOSPITAL HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 COMPLEX

Provider CCN: 14-1325

Peri od: Worksheet S-3 From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared: 2/24/2024 6:30 pm

						2/24/2024 6: 3	9 pm
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	The second secon	Workers				Pati ents	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	149	6	394	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)			99	47		2.00
3.00	HMO IPF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospi tal Adul ts & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8. 00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12. 00 13. 00
14. 00	Total (see instructions)	0.00	0	149	6	394	
15. 00	CAH visits	0.00	0	147	U	374	15.00
15. 10	REH hours and visits						15. 10
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						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)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RHC (CONSOLI DATED)	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33. 00 33. 01
	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care						34.00
34.00	Transporary Expansion Covid-19 PRE Acute Care	ı l		1 1	١		J 34. UU

10SPI	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 14-1325	Peri od: From 10/01/2022	Worksheet S-	-8
			Component	CCN: 14-3445	To 09/30/2023		
					RHC I	Cost	
	Clinic Address and Identification					. 00	
1. 00	Clinic Address and Identification Street				1051 WEST SOUT	TH STREET	1.0
	1011 001		С	ity	State	ZIP Code	1
				. 00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County		KEWANEE		IL	61443	2.0
						1. 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for	urban			0 3.00
					nt Award	Date	
	C C F. I I. F I.				1. 00	2. 00	
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		T			4.00
5. 00	Migrant Health Center (Section 329(d), PHS A						5.00
6. 00	Health Services for the Homeless (Section 34						6.00
7. 00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9. 00	OTHER (SPECI FY)						9.00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a h	•					0 10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o hours.)	r otner operati	ion(s) and the	e operating			
	illour 3.)					 	
		Sun	day	l N	londay	Luesday	
		Sun from	day to	from	londay to	Tuesday from	
11 00	Facility hours of operations (1)	from	to	from 3.00	to 4.00	from 5.00	11 00
11. 00	Facility hours of operations (1)	from	to	from	to	from	11.00
11. 00		from	to	from 3.00	to 4.00	from 5.00	11.00
12. 00	CLINIC Have you received an approval for an excepti	from 1.00 on to the produ	to 2.00	from 3.00	17: 00 1. 00 N	from 5.00 07:15	12.00
	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of in CMS Pub.	to 2.00	from 3.00 07:15 dard?	17: 00 1. 00 N	from 5.00 07:15	
12. 00	Have you received an approval for an exception is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	from 1.00 on to the product of in CMS Pub. umn 1. If yes,	to 2.00 uctivity stance 100-04, chapte enter in colu	from 3.00 07:15 dard? er 9, section umn 2 the	17: 00 1. 00 N	from 5.00 07:15	12.00
12. 00	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of in CMS Pub. umn 1. If yes,	to 2.00 uctivity stance 100-04, chapte enter in colu	from 3.00 07:15 dard? er 9, section umn 2 the	17: 00 1. 00 N	from 5.00 07:15	12.00
12. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report.	from 1.00 on to the product of in CMS Pub. umn 1. If yes,	to 2.00 uctivity stance 100-04, chapte enter in colu	from 3.00 07:15 dard? er 9, section umn 2 the ders and	17:00 1.00 N Y	from 5.00 07:15 2.00 CCN	12.00
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	from 1.00 on to the product of in CMS Pub. umn 1. If yes,	to 2.00 uctivity stance 100-04, chapte enter in colu	from 3.00 07:15 lard? er 9, section mn 2 the ders and Prov	17: 00 1. 00 N Y	from 5.00 07:15 2.00 CCN 2.00	12.00
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report.	from 1.00 on to the product of in CMS Pub. umn 1. If yes,	to 2.00 uctivity stance 100-04, chapte enter in colu	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN	17: 00 1. 00 N Y i der name 1. 00 II C	From 5. 00 07: 15 2. 00 CCN 2. 00 143445	12.00 3 13.00
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	from 1.00 on to the product of in CMS Pub. umn 1. If yes,	to 2.00 uctivity stance 100-04, chapte enter in colu	from 3.00 07:15 dard? er 9, section umn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD	from 5.00 07:15 2.00 CCN 2.00	12.00
12. 00 13. 00 14. 00 14. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	from 1.00 on to the product of in CMS Pub. umn 1. If yes,	to 2.00 uctivity stance 100-04, chapte enter in colu	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD	From 5. 00 07: 15 2. 00 CCN 2. 00 143445 148594	12.00 3 13.00 14.00 14.00 14.02
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN	on to the production of the pr	to 2.00 uctivity stand 100-04, chapte enter in colus s of all provi	dard? er 9, section imn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595	14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. RHC/FQHC name, CCN Have you provided all or substantially all	on to the production of the pr	to 2.00 uctivity stance 100-04, chapte enter in colus of all provi	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL XVIII	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595 Total Visits	14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an excepting this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. In the second secon	on to the production of the pr	to 2.00 uctivity stance 100-04, chapte enter in colus of all provi	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL XVIII	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595 Total Visits	14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. RHC/FQHC name, CCN Have you provided all or substantially all	on to the production of the pr	to 2.00 uctivity stance 100-04, chapte enter in colus of all provi	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL XVIII	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595 Total Visits	12.00 3 13.00 14.00 14.00 14.02
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the production of the pr	to 2.00 uctivity stance 100-04, chapte enter in colus of all provi	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL XVIII	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595 Total Visits	14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	on to the production of the pr	to 2.00 uctivity stance 100-04, chapte enter in colus of all provi	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL XVIII	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595 Total Visits	14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	on to the production of the pr	to 2.00 uctivity stance 100-04, chapte enter in colus of all provi	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL XVIII	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595 Total Visits	14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	on to the production of the pr	to 2.00 uctivity stance 100-04, chapte enter in colus s of all provi	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL XVIII	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595 Total Visits	14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	from 1.00 on to the product of in CMS Pub. The common of the product of the prod	to 2.00 uctivity stance 100-04, chapte enter in colus s of all provi V 2.00	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL XVIII 3.00	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX	From 5.00 07:15 2.00 CCN 2.00 143445 148594 148595 Total Visits	14. 00 14. 00 14. 00 15. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	from 1.00 on to the product of in CMS Pub. umn 1. If yes, List the names Y/N 1.00	to 2.00 uctivity stance 100-04, chapte enter in colus s of all provi V 2.00 Co 4 HENRY	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL 3.00	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX 4.00	CCN 2.00 CCN 2.00 143445 148594 148595 Total Visits 5.00	14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	from 1.00 on to the product of in CMS Pub. umn 1. If yes, List the names Y/N 1.00	to 2.00 uctivity stance 100-04, chapte enter in colus s of all provi V 2.00 Coo 4 HENRY Wedr	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL 3.00 unty 00	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX 4.00	CCN 2.00 CCN 2.00 143445 148594 148595 Total Visits 5.00	14. 00 14. 00 14. 00 15. 00
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	from 1.00 on to the product of in CMS Pub. umn 1. If yes, List the names Y/N 1.00	to 2.00 uctivity stance 100-04, chapte enter in colus s of all provi V 2.00 Co 4 HENRY	from 3.00 07:15 dard? er 9, section mn 2 the ders and Prov KEWANEE CLIN OSF MEDICAL OSF MEDICAL 3.00	to 4.00 17:00 1.00 N Y ider name 1.00 II C GROUP SHEFFIELD GROUP GALVA XIX 4.00	CCN 2.00 CCN 2.00 143445 148594 148595 Total Visits 5.00	14. 00 14. 00 14. 00 15. 00

Health Financial Systems 0	SF SAINT LUKE N	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1325	Peri od:	Worksheet S-8	
		Component	CCN, 14 244E	From 10/01/2022		norod.
		Component	CCN: 14-3445	To 09/30/2023	Date/Time Prep 2/24/2024 6:39	
				RHC I	Cost	
	Fri	day	Sa	turday		
	Fri from	day to	Sa from	turday to		
Facility hours of operations (1)	from	to	from	to		
	from 11.00	to	from	to		11.00

		INT LUKE MEDICAL CENTER			u of Form CMS-2	
HOSPII	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der C	F	Period: From 10/01/2022 To 09/30/2023		epared:
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1. 00	
	Uncompensated and Indigent Care Cost-to-Charge Ra	ti o				f
1.00	Cost to charge ratio (see instructions)				0. 345270	1.00
	Medicaid (see instructions for each line)]
2.00	Net revenue from Medicaid				4, 842, 187	
3.00	Did you receive DSH or supplemental payments from				Υ	3.00
4.00	If line 3 is yes, does line 2 include all DSH and			i d?	Υ	4.00
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplement Medicaid charges	ai payments from Medica	ıa		0 24, 039, 285	1 0.00
7. 00	Medicaid cost (line 1 times line 6)				8, 300, 044	
8. 00	Difference between net revenue and costs for Medi	caid program (see instr	uctions)		3, 457, 857	1
	Children's Health Insurance Program (CHIP) (see i				57 1517 551	1
9.00	Net revenue from stand-alone CHIP		•		0	1
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)				0	1
12.00	Difference between net revenue and costs for star Other state or local government indigent care pro				0	12.00
13 00	Net revenue from state or local indigent care pro)	0	13.00
14. 00	Charges for patients covered under state or local				0	
	10)	, 3, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,			-	
	State or local indigent care program cost (line 1				0	
16. 00	Difference between net revenue and costs for state				0	16. 00
	Grants, donations and total unreimbursed cost for	Medicaid, CHIP and sta	te/local indig	ent care progra	ıms (see	
17 00	instructions for each line) Private grants, donations, or endowment income re	estricted to funding char	rity care		0	17. 00
18.00					0	
19. 00				(sum of lines	3, 457, 857	19. 00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
20.00	Uncompensated care cost (see instructions for each Charity care charges and uninsured discounts (see		1, 366, 433	376, 319	1, 742, 752	20.00
	Cost of patients approved for charity care and ur		471, 788	1		
	1000 C Dationto approved for chartly cale and al	initiation di accounts (acc	7,1,700	3,0,317	040, 107	1 21.00
						1
20. 00 21. 00 22. 00	instructions) Payments received from patients for amounts previous charity care	ously written off as	C	0	0	22. 00

Health Financial Systems In Lieu of Form CMS-2552-10 RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 14-1325 Peri od: Worksheet A From 10/01/2022 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm Cost Center Description Sal ari es 0ther 1 Reclassi fi cat Recl assi fi ed Total (col. + col. 2) ions (See Trial Balance (col. 3 +-col. 4) A-6)2.00 4. 00 5.00 1.00 3.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 636, 848 636, 848 40,083 676, 931 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 596, 218 596, 218 2 00 596, 218 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 194, 412 1, 526, 049 1, 720, 461 2, 330, 348 4, 050, 809 4.00 00500 ADMINISTRATIVE & GENERAL 954, 292 8,051,400 9,005,692 5.00 415, 650 9, 421, 342 5.00 7.00 00700 OPERATION OF PLANT 285, 664 1, 715, 722 2,001,386 -463,003 1, 538, 383 7.00 00800 LAUNDRY & LINEN SERVICE 89.035 8.00 10,620 78, 415 7.872 96, 907 8 00 9.00 00900 HOUSEKEEPI NG 425, 329 202, 453 627, 782 -103, 504 524, 278 9.00 10.00 01000 DI ETARY 298, 721 279, 298 578, 019 -419, 005 159, 014 10 00 01100 CAFETERI A 333, 950 333, 950 11.00 11.00 0 01300 NURSING ADMINISTRATION 48, 199 244, 880 -41, 951 202, 929 13.00 196, 681 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 129, 649 111,019 240,668 -48, 291 192, 377 14.00 15.00 01500 PHARMACY 238, 155 1, 139, 574 1, 377, 729 -29, 302 1, 348, 427 15.00 01600 MEDICAL RECORDS & LIBRARY 56, 550 16.00 16,00 0 56, 550 0 01700 SOCIAL SERVICE 17.00 0 348, 592 348, 592 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 415, 966 1, 074, 010 2, 489, 976 -378, 308 2, 111, 668 30.00 03100 INTENSIVE CARE UNIT 33, 658 31.00 \cap 33, 658 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 535, 957 402, 044 938, 001 -133, 286 804, 715 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 05300 ANESTHESI OLOGY 53.00 62,760 -34, 455 28.305 -5.823 22, 482 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 465, 406 132, 212 597, 618 336, 677 934, 295 54.00 03440 MAMMOGRAPHY 54.01 104, 177 32, 666 136, 843 -21, 441 115, 402 54.01 56 00 05600 RADI OI SOTOPE 204.831 204, 831 205, 672 56 00 841 56.01 03630 ULTRA SOUND 223, 567 60, 352 283, 919 -49,313234, 606 56.01 57.00 05700 CT SCAN 208, 813 130, 170 338, 983 -55, 108 283, 875 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 218.726 -34, 731 183, 995 58.00 155, 526 63, 200 05900 CARDIAC CATHETERIZATION 59.00 Ω 59.00 60.00 06000 LABORATORY 899, 250 1, 196, 252 2,095,502 -168, 588 1, 926, 914 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 0 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 69, 298 69, 298 3 477 72 775 62 00 0 06500 RESPIRATORY THERAPY 65.00 275, 113 130, 158 405, 271 -67, 793 337, 478 65.00 06600 PHYSI CAL THERAPY 701, 130 224, 763 925, 893 -174, 343 751, 550 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 127, 759 34, 392 162, 151 -24, 221 137, 930 67.00 06800 SPEECH PATHOLOGY 45, 320 -8, 395 68 00 58, 785 50, 390 68 00 13, 465 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 -57, 235 259, 884 03160 CARDI OPULMONARY 247, 097 70, 022 69.01 317, 119 69.01 69.02 03650 VASCULAR LAB C 0 0 0 69.02 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 31, 828 31,828 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 422, 687 422, 687 0 422, 687 73.00 03480 ONCOLOGY 0 73.01 73.01 0 0 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 5, 131, 939 88.00 3, 007, 709 8, 139, 648 -1, 208, 947 6, 930, 701 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 Λ 89.00 09100 EMERGENCY 1, 790, 522 2, 052, 031 3, 842, 553 -341, 960 3,500,593 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 0 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 38, 794, 827 38<u>, 899, 805</u> 118. 00 118.00 15, 123, 825 23, 671, 002 104, 978 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 70, 762 47, 924 118, 686 -30, 873 87, 813 190. 00 70, 830 190. 01 190. 01 19001 FOUNDATI ON 0 144, 470 144, 470 -73, 640 190. 02 19002 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 190.02 Γ 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 6, 132 6. 132 6, 132 192.00 1, 100 194. 00 07950 INDUSTRIAL MEDICINE 817 635 194.00 283 -465 194. 01 07951 RESEARCH 01194 01 0 200.00 TOTAL (SUM OF LINES 118 through 199) 15, 195, 404 23, 869, 811 39, 065, 215 0 39, 065, 215 200. 00

Health FinancialSystemsOSFSAINT LURRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 14-1325

Peri od: Worksheet A From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm

				10 09/30/2023	2/24/2024 6: 39 pm
Cost	Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	RVI CE COST CENTERS			I	
1 1	REL COSTS-BLDG & FIXT	721, 388	1, 398, 319	•	1.00
	REL COSTS-MVBLE EQUIP	339, 881	936, 099		2.00
	OYEE BENEFITS DEPARTMENT	-37, 418	4, 013, 391		4.00
1 1	NI STRATI VE & GENERAL	-766, 559	8, 654, 783	•	5.00
	ATION OF PLANT	-14, 528	1, 523, 855	•	7.00
1 1	DRY & LINEN SERVICE	0	96, 907	•	8.00
9. 00 00900 HOUSI		0	524, 278	•	9.00
10. 00 01000 DI ETA		127.01/	159, 014	1	10.00
11. 00 01100 CAFE		-127, 816	206, 134	•	11.00
	ING ADMINISTRATION	372, 921	575, 850	•	13. 00 14. 00
1 1	RAL SERVICES & SUPPLY	0 -142	192, 377	•	15.00
1 1	CAL RECORDS & LIBRARY	-142 -60	1, 348, 285 56, 490	•	16.00
		-90, 879		•	17. 00
	ROUTINE SERVICE COST CENTERS	-90, 679	257, 713		17.00
	TS & PEDIATRICS	-514, 028	1, 597, 640		30.00
	NSIVE CARE UNIT	-514, U26 0	33, 658	1	31.00
	SERVICE COST CENTERS	U	33, 036		31.00
50. 00 05000 OPER		-70, 716	733, 999		50.00
	VERY ROOM & LABOR ROOM	-70, 710	733, 777	•	52.00
53. 00 05300 ANES		-18, 066	4, 416	1	53.00
1 1	OLOGY-DI AGNOSTI C	-20, 831	913, 464	•	54.00
54. 01 03440 MAMM		1, 166	116, 568	1	54.01
56. 00 05600 RADI		0	205, 672		56.00
56. 01 03630 ULTRA		Ö	234, 606	•	56. 01
57. 00 05700 CT S		Ö	283, 875	•	57. 00
	ETIC RESONANCE IMAGING (MRI)	0	183, 995	•	58.00
1 1	I AC CATHETERI ZATI ON	0	0	1	59.00
60. 00 06000 LABO		-58, 836	1, 868, 078	1	60.00
1 1	D LABORATORY	0	0		60. 01
1 1	E BLOOD & PACKED RED BLOOD CELLS	0	72, 775		62.00
	I RATORY THERAPY	-189	337, 289	•	65.00
	I CAL THERAPY	-86, 519	665, 031		66.00
1 1	PATI ONAL THERAPY	259	138, 189		67.00
	CH PATHOLOGY	94	50, 484	•	68. 00
	TROCARDI OLOGY	0	0	1	69.00
	I OPULMONARY	0	259, 884		69. 01
69. 02 03650 VASCI	ULAR LAB	0	0		69. 02
71. 00 07100 MEDI	CAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72. 00 07200 I MPL	. DEV. CHARGED TO PATIENTS	0	31, 828		72.00
73. 00 07300 DRUG	S CHARGED TO PATIENTS	-421, 074	1, 613		73.00
73. 01 03480 ONCO	LOGY	0	0		73. 01
77. 00 07700 ALLO	GENEIC HSCT ACQUISITION	0	0		77. 00
78. 00 07800 CAR	T-CELL IMMUNOTHERAPY	0	0		78. 00
OUTPATI ENT	SERVICE COST CENTERS				
88. 00 08800 RURA	L HEALTH CLINIC	-382, 402	6, 548, 299		88.00
89. 00 08900 FEDEI	RALLY QUALIFIED HEALTH CENTER	0	0		89. 00
91.00 09100 EMER	GENCY	-740, 283	2, 760, 310		91.00
92. 00 09200 OBSE	RVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIM	BURSABLE COST CENTERS				
	ID TREATMENT PROGRAM	0	0		102. 00
	RPOSE COST CENTERS				
113. 00 11300 I NTEI		0	0	1	113. 00
	OTALS (SUM OF LINES 1 through 117)	-1, 914, 637	36, 985, 168		118. 00
	SABLE COST CENTERS				
	, FLOWER, COFFEE SHOP & CANTEEN	0	87, 813	•	190. 00
190. 01 19001 FOUN		0	70, 830	•	190. 01
	BLE MEDICAL EQUIP-RENTED	0	0	1	190. 02
	ICIANS' PRIVATE OFFICES	0	6, 132	•	192. 00
194. 00 07950 I NDU:		0	635	•	194. 00
194. 01 07951 RESE		0	0	1	194. 01
200. 00 TOTA	L (SUM OF LINES 118 through 199)	-1, 914, 637	37, 150, 578	1	200. 00

OSF SALNT LUKE MEDICAL CENTER
Provi der CCN: 14-1325 Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared:

					1/2024 6: 39 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2.00	3. 00	4. 00	5. 00	
1 00	A - LAUNDRY EXPENSES	0.00	٥	0.042	1.00
1. 00	LAUNDRY & LINEN SERVICE		0	<u>9, 042</u> 9, 042	1.00
	B - CLINICAL ENGINEERING		<u> </u>	9, 042	
1.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	451, 264	1.00
2. 00	LABORATORY	60. 00	o	86, 927	2.00
				538, 191	
	C - CAFETERIA				
1.00	CAFETERI A	1100	204, 312	12 <u>9, 6</u> 38	1.00
	0		204, 312	129, 638	
1 00	D - BLOOD COSTS WHOLE BLOOD & PACKED RED	42.00	1 010	1 (/7	1 00
1. 00	BLOOD CELLS	62. 00	1, 810	1, 667	1.00
	0	+	1, 810	1, 667	
	E - RHC REGIONAL ADMIN EXPENSE		1,010	1,00,	
1.00	RURAL HEALTH CLINIC	88. 00	0	17, 209	1.00
	TOTALS		0	17, 209	
	F - RADIOLOGY SERVICES				
1. 00	MAMMOGRAPHY	54. 01	0	841	1.00
2.00	RADI OI SOTOPE	56.00	0	841	2.00
3. 00 4. 00	ULTRA SOUND CT SCAN	56. 01 57. 00	0	841 841	3. 00 4. 00
5. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	841	5.00
3.00	(MRI)	30.00	٥	041	3.00
	0	+		4, 205	
	H - MINISTRY ALLOCATIONS			· ·	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	187, 973	1.00
2.00	OPERATION OF PLANT	7. 00	0	104, 233	2.00
3. 00	PHARMACY	15. 00	0	45, 157	3. 00
4.00	SOCIAL SERVICE	17. 00	0	348, 592	4.00
5. 00 6. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0	22, 787 3, 991	5. 00 6. 00
7. 00	SPEECH PATHOLOGY	68. 00	0	3, 991 1, 447	7.00
7.00	0			714, 180	7.00
	I - OTHER THERAPUTIC SERVICES		<u> </u>	7 1 17 100	
1.00	OPERATI NG ROOM	50.00	10, 777	0	1.00
	0		10, 777		
	J - SURGEON RHC				
1. 00	OPERATI NG ROOM	<u>50.</u> 00	7 <u>0, 1</u> 03	<u>3, 4</u> 58	1.00
	0		70, 103	3, 458	
1 00	K - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72. 00	0	21 020	1 00
1. 00	PATIENTS	72.00	۷	31, 828	1.00
	0	+		31, 828	
	L - ICU COSTS		<u></u>	0.17.02.0	
1.00	INTENSIVE CARE UNIT	31. 00	32, 014	1, 644	1.00
	0		32, 014	1, 644	
	Q - RHC SHARED BENEFITS				
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	•	1,052,007	1.00
	O R - REPAIRS AND MAINTENANCE		0	1, 052, 007	
1. 00	OPERATION OF PLANT	7. 00	ol	32, 686	1.00
2. 00	OF EIGHT ON OF FEMALE	0. 00	o	32, 666	2.00
3. 00		0. 00	Ö	Ö	3.00
4.00		0. 00	o	0	4.00
5.00		0. 00	О	0	5. 00
6.00		0. 00	0	0	6. 00
7. 00		0.00	•	0	7. 00
	0		0	32, 686	
1 00	S - INSURANCE	1 00	ما	40,000	1 00
1.00	CAP REL COSTS-BLDG & FIXT ADMINISTRATIVE & GENERAL	1. 00 5. 00	0	40, 083	1.00
2. 00	0 GENERAL			<u>1, 325, 3</u> 76 1, 365, 459	2.00
	T - BENEFITS RECLASS		<u> </u>	1, 000, 407	
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 728, 891	1.00
2. 00		0. 00	O	0	2.00
3.00		0. 00	О	0	3.00
4. 00		0.00	0	0	4.00
5.00		0. 00	0	0	5.00
6.00		0.00	0	0	6.00
7. 00 8. 00		0.00	0	0	7. 00 8. 00
8. 00 9. 00		0. 00 0. 00	0	0	9.00
10. 00		0.00	0	0	10.00
	1	3. 33	ગ	٠,	

OSF SALNT LUKE MEDICAL CENTER
Provi der CCN: 14-1325 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/24/2024 6: 39 pm

Care Centre 11 10 10 10 10 10 10 1						2/24/2024 6: 39 pm	<u>m</u>
1.00			Increases				
11.00		Cost Center	Li ne #	Sal ary	Other		
12.00		2. 00	3.00	4. 00	5. 00		
13.00 13.00	11.00		0. 00	0	0	11.	. 00
13.00 13.00	12.00		0.00	o	0	12.	2. 00
14. 00				0			
15.00							
10.00				-			
17.00							
10.00				-			
19,00				9			
2.0.00 0.00 0.00 0.00 0.22.00 22.00				0			
21.00	19. 00		0. 00	0	0	19.	0. 00
22.00	20.00		0.00	0	0	20.	0. 00
23.00	21.00		0.00	0	0	21.	. 00
23.00	22.00		0.00	o	0	22.	2. 00
24.00				ol			
25.00				0	0		
26. 00				n			
1.00 ADMINISTRATIVE & CENERAL 5.00 5.737 0 1.00				0			
U - VACATIONS, PTD. BENARDS 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0	20.00		— — 0.00	— — - 4			. 00
1.00		U VACATIONS DECORDENADOS		Ŋ	2, 720, 091		
2.00 OPERATION OF PLANT 7.00 1.496 0 3.00 3.00 4.00 10USEKEEPING 9.00 2.276 0 4.00 5.50 0 0	4 00			I			
3.00 AUNDRY & LINEN SERVICE 8.00 56 0 4.00 4.00 HOUSEKEPING 9.00 2,278 0 4.00 5.00 DIETARY 10.00 1,566 0 5.00 6.00 NURSING ADMINISTRATION 13.00 1,031 0 6.00 NURSING ADMINISTRATION 13.00 1,031 0 6.00 ORGANIZA SERVICES & SUPPLY 14.00 680 0 7.00 CENTRAL SERVICES & SUPPLY 14.00 680 0 7.00 CENTRAL SERVICES & SUPPLY 14.00 680 0 7.00 ORGANIZA SERVICES & SUPPLY 14.00 680 0 7.00 ORGANIZA SERVICES & SUPPLY 14.00 680 0 7.00 ORGANIZA SERVICES & SUPPLY 14.00 1.00 7.00 ORGANIZA SERVICES & SUPPLY 14.00 1.00		II					
4.00 MUSEKEEPING 9.00 2.278 0 4.00 5.00 6.00 5.00 6.00 5.00 6.00 1.566 0 5.00 6.00 7.00 7.0							
5.00 DIETARY		1					3. 00
0.00 NURSING ADMINISTRATION 13.00 1.031 0.00 7.00 0	4.00	HOUSEKEEPI NG	9. 00	2, 278	0	4.	. 00
7.00 CENTRAL SERVICES & SUPPLY	5.00	DI ETARY	10. 00	1, 566	0	5.	. 00
7.00 CENTRAL SERVICES & SUPPLY	6. 00	NURSING ADMINISTRATION	13. 00	1, 031	0	6.	. 00
B. 00 HARRMACY		CENTRAL SERVICES & SUPPLY			0		
9,00 ADULTS & PEDIATRICS 30,00 7,424 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 10.00 0 10.00 0 10.00 0 10.00							
10.00 OPERATING ROOM							
11. 00 ANESTHESIOLOGY							
12.00 RADI OLOGY-DI AGNOSTI C 54.00 2,440 0 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 16.00 MAGNETI C RESONANCE I MAGI NG (NR) 16.00 MAGNETI C RESONANCE I MAGI NG (NR) 16.00 MAGNETI C RESONANCE I MAGI NG (NR) 17.00 18.00 18.00 RESPIRATORY 14.00 17.00 18.00 19.00							
13. 00 MAMMOGRAPHY							
14. 00 ULTRA SOUND 56. 01 1,172 0 15. 00 15. 00 15. 00 16							
15.00				1			
16. 00 MGNETIC RESONANCE I IMAGI NG 16. 00 17. 00 17. 00 17. 00 18. 00 19. 00							
(URI) 17.00 LABORATORY 60.00 4.715 0 18.00 18.00 18.00 RESPIRATORY THERAPY 65.00 1.442 0 18.00 19.00	15. 00	II.					6. 00
17. 00 LABORATORY 60. 00 4, 715 0 17. 00 18. 00 RESPIRATORY THERAPY 65. 00 1, 442 0 19. 00 19. 00 PHYSI CAL THERAPY 66. 00 3, 676 0 20. 00 20. 00 COULPATI ONAL THERAPY 67. 00 670 0 20. 00 21. 00 SPEECH PATHOLOGY 68. 00 238 0 21. 00 22. 00 CARDI OPULINONARY 69. 01 1, 296 0 22. 00 24. 00 CARDI OPULINONARY 69. 01 1, 296 0 22. 00 24. 00 EMERGENCY 91. 00 9, 388 0 24. 00 25. 00 IFF, FLOWER, COFFEE SHOP & 190. 00 371 0 25. 00 26. 00 INJUSTRI AL MEDICI NE 194. 00 4 0 0 27. 00 CARTIEN 0 0 0 0 0 29. 00 0 0 0 0 0 0 20. 00 0 0 0 0 0 0 0 20. 00 0 0 0 0 0 0 0 20. 00 0 0 0 0 0 0 0 20. 00 0 0 0 0 0 0 0 0 20. 00 0 0 0 0 0 0 0 0 20. 00 0 0 0 0 0 0 0 0 20. 00 0 0 0 0 0 0 0 0	16. 00	MAGNETIC RESONANCE I MAGING	58. 00	815	0	16.	. 00
18. 00 RESPI RATORY THERAPY 65. 00 1, 442 0 0 19. 00 0 0 0 0 0 0 0 0 0		(MRI)					
19, 00 PHYSI CAL THERAPY 66, 00 3, 676 0 20, 00 0 0 20 20 1 1 1 1 1 1 1 1 1	17.00	LABORATORY	60.00	4, 715	0	17.	. 00
9, 00 PHYSI CAL THERAPY	18.00	RESPIRATORY THERAPY	65. 00	1, 442	0	18.	3. 00
20.00 CCUPATI ONAL THERAPY 67.00 670 0 21.00	19.00	PHYSI CAL THERAPY	66, 00				. 00
21. 00 CARDI OPULMONARY 69. 01 1. 296 0 22. 00		1					
22.00 CARDI OPULMONARY				· ·			
23. 00 RURAL HEALTH CLINIC 88. 00 26, 907 0 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 24. 00 24. 00 25. 00 2		1					
24. 00		II					
25.00 GIFT, FLOWER, COFFEE SHOP & 190.00 371 0 26.00		1					
CANTEEN NDUSTRI AL MEDICINE 194.00 4 0 0 79,433 0 0 0 0 0 79,433 0 0 0 0 0 0 0 0 0		1					
ADUSTRI AL MEDICI NE 194.00 4 0 0 79,433 0 0 0 0 0 0 0 0 0	25.00		190.00	3/1	0	25.	. 00
O							
V - RETENTI ON BONUS 10	26. 00	I NDUSTRI AL MEDI CI NE	1 <u>94.</u> 00	4	0	26.	. 00
1. 00 ADMI NI STRATI VE & GENERAL 5.00 10,014 0 2. 00 OPERATI ON OF PLANT 7.00 2,999 0 3. 00 LAUNDRY & LI NEN SERVI CE 8.00 111 0 4. 00 HOUSEKEEPI NG 9.00 4,455 0 5. 00 DI ETARY 10.00 3,136 0 6. 00 NURSI NG ADMI NI STRATI ON 13.00 2,065 0 7. 00 CENTRAL SERVI CES & SUPPLY 14,00 1,361 0 8. 00 PHARMACY 15.00 2,500 0 9. 00 ADULTS & PEDI ATRI CS 30.00 33,508 0 10. 00 OPERATI NG ROOM 50.00 12,797 0 11. 00 ANESTHESI OLOGY 53.00 659 0 12. 00 RADI OLOGY-DI AGNOSTI C 54.00 4,885 0 13. 00 MAMMOGRAPHY 54.01 1,094 0 14. 00 ULTRA SOUND 57.00 2,192 0 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58.00 1,633 0 17. 00		0		79, 433	0		
2.00 OPERATION OF PLANT 7.00 2,999 0 3.00 3.00 LAUNDRY & LINEN SERVICE 8.00 111 0 3.00 4.40 4.00 4.00 4.00 4.05 6.00 5.00 DIETARY 10.00 3,136 0 5.00 6		V - RETENTION BONUS					
2.00 OPERATION OF PLANT 7.00 2,999 0 3.00 3.00 LAUNDRY & LINEN SERVICE 8.00 111 0 3.00 4.40 4.00 4.00 4.00 4.05 6.00 5.00 DIETARY 10.00 3,136 0 5.00 6	1.00	ADMINISTRATIVE & GENERAL	5. 00	10, 014	0	1.	. 00
3. 00 LAUNDRY & LI NEN SERVI CE	2.00		7. 00		0	2.	2. 00
4. 00 HOUSEKEEPI NG 9. 00 4, 465 0 5. 00 DI ETARY 10. 00 3, 136 0 6. 00 NURSI NG ADMI NI STRATI ON 13. 00 2, 065 0 7. 00 CENTRAL SERVI CES & SUPPLY 14. 00 1, 361 0 8. 00 PHARMACY 15. 00 2, 500 0 9. 00 ADULTS & PEDI ATRI CS 30. 00 33, 508 0 10. 00 OPERATI NG ROOM 50. 00 12, 797 0 11. 00 ANESTHESI OLOGY 53. 00 659 0 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 4, 885 0 13. 00 MAMMOGRAPHY 54. 00 4, 885 0 14. 00 ULTRA SOUND 56. 01 2, 347 0 13. 00 15. 00 CT SCAN 57. 00 2, 192 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58. 00 1, 633 0 17. 00 19. 00 PHYSI CAL THERAPY 65. 00 65. 30 0 17. 00 19. 00 PHYSI CAL THERAPY							
5. 00 DI ETARY 10. 00 3, 136 0 5. 00 6. 00 NURSI NG ADMI NI STRATI ON 13. 00 2, 065 0 6. 00 7. 00 CENTRAL SERVI CES & SUPPLY 14. 00 1, 361 0 7. 00 8. 00 PHARMACY 15. 00 2, 550 0 8. 00 9. 00 ADULTS & PEDI ATRI CS 30. 00 33, 508 0 9. 00 10. 00 OPERATI NG ROOM 50. 00 12, 797 0 10. 00 11. 00 ANESTHESI OLOGY 53. 00 659 0 11. 00 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 4, 885 0 11. 00 13. 00 MAMMOGRAPHY 54. 01 1, 094 0 13. 00 14. 00 ULTRA SOUND 56. 01 2, 347 0 14. 00 15. 00 C SCAN 57. 00 2, 192 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58. 00 1, 633 0 17. 00 18. 0							
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9. 00 ADULTS & PEDI ATRI CS 30. 00 33, 508 0 10. 00 10. 00 10. 00 11							
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14. 00 ULTRA SOUND 56. 01 2, 347 0 14. 00 15. 00 CT SCAN 57. 00 2, 192 0 15. 00 16. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58. 00 1, 633 0 16. 00 17. 00 LABORATORY 60. 00 9, 440 0 17. 00 18. 00 RESPI RATORY THERAPY 65. 00 6, 330 0 18. 00 19. 00 PHYSI CAL THERAPY 66. 00 7, 360 0 19. 00 20. 00 OCCUPATI ONAL THERAPY 67. 00 1, 341 0 20. 00 21. 00 SPEECH PATHOLOGY 68. 00 476 0 21. 00 22. 00 CARDI OPULMONARY 69. 01 3, 110 0 22. 00 23. 00 RURAL HEALTH CLINIC 88. 00 53, 871 0 23. 00	12.00	RADI OLOGY-DI AGNOSTI C	54.00	4, 885	0	12.	2. 00
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Health Financial Systems	OSF SAINT LUKE MEDICAL CENTER	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 14-1325	Period: Worksheet A-6 From 10/01/2022
		To 09/30/2023 Date/Time Prepared:

					То	09/30/2023	Date/Time Pr 2/24/2024 6:	epared: 39 pm
		Increases			<u> </u>			
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
25. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00	743	0				25. 00
26.00	INDUSTRIAL MEDICINE	194. 00	9	0				26.00
	TOTALS		194, 412					
	W - SHORT TERM DISABILITY							
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	881				1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2, 374				2.00
	TOTALS		0	3, 255				
	X - MINISTRY MEDICAL RECORDS							
1.00	MEDICAL RECORDS & LIBRARY	16. 00	0	<u>56, 5</u> 50				1.00
	0		0	56, 550				
	Y - FOUNDATION EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	70, 140				1.00
2.00	RURAL HEALTH CLINIC	88. 00	0	3, 500				2.00
	0		0	73, 640				
	Z - RHC PULMONARY PHY							
1.00	RESPIRATORY THERAPY	65. 00	189	0				1.00
	0		189	0				
500.00	Grand Total: Increases		593, 050	6, 763, 550				500.00

| Period: | Worksheet A-6 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS Provi der CCN: 14-1325

Cost Content							To 09/30/2023 Date/Time Pro 2/24/2024 6:3	epared: 39 pm
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Heal th	Financial Systems	C	OSF SAINT LUKE	MEDICAL CENTE	R	In Lieu of Form CMS-2552-10		
RECLAS	SI FI CATI ONS			Provi der	CCN: 14-1325	Peri od:	Worksheet A-	6
						From 10/01/2022 To 09/30/2023		epared: 39 pm
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	· .		
	6. 00	7. 00	8. 00	9. 00	10.00			
	W - SHORT TERM DISABILITY							
1.00	ADMINISTRATIVE & GENERAL	5. 00	881	(D	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	2, 374	()	0		2.00
	TOTALS		3, 255					
	X - MINISTRY MEDICAL RECORDS							
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	56, 550		0		1.00
	0		0	56, 550				
	Y - FOUNDATION EXPENSE							
1.00	FOUNDATI ON	190. 01	0	73, 640		0		1.00
2.00		0.00	0	(<u> </u>	ol		2.00

189 189 516, 872 _____0 0 6, 839, 728

1.00

500.00

88. 00

O
Z - RHC PULMONARY PHY
RURAL HEALTH CLINIC

500.00 Grand Total: Decreases

1.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-1325 Peri od: Worksheet A-7 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/24/2024 6:39 pm Acqui si ti ons Begi nni ng Purchases Total Disposals and Donati on Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 712, 018 1.00 Land 0 0 1, 390, 342 2.00 Land Improvements Ω 2.00 3.00 22, 093, 776 3.00 Buildings and Fixtures 0 292,600 292, 600 0 4.00 Building Improvements 0 4.00 Fi xed Equi pment 0 0 5.00 5.00 470, 162 0 470, 162 6.00 Movable Equipment 11, 902, 805 0 6.00 0 7.00 HIT designated Assets 4, 714, 976 0 7.00 8.00 Subtotal (sum of lines 1-7) 41, 813, 917 762, 762 0 762, 762 0 8.00 9.00 Reconciling Items 102, 510 232, 368 0 232, 368 0 9.00 Total (line 8 minus line 9) 530, 394 530, 394 10.00 10.00 41, 711, 407 0 0 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 712, 018 1.00 2.00 1, 390, 342 0 2.00 Land Improvements 3.00 Buildings and Fixtures 22, 386, 376 0 3.00 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 0 5.00 Movable Equipment 12, 372, 967 0 6.00 6.00

4, 714, 976

334, 878

42, 576, 679

42, 241, 801

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Heal th	n Financial Systems 0	SF SAINT LUKE N	MEDICAL CENTER		In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 14-1325	Peri od:	Worksheet A-7	
					From 10/01/2022		
					To 09/30/2023		
			CI	IMMARY OF OAR	1 = 41	2/24/2024 6: 3	9 pm
			SU	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
	cost center bescription	Depi eci ati on	Lease	Tillerest	(see	instructions)	
					instructions)	THIS (TUCTIONS)	
		0.00	10.00	11 00		13.00	
	DART II DECONCILIATION OF AMOUNTS FROM WOR	9.00	10.00	11.00	12. 00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2	_	_	
1. 00	CAP REL COSTS-BLDG & FLXT	636, 848			0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	596, 218	0		0	0	2.00
3.00	Total (sum of lines 1-2)	1, 233, 066	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
	•	Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	636, 848				1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	596, 218	1			2.00
3 00	Total (sum of lines 1-2)	0	1 233 066	1			3 00

0 0

636, 848 596, 218 1, 233, 066

1.00 2.00

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems C	SF SAINT LUKE N	SF SAINT LUKE MEDICAL CENTER			In Lieu of Form CMS-2552-10		
RECON	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 14-1325		Period: From 10/01/2022 To 09/30/2023		 Time Prepared:	
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF OTHER CAPITAL			
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance		
				(col. 1 - col. 2)	,			
		1. 00	2. 00	3.00	4.00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	25, 488, 736		25, 488, 736			1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	17, 087, 943		17, 087, 943			2.00	
3.00	Total (sum of lines 1-2)	42, 576, 679		42, 576, 679			3.00	
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL			OF CAPITAL			
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
			Capi tal -Rel at					
			ed Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(1, 358, 236		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(936, 099		2.00	
3.00	Total (sum of lines 1-2)	0	0	(2, 294, 335	0	3.00	
			Sl	JMMARY OF CAPI	ΓAL			
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)		
			(see	instructions)				
			instructions)		ed Costs (see	9 through 14)		
					instructions)			
	DART III DECONOLILATION OF CARLTAL COCTO	11. 00	12. 00	13. 00	14. 00	15. 00		

0 0 0 40, 083 0

40, 083

0 0 0 1, 398, 319 1. 00 936, 099 2. 00 2, 334, 418 3. 00

0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

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

ADJUSTMENTS TO EXPENSES Provi der CCN: 14-1325 Peri od: Worksheet A-8 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0 00 7.00 stations excluded) (chapter 8.00 Television and radio service O OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -2, 334, 043 10.00 Provi der-based physici an 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 538, 274 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 13.00 Laundry and linen service 0.00 Cafeteria-employees and guests -127, 816 CAFETERI A 14.00 В 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 -60 MEDICAL RECORDS & LIBRARY R 16.00 18.00 abstracts 19.00 Nursing and allied health 0 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 *** Cost Center Deleted *** 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP

0 *** Cost Center Deleted ***

O OCCUPATIONAL THERAPY

OADULTS & PEDIATRICS

19.00

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28.00

29 00

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instructions)

28.00

29 00

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30.99

Non-physician Anesthetist Physicians' assistant

Adjustment for occupational

therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see A-8-3

Provider CCN: 14-1325 Peri od: Worksheet A-8 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm Expense Classification on Worksheet A

			Expense Classification on Worksheet A				
			To/From Which the Amount is to be Adjusted				
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	·	(2)				Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31 00 Adi	ustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
	thology costs in excess of		ŭ	0. 220 1711102001	55. 55		01.00
	mitation (chapter 14)	Δ.	0	CAD DEL COCTO MUDI E FOLLID	2 00	0	22.00
	H HIT Adjustment for	Α	0	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32.00
	preciation and Interest						
33. 00 MIS	SC INC	В	-16	RURAL HEALTH CLINIC	88. 00	0	33. 00
33. 01 MIS	SC INC	В	-46, 240	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02 MIS	SC INC	В	-26, 955	PHYSI CAL THERAPY	66.00	0	33. 02
	SC INC	В		PHARMACY	15. 00	0	33. 03
4	SC INC	В		RURAL HEALTH CLINIC	88. 00	0	33. 04
4	SC INC	В			•	0	
4				LABORATORY	60. 00	U	33.05
	OVI DER TAX	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07 CRN	NA - SALARY	Α	-62, 760	ANESTHESI OLOGY	53. 00	0	33. 07
33. 08 CRN	NA - BENEFITS	Α	-12, 585	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.08
33. 09 CRN	NA - OTHER EXPENSE	Α	-25, 849	ANESTHESI OLOGY	53.00	0	33. 09
33. 10 LOE	BBYI NG	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
	AL ESTATE TAXES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
						9	
	PAIRMENT OF ASSETS	A		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 12
	PAIRMENT OF ASSETS	Α		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 13
	NALLOWABLE RHC COSTS	A		RURAL HEALTH CLINIC	88. 00	0	33. 14
33. 15 RE-	-LIFING OFFSET	Α	490, 551	CAP REL COSTS-BLDG & FLXT	1. 00	9	33. 15
33. 16 RE-	-LIFING OFFSET	Α	-10, 260	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 16
1	OB OFFSET	Α		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 17
	ORTSCARE SALARIES	A		PHYSI CAL THERAPY	66. 00	0	33. 18
	ORTSCARE EXPENSES				66.00	0	33. 19
		A		PHYSI CAL THERAPY		-	
1	ORTSCARE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 20
1	YSICIAN BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 21
33. 22 OTH	HER OPERATING REVENUE – FARM	В	-17, 875	ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
INC	COM						
33. 23 OSF	FMG CRNA EXPENSE	Α	72, 820	ANESTHESI OLOGY	53.00	0	33. 23
1	FMG ED REVENUE	Α		EMERGENCY	91.00	0	33. 24
	DICAL TRANSPORTATION SVCS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
		Α	-27, 723	ADMINISTRATIVE & GENERAL	5.00	U	33.23
	LARI ES		, ,,,,,,	ADMINISTRATING & CENEDAL	F 00		20.01
	DICAL TRANSPORTATION SVCS	Α	-6, 090	ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
	PENSES						
33. 27 MED	DICAL TRANSPORTATION SVCS	Α	-5, 960	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 27
BEN	NEFITS						
33. 28 OTH	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 28
(3)			Ü		0.00	ŭ	00.20
	YSICIAN RECRUITMENT	Α	000	EMERGENCY	91.00	0	33. 29
1					•	0	
	MMUNITY HEALTH SVCS SALARIES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 30
	MMUNITY HEALTH SVCS EXPENSES	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 31
33.32 COM	MMUNITY HEALTH SVCS BENEFITS	Α	-1, 021	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 32
33. 33 GUI	LD ADJUSTMENT	Α	2, 845	OPERATING ROOM	50.00	0	33. 33
33. 34 GUI	LD ADJUSTMENT	Α	2, 845	EMERGENCY	91.00	0	33. 34
	VERTISING AND MARKETING	A		MAMMOGRAPHY	54. 01	0	33. 35
	VERTISING AND MARKETING	A		RURAL HEALTH CLINIC	88. 00	0	33. 36
						0	
	BLIC RELATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	-	33. 37
	LPRACTICE EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 38
	TAL (sum of lines 1 thru 49)		-1, 914, 637				50.00
(Tr	ransfer to Worksheet A,						
col	umn 6, line 200.)						
	,						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 14-1325 OFFICE COSTS

Period: Worksheet A-8-1 From 10/01/2022

Line No. Cost Center Expense I tems Amount of All lowable Cost Included in Miss. A. column Section Amount of All lowable Cost Included in Miss. A. column Section Sect	OFFICE COSTS				From 10/01/2022	Date/Time Pre	nared.
Line No. Cost Center Expense I tems					10 07/30/2023		
1.00		Li ne No.	Cost Center	Expense Items	Amount of		
1.00				·	Allowable Cost	Included in	
1.00					l l	Wks. A, column	
A COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00							
OFFICE COSTS:							
1. 00			MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAIMED HOME	
2. 00							
3. 00 5. 00 ADMINI STRATIVE & GENERAL HO POOLED - ADMIN & GENERAL 1,70 692 3,779, 648 3. 00 4. 00 EMPLOYEE BENEFITS DEPARTMENT HO POOLED - ADMIN & GENERAL 1,70 692 3,779, 648 3. 00 3. 01 3. 01 3. 01 3. 01 3. 02 3. 00 3. 00 0.							
3. 01						ŭ	
3. 02 3. 0.00 PERATION OF PLANT MINISTRY ALLOCATION 104, 525 104, 525 3. 0.2 3. 0.3 3. 0.3 3. 0.00 ADULTS & PEDI ATRICS MINISTRY ALLOCATION 26, 712 0 3. 0.3 3. 0.3 3. 0.3 3. 0.3 3. 0.3 3. 0.00 ADULTS & PEDI ATRICS MINISTRY ALLOCATION 26, 712 0 3. 0.3 0.3 0.3 0.3 0.5 6. 0.00 PHYSICAL THERAPY MINISTRY ALLOCATION 24, 265 22, 787 3. 0.4 6. 0.00 PARABOLTO MAL THERAPY MINISTRY ALLOCATION 4, 250 3. 991 3. 0.5 6. 0.00 PARABOLTO MAL THERAPY MINISTRY ALLOCATION 4, 250 3. 991 3. 0.5 6. 0.00 PARABOLTO MINISTRY ALLOCATION 45, 157 45, 157 3. 0.7 3. 0.8 54. 00 RADI OLOGY-DI AGNOSTI C MINISTRY ALLOCATION 419 419 3. 0.8 6. 0.00 LABORATORY MINISTRY ALLOCATION 419 419 3. 0.8 18 1 81 8.1 8.1 8.1 8.1 9. 0.9 6. 0.00 LABORATORY MINISTRY ALLOCATION MINISTRY AL						3, 779, 648	
3. 03 30. 00 ADULTS & PEDI ATRI CS MIN ISTRY ALLOCATI ON 26, 712 0 3. 03 3. 03 3. 04 66. 00 PHYSI CAL THERAPY MIN ISTRY ALLOCATI ON 24, 265 22, 787 3. 04 3. 05 67. 00 OCCUPATI ONAL THERAPY MIN ISTRY ALLOCATI ON 4, 250 3, 991 3. 05 3. 06 68. 00 SPEECH PATHOLOGY MIN ISTRY ALLOCATI ON 1, 541 1, 447 3. 06 15. 00 PHARMACY MIN ISTRY ALLOCATI ON 45, 157 45, 157 3. 07 3. 07 3. 08 60. 00 RADI OLOGY-DI AGNOSTI C MIN ISTRY ALLOCATI ON 45, 157 45, 157 3. 07 3. 09 60. 00 LABORATORY MIN ISTRY ALLOCATI ON 419 419 3. 08 419 419 3. 08 60. 00 LABORATORY MIN ISTRY ALLOCATI ON 419 419 3. 08 410 3. 10 13. 00 NURSI NG ADMI NI STRATI ON HO FUNCTI ONAL - NURSI NG ADMI 98, 246 98, 246 3. 11 17. 00 SOCI AL SERVI CE 50 SADMI 18. 17. 00 SOCI AL SERVI CE 50 SADMI 18. 17. 00 SOCI AL SERVI CE 50 SADMI 18. 17. 00 SOCI AL SERVI CE 50 SADMI 18. 17. 00 SADMI NI STRATI VE & GENERAL 50. 00 ADMI NI STRATI VE & GENERAL 50.		1			187, 973	187, 973	3. 01
3. 04 66. 00 PHYSICAL THERAPY MINISTRY ALLOCATION 24, 265 3, 931 3. 04 67. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 4, 250 3, 931 3. 04 67. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 4, 250 3, 931 3. 04 3. 06 68. 00 SPEECH PATHOLOGY MINISTRY ALLOCATION 1, 1, 541 1, 447 3. 06 67. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 1, 1, 541 1, 447 3. 06 67. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 1, 1, 541 1, 447 3. 06 67. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 1, 1, 541 1, 447 3. 06 67. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 1, 1, 541 1, 447 3. 06 67. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 1, 1, 541 1, 447 3. 06 67. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 1, 1, 613 3. 09 13. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 1, 1, 613 3. 09 13. 00 DCCUPATIONAL THERAPY MINISTRY ALLOCATION 1, 614 1,	3.02	7. 00	OPERATION OF PLANT	MINISTRY ALLOCATION	104, 525	104, 525	3.02
3. 05	3.03	30.00	ADULTS & PEDIATRICS	MINISTRY ALLOCATION	26, 712	0	3.03
3. 06 68. 00 SPEECH PATHOLOGY MI NI STRY ALLOCATI ON 1, 541 1, 447 3. 06 3. 07 15. 00 PHARMACY MI NI STRY ALLOCATI ON 45, 157 45, 157 3. 07 3. 08 54. 00 RADI OLOGY-DI AGNOSTI C MI NI STRY ALLOCATI ON 419 419 3. 08 60. 00 LABORATORY MI NI STRY ALLOCATI ON 419 419 3. 08 60. 00 LABORATORY MI NI STRY ALLOCATI ON 81 81 3. 09 3. 10 13. 00 NURSI NG ADMI NI STRATI ON HO FUNCTI ONAL - NURSI NG ADMI 98, 246 98, 246 3. 11 17. 00 SOCI AL SERVI CE HO FUNCTI ONAL - NURSI NG ADMI 98, 246 98, 246 3. 11 3. 12 5. 00 ADMI NI STRATI ON HO FUNCTI ONAL - SOCI AL SERVI 257, 713 348, 592 3. 12 3. 13 3. 14 73. 00 DRUGS CHARGED TO PATI ENTS HO FUNCTI ONAL - ADMI N & GEN 3. 334, 134 1, 749, 719 3. 13 3. 15 54. 00 RADI OLOGY-DI AGNOSTI C SFI HTM EQUI PMENT RENTAL 456 464 3. 15 3. 16 5. 00 ADMI NI STRATI VE & GENERAL SFI CVO 3. 10	3.04	66.00	PHYSI CAL THERAPY	MINISTRY ALLOCATION	24, 265	22, 787	3.04
3. 07 3. 08 3. 07 3. 08 3. 09 4. 00 RADI OLOGY-DI AGNOSTI C MIN I STRY ALLOCATI ON 4. 19 4. 19 4. 19 3. 08 3. 09 3. 10 3. 10 3. 11 3. 00 NURSI NG ADMI NI STRATI ON 4. 19 4. 19 3. 08 3. 12 4. 17. 00 SOCI AL SERVI CE 4. 17. 00 SOCI AL SERVI CE 4. 00 RADI OLOGY-DI AGNOSTI C 5. 00 ADMI NI STRATI VE & GENERAL 5. 00 ADMI NI STRATI VE & GENERAL 6. 3. 15 6. 00 ADMI NI STRATI VE & GENERAL 7. 00 SOCI AL SERVI CE 7. 00 ADMI NI STRATI VE & GENERAL 7. 00 DRUGS CHARGED TO PATIENTS 7. 15 7. 00 ADMI NI STRATI VE & GENERAL 7. 00 DRUGS CHARGED TO PATIENTS 7. 16 7. 00 OPERATION OF PLANT 7. 17 7. 00 OPERATION OF PLANT 7. 00 OPERATION	3.05	67. 00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	4, 250	3, 991	3.05
3. 08	3.06	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	1, 541	1, 447	3.06
3. 09 3. 09 3. 10 3. 10 3. 10 3. 12 3. 11 3. 11 3. 12 3. 12 3. 13 3. 14 3. 13 3. 14 3. 15 3. 16 3. 16 3. 17 3. 10 3. 18 3. 17 3. 19 3. 18 3. 19 3. 19 3. 19 3. 10 4. 00 PADIOLOGY-DI AGNOSTI C 3. 10 5. 00 ADMI NI STRATI VE & GENERAL 3. 11 3. 16 3. 16 3. 17 3. 00 PROPERATION OF PLANT 5. 00 ADMI NI STRATI VE & GENERAL 3. 18 3. 19 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 4. 00 4. 01 4. 00 4. 01 4. 01 4. 02 4. 03 4. 04 5. 00 4. 01 4. 02 4. 03 4. 04 5. 00 4. 01 5. 00 ADMINI STRATI VE & GENERAL 4. 00 4. 03 4. 04 5. 00 ADMINI STRATI VE & GENERAL 5. 00 ADMINI STRATI VE & GENERAL 4. 00 4. 03 4. 04 5. 00 ADMINI STRATI VE & GENERAL 5. 00 ADMINI STRATI VE & GENERAL 4. 00 4. 03 6. 00 ADMINI STRATI VE & GENERAL 5. 00 ADMINI STRATI VE & GENERAL 5. 00 ADMINI STRATI VE & GENERAL 6. 00 ADMINI STRATI VE & GENERAL 7. 00 ADMINI STRATI VE & GENERAL 8. 00 ADMINI STRATI VE & GENERAL 9. PURCH SVCS-ST GABRI EL 2011, 193 1, 1856 3, 20 3,	3.07	15. 00	PHARMACY	MINISTRY ALLOCATION	45, 157	45, 157	3.07
3. 10 3. 10 3. 11 3. 12 3. 12 3. 12 3. 13 3. 14 3. 15 3. 14 3. 15 3. 16 3. 17 3. 00 RADI NI STRATI VE & GENERAL 3. 15 3. 16 3. 17 3. 00 RADI NI STRATI VE & GENERAL 3. 16 3. 17 3. 00 RADI NI STRATI VE & GENERAL 3. 17 3. 00 DRUGS CHARGED TO PATI ENTS 3. 16 3. 16 3. 17 3. 18 3. 18 3. 19 3. 19 3. 19 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 3. 10 4. 01 3. 10 3. 10 3. 10 3. 10 4. 01 3. 10 3. 10 3. 10 3. 10 4. 01 3. 10 3. 10 3. 10 4. 01 3. 10 3. 10 3. 10 3. 10 4. 01 3. 10 3. 10 3. 10 4. 01 3. 10 3. 10 5. 00 ADMI NI STRATI VE & GENERAL 5FI CVO 27, 490 27, 429 3. 16 3. 17 3. 18 3. 19 3. 10 3. 10 3. 10 3. 10 4. 01 3. 10 4. 01 3. 10 4. 01 3. 10 3. 10 3. 10 4. 01 3. 10 3. 10 4. 01 3. 10 3. 10 5. 00 ADMI NI STRATI VE & GENERAL 5FI EVO 3. 11 3. 12 3. 12 4. 00 4. 01 4. 02 4. 03 4. 04 5. 00 ADMI NI STRATI VE & GENERAL 5FI EVENDLOGY SV 5FI HEALTHCARE TECHNOLOGY SV 5FI HEALTHCARE TECHNOLO	3.08	54.00	RADI OLOGY-DI AGNOSTI C	MINISTRY ALLOCATION	419	419	3.08
3. 11	3.09	60.00	LABORATORY	MINISTRY ALLOCATION	81	81	3.09
3. 12	3. 10	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	372, 921	0	3. 10
3. 13	3. 11	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	98, 246	98, 246	3. 11
3. 14 3. 15 3. 16 3. 16 3. 17 3. 19 3. 18 3. 19 3. 19 3. 19 3. 19 3. 10 3. 19 3. 10	3. 12	17. 00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	257, 713	348, 592	3. 12
3. 15 3. 16 3. 16 3. 17 3. 18 3. 18 3. 19 3. 20 3. 20 3. 21 4. 00 4. 01 4. 00 4. 01 4. 01 4. 02 4. 01 4. 02 4. 01 4. 02 4. 03 4. 04 5. 00 ADMINISTRATIVE & GENERAL 3. 15 54. 00 RADIOLOGY-DIAGNOSTIC 55. 00 ADMINISTRATIVE & GENERAL 55. 00 ADMINISTRATIVE & GENERAL 55. 00 ADMINISTRATIVE & GENERAL 56. 00 ADMINISTRATIVE & GENERAL 57. 00 ADMINISTRATIVE & GENERAL 58. 00 ADMINISTRATIVE & GENERAL 59. 00 ADMINISTRATIVE & GENERAL 59. 00 ADMINISTRATIVE & GENERAL 50. 00 ADMINISTRATIVE & GENERAL 51. 190. 02 51. 190. 02 52. 01 52. 02 52.	3. 13	5. 00	ADMINISTRATIVE & GENERAL	HO FUNCTIONAL - ADMIN & GEN	3, 334, 134	1, 749, 719	3. 13
3. 16	3. 14	73.00	DRUGS CHARGED TO PATIENTS	HO FUNCTIONAL - PHARMACY	1, 613	0	3. 14
3. 17 3. 18 3. 19 3. 19 3. 00 3. 00 3. 19 3. 20 3. 21 4. 00 3. 21 4. 00 4. 01 4. 01 4. 02 4. 03 4. 03 4. 03 4. 03 4. 03 4. 03 4. 04 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	3. 15	54.00	RADI OLOGY-DI AGNOSTI C	SFI HTM EQUIPMENT RENTAL	456	464	3. 15
3. 18	3. 16	5. 00	ADMINISTRATIVE & GENERAL	SFI CVO	27, 490	27, 429	3. 16
3. 19 3. 20 3. 20 3. 21 4. 00 4. 01 4. 02 4. 02 4. 03 4. 03 4. 04 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	3. 17	7.00	OPERATION OF PLANT	SFI HEALTHCARE TECHNOLOGY SV	300, 327	314, 855	3. 17
3. 20 30. 00 ADULTS & PEDIATRICS 5. 00 ADMINISTRATIVE & GENERAL 4. 00 5. 00 CAP REL COSTS-MVBLE EQUIP 6. 00 CAP REL COSTS-MVBL	3. 18	54.00	RADI OLOGY-DI AGNOSTI C	SFI HEALTHCARE TECHNOLOGY SV	430, 433	451, 256	3. 18
3. 21	3. 19	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	82, 913	86, 924	3. 19
3. 21	3. 20	30.00	ADULTS & PEDIATRICS	ELCU	1, 193	1, 856	3. 20
4. 01	3. 21	5. 00	ADMINISTRATIVE & GENERAL	PURCH SVCS-ST GABRIEL			3. 21
4. 02 4. 03 4. 04 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	4.00	2.00	CAP REL COSTS-MVBLE EQUIP	OSFMG MINISTRY ALLOCATION	687	15, 976	4.00
4. 03 4. 04 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	4. 01	30.00	ADULTS & PEDIATRICS	OSFMG MINISTRY ALLOCATION	13, 840	47, 719	4. 01
4. 04 91. 00 EMERGENCY OSFMG MINISTRY ALLOCATION 2, 089 32, 814 4. 04 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	4. 02	53.00	ANESTHESI OLOGY	OSFMG MINISTRY ALLOCATION	155	2, 432	4.02
4. 04 91. 00 EMERGENCY OSFMG MINISTRY ALLOCATION 2, 089 32, 814 4. 04 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,							4.03
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	4.04			OSFMG MINISTRY ALLOCATION			4.04
Transfer column 6, line 5 to Worksheet A-8, column 2,		TOTALS (sum of lines 1-4).					5.00
Worksheet A-8, column 2,						.,, =	
line 12.							
		line 12.					

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

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

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

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

6. 00	В	0. 00 OSF HEALTHCARE 100. 00	6.00
7. 00		0.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10.00		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.

			2/24/2024 6: 3	pareu:
	Net	Wkst. A-7 Ref.	2, 2 1, 252 1 3	7 (2.11)
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	-182, 996	9		1.00
2.00	403, 630	9		2.00
3.00	-1, 077, 956	0		3.00
3. 01	0	0		3. 01
3.02	0	0		3. 02
3. 03	26, 712	0		3. 03
3.04	1, 478	0		3.04
3.05	259	0		3.05
3.06	94	0		3.06
3.07	0	0		3.07
3.08	0	0		3. 08
3.09	0	0		3.09
3. 10	372, 921	0		3. 10
3. 11	0	0		3. 11
3. 12	-90, 879	0		3. 12
3. 13	1, 584, 415	0		3. 13
3. 14	1, 613	0		3. 14
3. 15	-8	0		3. 15
3. 16	61	0		3. 16
3. 17	-14, 528	0		3. 17
3. 18	-20, 823	0		3. 18
3. 19	-4, 011	0		3. 19
3. 20	-663	0		3. 20
3. 21	-616	0		3. 21
4.00	-15, 289	9		4.00
4. 01	-33, 879	0		4. 01
4.02	-2, 277	0		4. 02
4.03	-378, 259	0		4. 03
4.04	-30, 725	0		4.04
5.00	538, 274			5.00

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

Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELATE	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.

i ci ilibui	Termbursement under trete Aviii.							
6.00	HOME OFFICE	6.00						
7.00		7.00						
8.00		8.00						
9.00		9.00						
9. 00 10. 00		10.00						
100.00		100.00						

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 14-1325

							To 09/30/2023	Date/Time Pre 2/24/2024 6:3	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration		ssi onal onent	Provider Component	RCE Amount	Physician/Provider Component	
								Hours	
	1. 00	2.00	3. 00	4.	00	5. 00	6.00	7. 00	
1.00		ADULTS & PEDIATRICS	506, 198	3	506, 198	C	_	_	1.00
2.00	50.00	OPERATING ROOM	73, 561		73, 561	C		_	2.00
3.00	1	LABORATORY	23, 000		23, 000	C	0	1	3.00
4.00	1	RESPI RATORY THERAPY	189		189	C	0	0	4. 00
5. 00		EMERGENCY	2, 305, 053		731, 095	573, 958	l .	0	5. 00
6.00		EMERGENCY	45, 000)	0	45, 000	0	0	6. 00
7. 00	0.00		0		0	C	0	0	7. 00
8.00	0.00		0		0	C	0	0	8. 00
9. 00	0.00		0		0	C	0	0	9. 00
10.00	0.00		0		0	C	0	0	10.00
200.00			2, 953, 001		334, 043			0	200.00
	Wkst. A Line #	l	Unadjusted RCE			Cost of	Provi der	Physician Cost	
		I denti fi er	Li mi t			Memberships &	Component	of Malpractice	
				Li	mi t	Continuing	Share of col.	Insurance	
	4.00	2.00	0.00	-	00	Education	12	14.00	
1 00	1.00	2.00	8. 00	9.	00	12. 00	13. 00	14.00	1.00
1.00		ADULTS & PEDIATRICS	0		0	C	_	_	1
2. 00 3. 00		OPERATING ROOM LABORATORY	0		0	•	·	_	
		RESPIRATORY THERAPY	0		0		0	_	
4. 00 5. 00		EMERGENCY	0		0		0	1	4. 00 5. 00
		EMERGENCY	0	()	0	U	0	0	
6. 00 7. 00	91.00		0		0	U	0	0	6. 00 7. 00
7. 00 8. 00	0.00		0		0	0	0	0	8.00
9. 00	0.00	l .	0		0	0	0	0	9.00
10.00	0.00				0		0	0	10.00
200.00					0		0	·	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adi us	ted RCE	RCF	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component		mi t	Di sal I owance	Aujustillerit		
		Tueller Trei	Share of col.	"		Di Sai i Owanee			
			14						
	1.00	2.00	15. 00	16	. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0		0	C			1. 00
2.00		OPERATING ROOM	0		0	C		•	2.00
3.00	1	LABORATORY	0		0	C	· ·	•	3. 00
4.00	65. 00	RESPIRATORY THERAPY	0		0	C	189		4.00
5.00	91.00	EMERGENCY	0		0	C	1, 731, 095		5. 00
6.00		EMERGENCY	0	o	0	C	0		6.00
7.00	0.00	1	0	o	0	C	0		7.00
8. 00	0.00		0		0	C	0		8.00
9.00	0.00		0	o	0	C	0		9.00
10.00	0.00		0	o	0	C	0		10.00
200.00			0		0	C	2, 334, 043		200.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1325 Peri od: Worksheet B From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1, 398, 319 1, 398, 319 1.00 00200 CAP REL COSTS-MVBLE EQUIP 936, 099 936, 099 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 013, 391 90 4, 013, 481 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 8, 654, 783 249, 252 9, 208, 777 244, 119 60, 623 7.00 00700 OPERATION OF PLANT 1, 523, 855 116, 037 77, 322 77, 405 1, 794, 619 7.00 5, 909 8.00 00800 LAUNDRY & LINEN SERVICE 96, 907 0 2, 878 105, 694 8.00 115, 263 00900 HOUSEKEEPI NG 524, 278 11, 361 650, 902 9.00 9 00 Ω 01000 DI ETARY 159, 014 228, 971 10.00 31,628 11, 889 26, 440 10.00 11. 00 01100 CAFETERI A 206, 134 10, 790 54, 504 271, 428 11.00 01300 NURSING ADMINISTRATION 13.00 575, 850 4, 111 0 53, 294 633, 255 13.00 01400 CENTRAL SERVICES & SUPPLY 192, 377 238, 922 14 00 14 00 11, 414 35, 131 C 01500 PHARMACY 15.00 1, 348, 285 19, 425 56, 048 64, 532 1, 488, 290 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 56, 490 7, 022 0 63, 512 16.00 0 01700 SOCIAL SERVICE 257, 713 257, 713 17.00 17.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 597, 640 257, 693 167, 471 376, 604 2, 399, 408 30.00 03100 INTENSIVE CARE UNIT 31.00 36, 424 33, 658 8, 540 78, 622 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 733, 999 136,803 252, 413 150, 014 1, 273, 229 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 1, 927 53.00 05300 ANESTHESI OLOGY 4, 416 6.566 264 13, 173 53.00 05400 RADI OLOGY-DI AGNOSTI C 913, 464 65, 212 126, 109 1, 172, 851 54 00 68,066 54 00 54.01 03440 MAMMOGRAPHY 116, 568 2, 469 0 28, 228 147, 265 54.01 56.00 05600 RADI OI SOTOPE 205, 672 3, 854 209, 526 0 56.00 03630 ULTRA SOUND 234, 606 3, 340 60, 579 298, 747 56.01 222 56.01 57. 00 05700 CT SCAN 5, 395 283.875 345, 851 57.00 0 56, 581 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 183, 995 26, 861 2, 408 42, 142 255, 406 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0 60. 00 06000 LABORATORY 1, 868, 078 28, 203 91, 353 243, 183 2, 230, 817 60.00

60. 00 06000 LABORATORY	1, 868, 078	28, 203	91, 353	243, 183	2, 230, 817 60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0 60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	72, 775	2, 569	0	483	75, 827 62. 00
65. 00 06500 RESPIRATORY THERAPY	337, 289	7, 964	21, 372	75, 464	442, 089 65. 00
66. 00 06600 PHYSI CAL THERAPY	665, 031	48, 070	10, 048	174, 289	897, 438 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	138, 189	4, 367	0	34, 618	177, 174 67. 00
68. 00 06800 SPEECH PATHOLOGY	50, 484	1, 541	934	12, 280	65, 239 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0 69.00
69. 01 03160 CARDI OPULMONARY	259, 884	28, 888	30, 388	67, 093	386, 253 69. 01
69. 02 03650 VASCULAR LAB	0	1, 541	0	0	1, 541 69. 02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	31, 828	0	0	0	31, 828 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 613	0	0	0	1, 613 73.00
73. 01 03480 ONCOLOGY	o	O	0	o	0 73.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	O	0	o	0 77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0 78.00
OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u> </u>	
88. 00 08800 RURAL HEALTH CLINIC	6, 548, 299	133, 934	31, 055	1, 371, 833	8, 085, 121 88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91. 00 09100 EMERGENCY	2, 760, 310	100, 808	29, 467	487, 083	3, 377, 668 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	36, 985, 168	1, 348, 265	929, 149	3, 994, 086	<u>36, 908, 769</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	87, 813	12, 917	0	19, 174	119, 904 190. 00
190. 01 19001 FOUNDATI ON	70, 830	0	6, 950	0	77, 780 190. 01
190. 02 19002 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 190. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	6, 132	37, 137	0	0	43, 269 192. 00
194.00 07950 INDUSTRIAL MEDICINE	635	0	0	221	856 194.00
194. 01 07951 RESEARCH	0	0	0	0	0 194. 01
200.00 Cross Foot Adjustments					0 200. 00
201.00 Negative Cost Centers		0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	37, 150, 578	1, 398, 319	936, 099	4, 013, 481	37, 150, 578 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS OSF SAINT LUKE MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 14-1325 Period: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

			To	09/30/2023	Date/Time Pre 2/24/2024 6:3	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY) piii
	E & GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
GENERAL SERVICE COST CENTERS	5. 00	7. 00	8.00	9. 00	10. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	9, 208, 777					5. 00
7. 00 00700 OPERATION OF PLANT	591, 453	2, 386, 072				7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	34, 834 214, 518	13, 581 26, 112		908, 129		8. 00 9. 00
10. 00 01000 DI ETARY	75, 462	72, 693		29, 816	406, 942	10.00
11. 00 01100 CAFETERI A	89, 455	24, 800		0	0	11.00
13.00 01300 NURSING ADMINISTRATION	208, 702	9, 447		9, 699	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	78, 742	0	66	11, 136	0	14.00
15. 00 01500 PHARMACY	490, 496	44, 646		8, 621	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	20, 932	16, 139		(107	0	16.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	84, 934	0	0	6, 107	0	17. 00
30. 00 03000 ADULTS & PEDIATRICS	790, 773	592, 270	38, 241	304, 267	402, 105	30.00
31. 00 03100 INTENSIVE CARE UNIT	25, 911	83, 715		14, 369	4, 837	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	419, 618	314, 423		116, 031	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	-	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	4, 341	4, 428		40.350	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03440 MAMMOGRAPHY	386, 537 48, 534	149, 880 5, 675		60, 350	0	54. 00 54. 01
56. 00 05600 RADI OI SOTOPE	69, 053	8, 857		0	0	56.00
56. 01 03630 ULTRA SOUND	98, 458	7, 676		o	0	56. 01
57.00 05700 CT SCAN	113, 982	12, 400		8, 981	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	84, 174	61, 736	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	-	0	0	59.00
60. 00 06000 LABORATORY	735, 210	64, 820	0	41, 670	0	60.00
60. 01 06001 BLOOD LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	24, 990	5, 905	0	0	0	60. 01 62. 00
65. 00 06500 RESPIRATORY THERAPY	145, 699	18, 304		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	295, 769	110, 483	•	30, 534	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	58, 391	10, 038		8, 262	0	67.00
68.00 06800 SPEECH PATHOLOGY	21, 501	3, 543	0	7, 544	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69. 01 03160 CARDI OPULMONARY	127, 297	66, 395		23, 350	0	69. 01
69. 02 03650 VASCULAR LAB 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	508	3, 543 0	1	8, 981	0	69. 02 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 490	0	il .	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	532	0	Ö	o	0	73.00
73. 01 03480 ONCOLOGY	o	0	0	O	0	73. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00 07800 CAR T-CELL I MMUNOTHERAPY	0	0	0	0	0	78. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	2, 664, 610	307, 829	0	53, 166	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	2,004,010	0 0	o o	0	0	l
91. 00 09100 EMERGENCY	1, 113, 178	231, 692	48, 931	145, 847	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	9, 129, 084	2, 271, 030	154, 109	888, 731	406, 942	
NONREI MBURSABLE COST CENTERS) 1,121,1001	2,2,1,000	1017107	000, 701	1007 7 12	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	39, 517	29, 687	0	0		190. 00
190. 01 19001 FOUNDATI ON	25, 634	0	1	0		190. 01
190. 02 19002 DURABLE MEDI CAL EQUI P-RENTED	0	0 0 0 0	0	10, 200		190. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 INDUSTRIAL MEDICINE	14, 260 282	85, 355		19, 398		192. 00 194. 00
194. 00 07950 TND05TRFAL MEDICINE 194. 01 07951 RESEARCH	202	0		ol Ol		194. 00
200.00 Cross Foot Adjustments		O]	ĭ	O	200.00
201.00 Negative Cost Centers	0	0	0	О		201. 00
202.00 TOTAL (sum lines 118 through 201)	9, 208, 777	2, 386, 072	154, 109	908, 129	406, 942	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 OSF SAINT LUKE MEDICAL CENTER | Peri od: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-1325

				10	09/30/2023	Date/IIme Pre 2/24/2024 6:3	
Cost Center Description	CA	FETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, p
			ADMI NI STRATI O	SERVICES &		RECORDS &	
		11 00	N 13.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS		11. 00	13. 00	14. 00	15. 00	16. 00	
1. 00 00100 CAP REL COSTS-BLDG & FI	XT			T	T		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQU							2.00
4.00 00400 EMPLOYEE BENEFITS DEPAR	l l						4.00
5.00 00500 ADMINISTRATIVE & GENERA	ıL						5.00
7.00 00700 OPERATION OF PLANT							7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8. 00
9. 00 00900 HOUSEKEEPI NG							9. 00
10. 00 01000 DI ETARY							10.00
11. 00 01100 CAFETERI A		385, 683	0/7 574				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	N V	6, 468	867, 571	227 450			13.00
14. 00 01400 CENTRAL SERVICES & SUPP 15. 00 01500 PHARMACY	'L Y	8, 584 6, 468	43, 439	337, 450 6, 603	2, 088, 563		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRA	.DV	0, 400	43, 439 0	0, 603	2,000,503	100, 583	16.00
17. 00 01700 SOCIAL SERVICE		0	0	0	o	0	17.00
INPATIENT ROUTINE SERVICE COS	ST CENTERS	<u>_</u>	<u> </u>	<u> </u>	<u> </u>		17.00
30. 00 03000 ADULTS & PEDIATRICS		45, 364	304, 671	19, 003	0	2, 208	30.00
31.00 03100 INTENSIVE CARE UNIT		1, 043	7, 006	0	0	57	31.00
ANCILLARY SERVICE COST CENTER	RS				<u> </u>		
50. 00 05000 OPERATI NG ROOM		19, 254	129, 315	52, 816	0	3, 913	1
52. 00 05200 DELI VERY ROOM & LABOR R	ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY		507	0	723	0	779	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03440 MAMMOGRAPHY		17, 436	0	1, 069	0	3, 608	54. 00 54. 01
56. 00 05600 RADI 0I SOTOPE		3, 785 0	0	1, 225 577	0	1, 021 1, 385	1
56. 01 03630 ULTRA SOUND		7, 213	0	1, 798	0	1, 966	56.00
57. 00 05700 CT SCAN		8, 346	0	19, 890	0	15, 439	1
58. 00 05800 MAGNETIC RESONANCE IMAG	ING (MRI)	5, 872	0	3, 900	0	5, 491	
59. 00 05900 CARDI AC CATHETERI ZATI ON	, ,	O	0	0	О	0	59.00
60. 00 06000 LABORATORY		38, 360	0	131, 707	0	21, 388	60.00
60. 01 06001 BLOOD LABORATORY		0	0	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RE	D BLOOD CELLS	89	0	0	0	289	62.00
65. 00 06500 RESPI RATORY THERAPY		10, 492	0	5, 105	0	1, 943	1
66. 00 06600 PHYSI CAL THERAPY		24, 500	0	568	0	2, 652	1
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		4, 173	0	176	0	657	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		1, 639 0	0	10	0	121 0	68. 00 69. 00
69. 01 03160 CARDI OPULMONARY		9, 866	0	414	0	4, 216	1
69. 02 03650 VASCULAR LAB		0	0	0	Ö	798	
71.00 07100 MEDICAL SUPPLIES CHARGE	D TO PATIENTS	o	0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO P		o	0	0	0	342	72.00
73.00 07300 DRUGS CHARGED TO PATIEN	ITS	o	0	0	2, 088, 563	6, 608	73.00
73. 01 03480 ONCOLOGY		0	0	0	0	0	73. 01
77.00 07700 ALLOGENEIC HSCT ACQUISI	l l	0	0	0	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAP		0	0	0	0	0	78. 00
88.00 08800 RURAL HEALTH CLINIC	:KS	105, 092	0	26, 043	0	11, 965	88.00
89. 00 08900 FEDERALLY QUALIFIED HEA	ITH CENTER	103, 092	0	20, 043	o	11, 403	
91. 00 09100 EMERGENCY	JENTER	57, 048	383, 140	65, 732	o	13, 737	
92.00 09200 OBSERVATION BEDS (NON-D	ISTINCT PART)	21, 210	222,				92.00
OTHER REIMBURSABLE COST CENTE		'		<u>'</u>	<u>'</u>		
102.00 10200 OPI OID TREATMENT PROGRA	M	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS							
113. 00 11300 INTEREST EXPENSE		004 500	0/7 574	007.050	0 000 540	400 500	113.00
118. 00 SUBTOTALS (SUM OF LINES	1 through 11/)	381, 599	867, 571	337, 359	2, 088, 563	100, 583	1118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SH	IOD & CANTEEN	4, 054	0	6	٥	0	190. 00
190. 00 19000 GTFT, FLOWER, COFFEE 3F	IOP & CANTEEN	4, 034	0	6	0		190.00
190. 02 19002 DURABLE MEDICAL EQUIP-R	RENTED	n	n	0	0		190.01
192. 00 19200 PHYSI CI ANS' PRI VATE OFF		ő	o O	85	ol O		192.00
194. 00 07950 I NDUSTRI AL MEDI CI NE	-	30	Ö	0	ol		194.00
194. 01 07951 RESEARCH		O	o	0	0		194. 01
200.00 Cross Foot Adjustments							200. 00
201.00 Negative Cost Centers		0	0	0	0		201.00
202.00 TOTAL (sum lines 118 th	rough 201)	385, 683	867, 571	337, 450	2, 088, 563	100, 583	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1325 Peri od: Worksheet B From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/24/2024 6:39 pm Cost Center Description SOCI AL Intern & Total Subtotal SERVI CE Resi dents Cost & Post Stepdown Adjustments 17. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 348, 754 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 344.608 5, 242, 918 5, 242, 918 30.00 0 31.00 03100 INTENSIVE CARE UNIT 4, 146 219, 706 219, 706 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 334, 412 50.00 2.334.412 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 0 23, 951 0 23, 951 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0000000000000000000 1, 809, 453 0 1, 809, 453 54.00 207, 505 54 01 03440 MAMMOGRAPHY 0 207. 505 54 01 05600 RADI OI SOTOPE 0 56.00 289, 398 289, 398 56.00 56.01 03630 ULTRA SOUND 415, 858 415, 858 56.01 0 57.00 05700 CT SCAN 524, 889 524, 889 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 416, 579 416, 579 58 00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 3, 263, 972 3, 263, 972 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 107, 100 62 00 107, 100 62 00 06500 RESPIRATORY THERAPY 0 65.00 623, 632 623, 632 65.00 06600 PHYSI CAL THERAPY 1, 380, 800 66.00 1, 380, 800 66.00 67.00 06700 OCCUPATI ONAL THERAPY 258.871 0 258, 871 67.00 06800 SPEECH PATHOLOGY 0 99, 597 68.00 68.00 99, 597 69.00 06900 ELECTROCARDI OLOGY 69.00 69.01 03160 CARDI OPULMONARY 625, 674 625, 674 69.01 03650 VASCULAR LAB 15, 371 69.02 69.02 15, 371 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 42,660 0 42,660 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 2,097,316 2, 097, 316 73.00 0 73.01 03480 ONCOLOGY 0 73.01 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 11, 253, 826 0 11, 253, 826 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 09100 EMERGENCY 0 0 91.00 5, 436, 973 5, 436, 973 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 348, 754 0 118.00 36, 690, 461 36, 690, 461 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 193, 168 0 193, 168 190. 01 19001 FOUNDATION 0 0 190.01 103, 414 103, 414 190. 02 19002 DURABLE MEDICAL EQUIP-RENTED 0 190.02 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 162, 367 0 162, 367 192.00 0 194. 00 07950 INDUSTRIAL MEDICINE 0 194. 00 1.168 1, 168 0 194. 01 07951 RESEARCH 194.01 0 C 0 200.00 Cross Foot Adjustments 0 0 200.00 C 201.00 Negative Cost Centers 0 0 201.00 ō TOTAL (sum lines 118 through 201) 348, 754 37, 150, 578 37, 150, 578 202.00 202.00

| Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1325

				То	09/30/2023	Date/Time Pre 2/24/2024 6:3	
			CAPI TAL REI	LATED COSTS		2/24/2024 0.3	y pili
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs				DEFARTIVIENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P			00	00	00	2.00
4. 00 5. 00	OO4OO EMPLOYEE BENEFITS DEPARTMENT OO5OO ADMINISTRATIVE & GENERAL	0	0 244, 119		90 304, 742	90	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	0	116, 037		193, 359		7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	5, 909		5, 909		8. 00
9.00	00900 HOUSEKEEPI NG	0	11, 361		11, 361	3	9.00
10.00	01000 DI ETARY	0	31, 628	11, 889	43, 517	1	10.00
11. 00	01100 CAFETERI A	0	10, 790		10, 790		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	4, 111	0	4, 111	1	13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0	0 19, 425		11, 414 75, 473	1 1	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	7, 022		7, 022		16.00
	01700 SOCIAL SERVICE	0	0		0, 022		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
	03000 ADULTS & PEDIATRICS	0			425, 164	8	30.00
31. 00	03100 INTENSI VE CARE UNI T	0	36, 424	0	36, 424	0	31. 00
FO 00	ANCILLARY SERVICE COST CENTERS		127 002	252 412	200 21/	2	F0 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	136, 803 0		389, 216 0	3	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	1, 927	-	8, 493		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	65, 212		133, 278	3	54.00
54. 01	03440 MAMMOGRAPHY	0	2, 469		2, 469	1	54. 01
56.00	05600 RADI OI SOTOPE	0	3, 854		3, 854	0	56. 00
56. 01	03630 ULTRA SOUND	0	3, 340		3, 562	1	56. 01
57. 00	05700 CT SCAN	0	5, 395		5, 395		57.00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	26, 861 0	2, 408	29, 269 0	1 0	58. 00 59. 00
60.00	06000 LABORATORY	0	28, 203	_	119, 556		60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	Ö	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2, 569	0	2, 569	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	7, 964		29, 336	2	65.00
66.00	06600 PHYSI CAL THERAPY	0	48, 070		58, 118		66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	4, 367 1, 541	934	4, 367 2, 475	1 0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 541		2, 475	0	69.00
69. 01	03160 CARDI OPULMONARY	0	28, 888	-	59, 276		69. 01
69. 02	03650 VASCULAR LAB	0	1, 541	0	1, 541	0	69. 02
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 73. 01	O7300 DRUGS CHARGED TO PATIENTS O3480 ONCOLOGY	0	0	0	0	0	73. 00 73. 01
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	Ö	0	_	78.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	133, 934	31, 055	164, 989		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	100, 808	29, 467	130, 275 0		91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS				U		92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
118.00	7	0	1, 348, 265	929, 149	2, 277, 414	90	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	12 017		12 017	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 917 0		12, 917 6, 950		190. 00
	19002 DURABLE MEDICAL EQUIP-RENTED	0	0	0, 730	0, 930		190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	37, 137		37, 137		192.00
194.00	07950 INDUSTRIAL MEDICINE	0	0	0	0	0	194. 00
	07951 RESEARCH	0	0	0	0		194. 01
200.00			_		0		200.00
201. 00 202. 00		0	0 1, 398, 319	936, 099	0 2, 334, 418		201. 00 202. 00
202.00	TOTAL (Sum Times The till bugil 201)	1	1,370,319	730, 079	2, 334, 410	1 70	₁ 202.00

Health Financial Systems

OSF SAINT LUKE MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2022
From 10/01/2022
To 09/30/2023

Date/Time Prepared:
2/24/2024 6: 39 pm

Cost Center Description

ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPING DIETARY

E & GENERAL PLANT LINEN SERVICE

5.00 7.00 8.00 9.00 10.00

GENERAL SERVICE COST CENTERS

1.00 00100 CAP REL COSTS BLDG & FIXT
2.00 00200 CAP REL COSTS MANUE FOULD

		Cost Center Description	ADMI NI STRATI V		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			E & GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	204 740					4.00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	304, 748 19, 574					5. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	1, 153					8.00
9. 00	1	HOUSEKEEPI NG	7, 099			21, 684		9.00
10.00		DI ETARY	2, 497			712	53, 214	
11. 00		CAFETERI A	2, 960			0	0	11.00
13.00		NURSING ADMINISTRATION	6, 907	843		232	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2, 606	0	4	266	0	14.00
15.00		PHARMACY	16, 233			206	0	15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	693			0	0	16.00
17. 00		SOCIAL SERVICE	2, 811	0	0	146	0	17. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	2/ 170	E2 0E7	2.052	7.044	F2 F01	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	26, 170 858			7, 266 343	52, 581 633	30. 00 31. 00
31.00		LARY SERVICE COST CENTERS	000	7,471	0	343	033	31.00
50.00		OPERATING ROOM	13, 887	28, 059	312	2, 771	0	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	0			2, , , 1	0	52.00
53.00		ANESTHESI OLOGY	144	395		0	0	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	12, 792	13, 375	951	1, 441	0	54.00
54. 01	03440	MAMMOGRAPHY	1, 606		0	0	0	54. 01
56.00		RADI OI SOTOPE	2, 285			0	0	56.00
56. 01		ULTRA SOUND	3, 258			0	0	56. 01
57. 00		CT SCAN	3, 772			214	0	57.00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	2, 786			0	0	58.00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	0	_	0 995	0	59. 00 60. 00
60.00	1	BLOOD LABORATORY	24, 332	5, 785 0		995	0	60.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	827	527		0	0	62.00
65. 00		RESPIRATORY THERAPY	4, 822			Ö	0	65.00
66. 00		PHYSI CAL THERAPY	9, 788			729	0	66.00
67.00		OCCUPATI ONAL THERAPY	1, 932			197	0	67.00
68.00	06800	SPEECH PATHOLOGY	712	316	0	180	0	68. 00
69. 00		ELECTROCARDI OLOGY	0	0	_	0	0	69. 00
69. 01		CARDI OPULMONARY	4, 213			558	0	69. 01
69. 02		VASCULAR LAB	17	316		214	0	69. 02
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1		0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	347 18	0	0	0	0	72. 00 73. 00
73.00		ONCOLOGY	10			0	0	73.00
77. 00		ALLOGENEIC HSCT ACQUISITION	0	Ö		Ö	0	77.00
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0		o	0	78.00
		TIENT SERVICE COST CENTERS				- 1		
88.00	08800	RURAL HEALTH CLINIC	88, 172	27, 471	0	1, 269	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
		EMERGENCY	36, 840	20, 676	2, 628	3, 482	0	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
400.00		REIMBURSABLE COST CENTERS						100.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113 00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	302, 111	202, 669	8, 274	21, 221	53, 214	
110.00		IMBURSABLE COST CENTERS	002,111	202,007	0,271	21,221	00,211	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 308	2, 649	0	0	0	190. 00
190. 01	1 19001	FOUNDATI ON	848		0	0	0	190. 01
		DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190. 02
	1	PHYSICIANS' PRIVATE OFFICES	472	7, 617	0	463		192. 00
		I NDUSTRI AL MEDI CI NE	9	0	0	0		194.00
		RESEARCH	0	0	0	0	0	194. 01
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers	_	_			0	200. 00 201. 00
201.00	1	TOTAL (sum lines 118 through 201)	304, 748	212, 935	8, 274	21, 684	53, 214	
202.00	-1	1.5 (Sam 111105 110 till bagir 201)	307,740	1 212,733	0,274	21,004	55, 214	1-02.00

Health Financial Systems OSF SAINT LUKE MEDICAL CENTER In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325
From 10/01/2022
To 09/30/2023 Date/Time Prepared:

				То	09/30/2023	Date/Time Pre 2/24/2024 6:3	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL) piii
			ADMINISTRATIO	SERVICES &		RECORDS &	
		11. 00	N 13. 00	SUPPLY 14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	15, 964					10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	268	ł				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	355	•	14, 646			14. 00
15.00	01500 PHARMACY	268	619	287	97, 071		15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	•		0	9, 155	1
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 878	4, 341	825	0	200	30.00
31. 00	03100 NTENSI VE CARE UNI T	43		0	o	5	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	797	1, 843		0	355	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0 0		0	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	21 722		31	0	71 328	53. 00 54. 00
54. 01	03440 MAMMOGRAPHY	157	0	53	o	93	
56.00	05600 RADI OI SOTOPE	0		25	0	126	56.00
56. 01	03630 ULTRA SOUND	299		78	0	178	
57. 00 58. 00	05700 CT SCAN	345		863	0	1, 402	
59.00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	243		169	0	499 0	ı
60.00	06000 LABORATORY	1, 588	-	5, 717	Ö	1, 963	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4	0		0	26	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	434 1, 014		222 25	0	176 241	65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	173		8	0	60	1
68. 00	06800 SPEECH PATHOLOGY	68	•	1	ő	11	68.00
69. 00	06900 ELECTROCARDI OLOGY	0		0	0	0	1
69. 01	03160 CARDI OPULMONARY	408			0	383	1
69. 02	03650 VASCULAR LAB	0		1	0	72	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 31	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		97, 071	600	1
73. 01	03480 ONCOLOGY	0	0	Ö	0	0	73. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	4, 349	1	1, 130	ol	1 087	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			o	1,007	
91.00	09100 EMERGENCY	2, 361	5, 459	2, 853	0	1, 248	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
100.00	OTHER REIMBURSABLE COST CENTERS	1 0	Ι ο		ما		100.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113.00	11300 I NTEREST EXPENSE						113.00
118.00	1 1	15, 795	12, 362	14, 642	97, 071	9, 155	118.00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	168		1	0		190.00
	19001 FOUNDATION 19002 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		190. 01 190. 02
	19002 DURABLE MEDICAL EQUIP-RENTED	0	0	4	0		190.02
	07950 I NDUSTRI AL MEDI CI NE	1	0	o o	Ö	0	194.00
194. 01	07951 RESEARCH	0	0	0	0	0	194. 01
200.00						_	200.00
201. 00 202. 00		15, 964	0 12, 362	14, 646	0 97, 071		201. 00 202. 00
∠UZ. UC	I TOTAL (Sum TIMES TTO LIMOUGH 201)	15, 964	12, 302	14,040	91,011	9, 105	1202. UU

Heal th	Financial Systems	OSF SAINT LUKE M	EDICAL CENTER		In Lie	u of Form CMS-2552-10
ALLOCA	NTION OF CAPITAL RELATED COSTS		Provi der CO		Period: From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Prepared: 2/24/2024 6:39 pm
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS			Г		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					16.00
17. 00	01700 SOCIAL SERVICE	2, 957				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	2, 922	576, 265		576, 265	30.00
31. 00	03100 INTENSI VE CARE UNI T	35	45, 912		0 45, 912	31.00
E0 00	ANCILLARY SERVICE COST CENTERS		420 F2F		120 525	F0 00
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	439, 535 0		0 439, 535 0 0	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	9, 155		9, 155	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	162, 936		162, 936	54.00
54. 01	03440 MAMMOGRAPHY	0	4, 885		0 4, 885	54. 01
56.00	05600 RADI 0I SOTOPE	0	7, 080		7, 080	56. 00
56. 01	03630 ULTRA SOUND	0	8, 061		8, 061	56. 01
57. 00 58. 00	05700 CT SCAN	0	13, 099		0 13, 099 0 38, 476	57.00
59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	38, 476		0 38, 476 0 0	58. 00 59. 00
60. 00	06000 LABORATORY		159, 941		0 159, 941	60.00
60. 01	06001 BLOOD LABORATORY	o	0		0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3, 953		3, 953	62.00
65.00	06500 RESPI RATORY THERAPY	0	36, 626		36, 626	65. 00
66.00	06600 PHYSI CAL THERAPY	0	80, 791		0 80, 791	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	7, 634 3, 762		0 7, 634 0 3, 762	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	0	3, 702 0		0 3, 762	69.00
69. 01	03160 CARDI OPULMONARY		71, 206		71, 206	69. 01
69. 02	03650 VASCULAR LAB	0	2, 160		2, 160	69. 02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	378		0 378	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	97, 689		97, 689	73.00
73.01	03480 ONCOLOGY 07700 ALLOGENEIC HSCT ACQUISITION	0	0			73. 01 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0			78.00
	OUTPATIENT SERVICE COST CENTERS	-1			-, -,	
88. 00	08800 RURAL HEALTH CLINIC	0	288, 498		0 288, 498	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	89. 00
91.00	09100 EMERGENCY	0	205, 833		0 205, 833	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0	92. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			0 0	102.00
113.00	11300 I NTEREST EXPENSE					113. 00
118.00) 2, 957	2, 263, 875		0 2, 263, 875	118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 042		0 17, 042	190.00
	19001 FOUNDATION 19002 DURABLE MEDICAL EQUIP-RENTED		7, 798		0 7, 798 0 0	190. 01 190. 02
	19002 DURABLE MEDICAL EQUIP-RENTED		45, 693		0 45, 693	190.02
	07950 INDUSTRIAL MEDICINE		10		0 10	194. 00
194. 01	07951 RESEARCH	0	0		0 0	194. 01
200.00	1 1		0		0 0	200.00
201.00		0	2 224 440		0 2 224 419	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 957	2, 334, 418	·	0 2, 334, 418	202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1325 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV (SQUARE FEET) (DOLLAR BENEFITS F & GENERAL n DEPARTMENT (ACCUM. COST) VALUE) (GROSS SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 97.972 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 569, 984 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 15, 044, 884 4.00 55 4.00 00500 ADMINISTRATIVE & GENERAL 27, 941, 801 5.00 17, 104 36, 913 934, 344 -9, 208, 777 5.00 7.00 00700 OPERATION OF PLANT 8, 130 47,081 290, 161 1, 794, 619 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 414 10, 787 0 105, 694 8.00 00900 HOUSEKEEPI NG 796 0 650, 902 9 00 432 072 9 00 0 10.00 01000 DI ETARY 2, 216 7, 239 99, 111 228, 971 10.00 11.00 01100 CAFETERI A 756 204, 312 271, 428 11.00 13.00 01300 NURSING ADMINISTRATION 288 199, 777 0 0 633, 255 13.00 01400 CENTRAL SERVICES & SUPPLY 6, 950 14 00 131, 690 238, 922 14 00 Ω 15.00 01500 PHARMACY 1, 361 34, 127 241, 904 1, 488, 290 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 492 0 63, 512 16.00 01700 SOCIAL SERVICE 0 257, 713 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18, 055 101, 972 1, 411, 733 0 2, 399, 408 30.00 03100 INTENSIVE CARE UNIT 31.00 2, 552 32, 014 0 78, 622 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9,585 153, 693 562, 341 0 1, 273, 229 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 53.00 05300 ANESTHESI OLOGY 135 3, 998 988 13.173 53.00 472, 731 05400 RADI OLOGY-DI AGNOSTI C 54 00 4,569 41, 445 1, 172, 851 54 00 0 54.01 03440 MAMMOGRAPHY 173 105, 817 147, 265 54.01 05600 RADI OI SOTOPE 0 209, 526 56.00 270 56.00 0 03630 ULTRA SOUND 227, 086 298, 747 56.01 234 135 56.01 05700 CT SCAN 57.00 378 212, 100 345, 851 57.00 1, 466 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,882 157, 974 0 0 0 255, 406 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 59 00 06000 LABORATORY 911, 595 2, 230, 817 60.00 60.00 1,976 55, 624 06001 BLOOD LABORATORY 60.01 60.01 \cap 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 180 1,810 75,827 62.00 06500 RESPIRATORY THERAPY 65.00 558 13, 013 282, 885 0 0 442, 089 65.00 897, 438 06600 PHYSI CAL THERAPY 66.00 653, 338 3, 368 6, 118 66, 00 06700 OCCUPATI ONAL THERAPY 67.00 306 129, 770 177, 174 67.00 0 68.00 06800 SPEECH PATHOLOGY 108 569 46,034 65, 239 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 0 03160 CARDI OPULMONARY 2,024 18, 503 251, 503 386, 253 69 01 69 01 0 69.02 03650 VASCULAR LAB 108 0 1,541 69.02 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 31,828 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 1, 613 73.00 73.01 03480 ONCOLOGY 0 73.01 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 \cap 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 9, 384 18, 909 5, 142, 425 0 8, 085, 121 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 91.00 09100 EMERGENCY 7,063 17, 942 1, 825, 876 0 3, 377, 668 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102, 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 94, 465 565, 752 14, 972, 178 -9, 208, 777 27, 699, 992 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 905 71,876 119, 904 190, 00 190. 01 19001 FOUNDATI ON 0 77, 780 190. 01 0 4.232 0 190. 02 19002 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 190.02 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 43, 269 192, 00 2.602 C 194. 00 07950 INDUSTRIAL MEDICINE 830 0 856 194.00 C 0 194.01 194. 01 07951 RESEARCH 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 1, 398, 319 4, 013, 481 9, 208, 777 202. 00 936, 099 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 14. 272639 1.642325 0. 329570 203. 00 0.266767 Cost to be allocated (per Wkst. B, 304, 748 204. 00 204.00 90 Part II)

OSF SAINT LUKE I	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
			To 09/30/2023		
CAPI TAL REI	LATED COSTS				
BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
(SQUARE FEET)	(DOLLAR	BENEFITS	n	E & GENERAL	
	VALUE)	DEPARTMENT		(ACCUM. COST)	
		(GROSS			
		SALARI ES)			
1. 00	2. 00	4. 00	5A		
		0. 00000	6	0. 010907	205. 00
d					206. 00
					207. 00
	CAPITAL REI BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) WVBLE EQUIP (DOLLAR VALUE) 1.00 2.00	CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP (SQUARE FEET) (DOLLAR VALUE) EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 1.00 2.00 4.00 0.00000	Provider CCN: 14-1325	Provider CCN: 14-1325

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1325 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (PATI ENT PLANT (TIME SPENT) (FTE'S) (SQUARE FEET) (POUNDS OF DAYS) I AUNDRY) 7. 00 10.00 11.00 9.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 72, 738 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 414 16, 305 8 00 1, 756 9.00 00900 HOUSEKEEPI NG 796 9.00 2,528 10.00 01000 DI ETARY 2, 216 83 1, 346 10.00 01100 CAFETERI A 12, 940 11.00 756 11.00 C 0 01300 NURSING ADMINISTRATION 13.00 288 C 27 0 217 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 31 0 288 14.00 15.00 01500 PHARMACY 1, 361 24 0 217 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 492 0 0 C 0 01700 SOCIAL SERVICE 17.00 17 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18, 055 1, 330 1, 522 30.00 4.046 847 03100 INTENSIVE CARE UNIT 2, 552 31.00 40 16 35 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 585 615 323 646 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 0 0 05300 ANESTHESI OLOGY 53.00 135 0 17 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4,569 1,875 168 0 585 54.00 03440 MAMMOGRAPHY 54.01 173 0 0 0 127 54.01 0 56 00 05600 RADI OI SOTOPE 270 0 56 00 Ω 0 56.01 03630 ULTRA SOUND 234 C 0 242 56.01 57.00 05700 CT SCAN 378 25 280 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 197 1.882 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 C 0 0 59.00 60.00 06000 LABORATORY 1,976 C 116 1, 287 60.00 60.01 06001 BLOOD LABORATORY C 0 0 0 0 60.01 0 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 180 C 0 62 00 06500 RESPIRATORY THERAPY 65.00 558 0 352 65.00 06600 PHYSI CAL THERAPY 1, 995 0 0 0 822 66.00 3.368 85 66.00 67.00 06700 OCCUPATI ONAL THERAPY 306 23 140 67.00 06800 SPEECH PATHOLOGY 68 00 108 21 55 68 00 C 69.00 06900 ELECTROCARDI OLOGY 0 C 0 0 69.00 0 03160 CARDI OPULMONARY 331 69.01 69.01 2.024 834 65 69.02 03650 VASCULAR LAB 108 25 0 0 69.02 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 C 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 0 73.00 03480 ONCOLOGY 0 73.01 0 0 73.01 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 148 9, 384 0 0 3,526 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 r 0 0 Λ 89.00 09100 EMERGENCY 7,063 ol 1,914 91.00 5, 177 406 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 69, 231 16, 305 2, 474 1, 346 12, 803 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 905 n 136 190. 00 0 190.01 190. 01 19001 FOUNDATI ON 0 C 0 0 190. 02 19002 DURABLE MEDICAL EQUIP-RENTED 0 C 0 0 0 190.02 0 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 2,602 54 0 194. 00 07950 I NDUSTRI AL MEDI CI NE 0 194.00 C 0 194. 01 07951 RESEARCH 0 194, 01 0 C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 385, 683 202. 00 202.00 Cost to be allocated (per Wkst. B, 2.386.072 154, 109 908. 129 406, 942 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 32. 803651 9. 451641 359. 228244 302. 334324 29. 805487 203. 00 15, 964 204. 00 204.00 Cost to be allocated (per Wkst. B, 212, 935 8, 274 21,684 53, 214 Part II) 205.00 1. 233694 205. 00 Unit cost multiplier (Wkst. B, Part 2.927424 0.507452 8.577532 39. 534918 11)

Health Financial Systems 0	SF SAINT LUKE	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 10/01/2022 To 09/30/2023	Date/Time Pre 2/24/2024 6:3	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO		CAFETERI A	
	PLANT	LINEN SERVICE	(TIME SPENT)	(PATI ENT	(FTE' S)	
	(SQUARE FEET)	(POUNDS OF		DAYS)		
		LAUNDRY)				
	7. 00	8. 00	9. 00	10.00	11. 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)						

Heal th Fi	nancial Systems (OSF SAINT LUKE M	EDICAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provi der C		Period: From 10/01/2022	Worksheet B-1	
					To 09/30/2023	Date/Time Pro 2/24/2024 6:3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	S0CI AL) DIII
	'	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	
		N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(NURSI NG	(COSTED		(GROSS		
		FTE' S) 13. 00	REQUI S.) 14. 00	15.00	CHARGES) 16.00	17. 00	
GEI	NERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	17.00	
	100 CAP REL COSTS-BLDG & FLXT						1.00
1	200 CAP REL COSTS-MVBLE EQUIP						2.00
1	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT						5. 00 7. 00
	800 LAUNDRY & LINEN SERVICE						8.00
	900 HOUSEKEEPI NG						9. 00
	000 DI ETARY						10.00
	100 CAFETERI A	4 224					11.00
	300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY	4, 334	1, 081, 957	,			13. 00 14. 00
	500 PHARMACY	217	21, 170		o		15. 00
16. 00 016	600 MEDICAL RECORDS & LIBRARY	0	0		106, 265, 905		16.00
	700 SOCIAL SERVICE	0	0)	0	1, 346	17. 00
	PATIENT ROUTINE SERVICE COST CENTERS	4 500	/0.000		0 004 044	4 000	00.00
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	1, 522 35	60, 928 0		2, 331, 211 60, 655	1, 330 16	1
	CILLARY SERVICE COST CENTERS	33		'I	5 00,033	10	31.00
	OOO OPERATING ROOM	646	169, 342	2	4, 132, 070	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 0	0	52.00
	300 ANESTHESI OLOGY	0	2, 319	1	822, 927	0	
	400 RADI OLOGY-DI AGNOSTI C 440 MAMMOGRAPHY	0	3, 427 3, 927		3, 809, 688 1, 078, 666	0	54. 00 54. 01
4	600 RADI OI SOTOPE	0	1, 851	1	1, 462, 993	0	56.00
	630 ULTRA SOUND	0	5, 766	1	2, 075, 506	0	56. 01
1	700 CT SCAN	0	63, 774	1	16, 303, 131	0	57.00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	12, 506	1	5, 797, 886	0	58.00
	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY	0	422, 285	•	0 22, 636, 992	0	59. 00 60. 00
	001 BLOOD LABORATORY	o	0		0 0	0	60. 01
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)	305, 390	0	62.00
	500 RESPI RATORY THERAPY	0	16, 368	1	2, 052, 245	0	65.00
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	0	1, 821	1	2, 800, 170	0	66. 00 67. 00
	800 SPEECH PATHOLOGY	0	563 31	1	694, 131 127, 555	0	68.00
	900 ELECTROCARDI OLOGY	O	0		0 127,000	0	
	160 CARDI OPULMONARY	0	1, 328	3	4, 451, 623	0	
	650 VASCULAR LAB	0	0		842, 625	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS		0		361, 017	0	
	300 DRUGS CHARGED TO PATTENTS	0	0	1	· ·	0	1
	480 ONCOLOGY	o	0	1	0	Ō	
	700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0 0	0	
	800 CAR T-CELL IMMUNOTHERAPY	0	0)	0 0	0	78. 00
	TPATIENT SERVICE COST CENTERS 800 RURAL HEALTH CLINIC	0	83, 502		12, 634, 815	0	88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	03, 302	1	0 12,034,013	0	
91.00 09	100 EMERGENCY	1, 914	210, 756	,	14, 506, 288	0	1
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	HER REIMBURSABLE COST CENTERS 200 OPIOID TREATMENT PROGRAM	0	0	1	0 (0	102.00
	ECIAL PURPOSE COST CENTERS	J U	0	'	5 0	0	1102.00
	300 I NTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 334	1, 081, 664	10	106, 265, 905	1, 346	118. 00
	NREIMBURSABLE COST CENTERS OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN		19	1	0 (0	190. 00
	001 FOUNDATION	0	0	1	0		190.00
	DO2 DURABLE MEDICAL EQUIP-RENTED	0	0)	0		190. 02
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	274		0		192.00
	950 I NDUSTRI AL MEDI CI NE	0	0		0		194.00
200.00	951 RESEARCH Cross Foot Adjustments		U	'	0	0	194. 01 200. 00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	867, 571	337, 450	2, 088, 56	3 100, 583	348, 754	202. 00
202 62	Part I)	200 47705	0.011055	20 005 1005	0.0000:=		
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	200. 177896 12, 362	0. 311889 14, 646			259. 104012 2 957	203.00
204.00	Part II)	12, 302	14, 040	77,07	7, 133	2, 737	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	2. 852330	0. 013537	970. 71000	0. 000086	2. 196880	205. 00
	11)			<u> </u>		<u> </u>	<u> </u>

Health Financial Systems	05	SF SAINT LUKE N	MEDICAL CENTER		In Lieu of Form CMS-		
COST ALLOCATION - STATISTICAL BASIS				Peri od:	Worksheet B-1		
					From 10/01/2022 To 09/30/2023	Date/Time Pre 2/24/2024 6:3	
Cost Center Description		NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	
		N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(NURSI NG	(COSTED		(GROSS		
		FTE' S)	REQUIS.)		CHARGES)		
		13. 00	14. 00	15. 00	16.00	17. 00	
206.00 NAHE adjustment amount t	to be allocated						206.00
(per Wkst. B-2)							
207.00 NAHE unit cost multiplie	er (Wkst. D,						207.00
Parts III and IV)							

Health Financial Systems	OSF SAINT LUKE MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1325	Peri od: From 10/01/2022	Worksheet C Part I

					From 10/01/2022 To 09/30/2023	Part I Date/Time Pre 2/24/2024 6:3	pared: 9 pm
			Title	XVIII	Hospi tal	Cost	
			<u> </u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	,				
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	5, 242, 918		5, 242, 91	8 0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	219, 706		219, 70	6 0	0	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 334, 412		2, 334, 41	2 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	23, 951		23, 95	1 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 809, 453		1, 809, 45	3 0	0	54.00
54. 01	03440 MAMMOGRAPHY	207, 505		207, 50	5 0	0	54.01
56.00	05600 RADI 0I S0T0PE	289, 398		289, 39	8 0	0	56.00
	03630 ULTRA SOUND	415, 858		415, 85	8 0	0	56. 01
57.00	05700 CT SCAN	524, 889		524, 88	9 0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	416, 579		416, 57	9 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
	06000 LABORATORY	3, 263, 972		3, 263, 97	2 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0			0 0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	107, 100		107, 10	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	623, 632	0	623, 63	2 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 380, 800	0	1, 380, 80	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	258, 871	0	258, 87	1 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	99, 597	0	99, 59	7 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0			0	0	69. 00
69. 01	03160 CARDI OPULMONARY	625, 674		625, 67	4 0	0	69. 01
	03650 VASCULAR LAB	15, 371		15, 37	1 0	0	69. 02
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	42, 660		42, 66	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 097, 316		2, 097, 31	6 0	0	73.00
	03480 ONCOLOGY	0			0 0	0	73. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0			0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	11, 253, 826		11, 253, 82		0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
	09100 EMERGENCY	5, 436, 973		5, 436, 97		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 299, 336		1, 299, 33	6	0	92.00
	OTHER REIMBURSABLE COST CENTERS	,		,	, , , , , , , , , , , , , , , , , , , ,		
	10200 OPIOID TREATMENT PROGRAM	0			O	0	102.00
	SPECIAL PURPOSE COST CENTERS	1		·			
	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	37, 989, 797	0				200.00
201.00	Less Observation Beds	1, 299, 336	_	1, 299, 33			201.00
202. 00	Total (see instructions)	36, 690, 461	0	36, 690, 46	1 0	0	202. 00

COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 10/01/2022	Worksheet C Part I	
					Fo 09/30/2023	Date/Time Pre	nared.
					10 077 007 2020	2/24/2024 6: 3	9 pm
			Title	XVIII	Hospi tal	Cost	
			Charges		· ·		
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	'	'	+ col. 7)	Ratio	I npati ent	
				,		Rati o	
		6. 00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	'			<u>'</u>		
30.00	03000 ADULTS & PEDIATRICS	1, 993, 249		1, 993, 24	7		30.00
31.00	03100 INTENSIVE CARE UNIT	60, 655		60, 65	5		31.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	48, 163	4, 083, 907	4, 132, 07	0. 564950	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0.000000	52.00
53.00	05300 ANESTHESI OLOGY	16, 923	806, 004	822, 92	0. 029105	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	100, 478	3, 709, 210	3, 809, 68	0. 474961	0.000000	54.00
54.01	03440 MAMMOGRAPHY	O	1, 078, 666	1, 078, 66	0. 192372	0.000000	54. 01
56.00	05600 RADI OI SOTOPE	24, 927	1, 438, 066	1, 462, 99	0. 197812	0.000000	56.00
56. 01	03630 ULTRA SOUND	21, 854	2, 053, 652	2, 075, 50		0.000000	56. 01
57.00	05700 CT SCAN	444, 130	15, 859, 001	16, 303, 13	0. 032196	0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	90, 884	5, 707, 002			0. 000000	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0.000000	1
60.00	06000 LABORATORY	1, 111, 592	21, 525, 400	22, 636, 99		0.000000	1
60. 01	06001 BLOOD LABORATORY	0	0	,	0. 000000	0. 000000	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	33, 157	272, 233	305, 39		0.000000	
65.00	06500 RESPIRATORY THERAPY	444, 207	1, 608, 038	2, 052, 24		0.000000	65.00
66. 00	06600 PHYSI CAL THERAPY	258, 779	2, 541, 391	2, 800, 17		0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	189, 414	504, 717	694, 13		0. 000000	
68. 00	06800 SPEECH PATHOLOGY	15, 263	112, 292	127, 55		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	. 0			0.000000	
69. 01	03160 CARDI OPULMONARY	235, 487	4, 216, 136	4, 451, 62		0.000000	
69. 02	03650 VASCULAR LAB	24, 340	818, 285	842, 62		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	J,		0. 000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	361, 017	361, 01		0. 000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	994, 168	5, 984, 153	6, 978, 32		0. 000000	1
73. 01	03480 ONCOLOGY	0	0	3,,		0. 000000	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	l o	0			0. 000000	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0		0. 000000	0. 000000	1
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			0.00000	0.00000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	12, 634, 815	12, 634, 81	5		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	l ol	0	,,			89. 00
91. 00	09100 EMERGENCY	356, 808	14, 149, 480	14, 506, 28	0. 374801	0. 000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	50, 762	287, 200	337, 96		0. 000000	1
72.00	OTHER REIMBURSABLE COST CENTERS	007.02	207, 200	00.770	- 0.011022	0.00000	12.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0				102.00
. 52. 00	SPECIAL PURPOSE COST CENTERS	٩			-1		1.32.00
113 00	11300 I NTEREST EXPENSE						113.00
200.00	1 1	6, 515, 240	99, 750, 665	106, 265, 90	5		200.00
201.00		3,313,240	, , , , , , , , , , , , , , , , , , ,				201.00
202.00	1 1	6, 515, 240	99, 750, 665	106, 265, 90	5		202.00
202.00	1.56. (500 11150 400 0115)	0,010,240	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100, 200, 70	~1	l	1-32.00

Health Financial Systems	OSF SAINT LUKE MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1325	From 10/01/2022	Worksheet C Part I Date/Time Prepared: 2/24/2024 6:39 pm

					2/24/2024 6: 39 pm
			Title XVIII	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00					31.00
	ANCILLARY SERVICE COST CENTERS				
50.00		0. 000000			50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00		0. 000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01	03440 MAMMOGRAPHY	0. 000000			54.01
56. 00	05600 RADI OI SOTOPE	0. 000000			56.00
56. 01	03630 ULTRA SOUND	0. 000000			56. 01
57. 00		0. 000000			57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000 0. 000000			59.00
	l l				
60.00	06000 LABORATORY	0.000000			60.00
60. 01	06001 BLOOD LABORATORY	0.000000			60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000			65.00
66.00		0. 000000			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00		0. 000000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01	03160 CARDI OPULMONARY	0. 000000			69. 01
69. 02		0. 000000			69. 02
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00		0. 000000			73.00
73. 01	03480 ONCOLOGY	0. 000000			73. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOLD TREATMENT PROGRAM				102.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 I NTEREST EXPENSE				113.00
200.00	l l				200.00
201.00					201.00
202.00	1				202.00
	(222 :)	1			1=02.00

Health Financial Systems	OSF SAINT LUKE MEDICAL C	ENTER	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi	der CCN: 14-1325	Peri od:	Worksheet C
			From 10/01/2022	Part I
			T- 00 /20 /2022	D-+- /T! D

			T	0 09/30/2023	Date/Time Pre 2/24/2024 6:3	pared:
		Ti tl	e XIX	Hospi tal	Cost	7 piii
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
· ·	(from Wkst.	Áďj.		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 242, 918		5, 242, 918	0	5, 242, 918	30.00
31.00 03100 INTENSIVE CARE UNIT	219, 706		219, 706	0	219, 706	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 334, 412		2, 334, 412	0	2, 334, 412	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	23, 951		23, 951	0	23, 951	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 809, 453		1, 809, 453	0	1, 809, 453	54.00
54. 01 03440 MAMMOGRAPHY	207, 505		207, 505	0	207, 505	54. 01
56. 00 05600 RADI 0I SOTOPE	289, 398		289, 398	0	289, 398	56.00
56. 01 03630 ULTRA SOUND	415, 858		415, 858	0	415, 858	56. 01
57. 00 05700 CT SCAN	524, 889		524, 889	0	524, 889	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	416, 579		416, 579	0	416, 579	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60. 00 06000 LABORATORY	3, 263, 972		3, 263, 972	0	3, 263, 972	60.00
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	107, 100		107, 100	0	107, 100	62.00
65. 00 06500 RESPIRATORY THERAPY	623, 632	0	623, 632	0	623, 632	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 380, 800	0	1, 380, 800	0	1, 380, 800	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	258, 871	0	258, 871	0	258, 871	67.00
68. 00 06800 SPEECH PATHOLOGY	99, 597	0	99, 597	0	99, 597	
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	0	
69. 01 03160 CARDI OPULMONARY	625, 674		625, 674	0	625, 674	69. 01
69. 02 03650 VASCULAR LAB	15, 371		15, 371	0	15, 371	69. 02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	42, 660		42, 660	0	42, 660	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 097, 316		2, 097, 316	0	2, 097, 316	73. 00
73. 01 03480 ONCOLOGY	0		0	0	0	73. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	11, 253, 826		11, 253, 826	0	11, 253, 826	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
91. 00 09100 EMERGENCY	5, 436, 973		5, 436, 973	0	5, 436, 973	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 299, 336		1, 299, 336		1, 299, 336	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0		0		0	102. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	37, 989, 797	0	37, 989, 797	0	37, 989, 797	
201.00 Less Observation Beds	1, 299, 336		1, 299, 336		1, 299, 336	
202.00 Total (see instructions)	36, 690, 461	0	36, 690, 461	0	36, 690, 461	202. 00

COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
					From 10/01/2022 To 09/30/2023		nared:
					10 07/30/2023	2/24/2024 6: 3	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
				ĺ		Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
I NPAT	TENT ROUTINE SERVICE COST CENTERS				<u>'</u>		
	ADULTS & PEDIATRICS	1, 993, 249		1, 993, 24	9		30.00
31.00 03100	INTENSIVE CARE UNIT	60, 655		60, 65	5		31.00
ANCI L	LARY SERVICE COST CENTERS				<u> </u>		
50.00 05000	OPERATING ROOM	48, 163	4, 083, 907	4, 132, 07	0.564950	0.000000	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0.000000	52.00
	ANESTHESI OLOGY	16, 923	806, 004	822, 92		0. 000000	
54.00 05400	RADI OLOGY-DI AGNOSTI C	100, 478	3, 709, 210	3, 809, 68	8 0. 474961	0. 000000	54.00
	MAMMOGRAPHY	0	1, 078, 666			0.000000	
	RADI OI SOTOPE	24, 927	1, 438, 066			0. 000000	l
	ULTRA SOUND	21, 854	2, 053, 652	2, 075, 50		0. 000000	
	CT SCAN	444, 130	15, 859, 001	16, 303, 13		0. 000000	57.00
	MAGNETIC RESONANCE IMAGING (MRI)	90, 884	5, 707, 002			0. 000000	58.00
	CARDI AC CATHETERI ZATI ON	70,001	0,707,002	0,777,00	0. 000000	0. 000000	59.00
	LABORATORY	1, 111, 592	21, 525, 400	22, 636, 99		0. 000000	60.00
	BLOOD LABORATORY	1, 111, 372	21, 323, 400	22,000,77	0. 000000	0. 000000	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	33, 157	272, 233	305, 39		0. 000000	1
	RESPIRATORY THERAPY	444, 207	1, 608, 038			0. 000000	l .
	PHYSI CAL THERAPY	258, 779	2, 541, 391	2, 800, 17		0.000000	•
	OCCUPATIONAL THERAPY	189, 414	504, 717	694, 13		0.000000	
	SPEECH PATHOLOGY	15, 263	112, 292			0.000000	1
•	ELECTROCARDI OLOGY	13, 203	112, 272		0. 000000	0.000000	1
•	CARDI OPULMONARY	235, 487	4, 216, 136			0.000000	1
	VASCULAR LAB	24, 340	818, 285	842, 62		0.000000	69. 02
	MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 340	010, 203	042,02	0.000000	0.000000	
	IMPL. DEV. CHARGED TO PATIENTS		361, 017	361, 01		0.000000	1
	DRUGS CHARGED TO PATTENTS	994, 168	5, 984, 153	6, 978, 32		0.000000	1
	ONCOLOGY	994, 100	0, 964, 103	0, 970, 32	0. 300347	0.00000	1
	ALLOGENEIC HSCT ACQUISITION		0		0.00000	0.00000	1
		١	-			l	ł
	CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	0	0		0.000000	0.000000	78. 00
	RURAL HEALTH CLINIC	O	12 (24 015	12 (24 01	5 0. 890700	0.000000	88. 00
		0	12, 634, 815			l	
	FEDERALLY QUALIFIED HEALTH CENTER	· · · · · · · · · · · · · · · · · · ·	0		0.000000	0.000000	1
	EMERGENCY	356, 808	14, 149, 480			0.000000	
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	50, 762	287, 200	337, 96	2 3. 844622	0.000000	92.00
	REIMBURSABLE COST CENTERS	ما					102.00
	OPIOID TREATMENT PROGRAM	0	0		0		102. 00
	AL PURPOSE COST CENTERS						110.00
	INTEREST EXPENSE	, 515 0.5	00 750 /:-	40/ 0/5	_		113.00
200.00	Subtotal (see instructions)	6, 515, 240	99, 750, 665	106, 265, 90	5		200.00
201. 00	Less Observation Beds	, 545 649	00 750 //5	40/ 0/5 00	_		201.00
202. 00	Total (see instructions)	6, 515, 240	99, 750, 665	106, 265, 90	5	l	202. 00

Cost Center Description				10 09/30/2023	2/24/2024 6: 39 pm
INPATENT ROUTINE SERVICE COST CENTERS 11.00			Title XIX	Hospi tal	
NPATIENT ROUTINE SERVICE COST CENTERS 30.00 33000 ADULTS & PEDIATRI CS 30.00 33000 ADULTS & PEDIATRI CS 31.00 3310 NTERIS WE CABE UNIT 31.00 33100 NTERIS WE CABE UNIT 31.00 NTERIS WE NTERIS WE NOW ONLY 31.00 NTERIS WE NTERIS WE NOW ONL	Cost Center Description	PPS Inpatient			
INPATTENT ROUTINE SERVICE COST CENTERS 30.00 31.00 AULTS & PEDI ATRI CS 31.00 31.00 AULTS & PEDI ATRI CS 31.00 31.00 AURTS VE CARE UNIT 31.00 AURTS VERVICE COST CENTERS 31.00 30.00		Ratio			
30. 00 30000 ADULTS & PEDI ATRICS 31. 00 31.00 10. TRICKING CARE UNIT 31. 00 31.00 10. TRICKING CARE UNIT 31. 00 31.00 03.00 07.00		11. 00			
31.00 03100 INTERSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS				
ANCI LLARY SERVICE COST CENTERS 50.00 50	30. 00 03000 ADULTS & PEDIATRICS				30.00
50.00 05000 0FEATING ROOM 0.000000 55.00 55.00 55.00 55.00 55.00 05300 DELIVERY ROOM & LABOR ROOM 0.000000 53.00 0.05300 ANESTHESI OLOGY 0.000000 54.00 55.00 55	31.00 03100 INTENSIVE CARE UNIT				31.00
52.00	ANCILLARY SERVICE COST CENTERS				
53.00 OS300 ANESTHESI OLOGY 0.000000 53.00	50. 00 05000 OPERATING ROOM	0. 000000			50.00
53.00 OS300 ANESTHESI OLOGY 0.000000 53.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.01 03440 MAMMOGRAPHY 0.0000000 55.00 056.01 03630 ULTRA SOUND 0.000000 55.00 056.01 03630 ULTRA SOUND 0.000000 55.00 05700 CT SCAN 0.000000 55.00 05700 CT SCAN 0.000000 55.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 58.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 58.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 58.00 05900 CARDIAC CATHETERI ZATI ON 0.000000 58.00 05900 CARDIAC CATHETERI ZATI ON 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					53.00
54.40 03440 MAMMOGRAPHY					54.00
56. 00 05600 RADI OI SOTOPE 0. 000000 55. 00		1			
56. 01 03430 LITRA SOUND 0. 000000 55. 00					
57. 00 05700 CT SCAN 0.000000 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58. 00 05900 CARDIAC CATHETERIZATION 0.000000 59. 00 06000 LABORATORY 0.000000 60. 00 06000 LABORATORY 0.000000 60. 00 06000 LABORATORY 0.000000 62. 00 06000 LABORATORY 0.000000 62. 00 06500 RESPIRATORY THERAPY 0.000000 62. 00 06500 RESPIRATORY THERAPY 0.000000 65. 00 06500 PHYSI CAL THERAPY 0.000000 65. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 06600 06600 PHYSI CAL THERAPY 0.000000 67. 00 066000 06600 06600 06600 06600 06600 06					
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0,000000 59.00 69. 00 05900 CARDIAC CATHETERIZATION 0,000000 59.00 60. 00 06000 LABORATORY 0,000000 60.00 60. 01 06001 BLOOD LABORATORY 0,000000 62.00 65. 00 06500 RESPIRATORY THERAPY 0,000000 62.00 66. 00 06600 PHYSI CAL THERAPY 0,000000 65.00 67. 00 06700 OCCUPATIONAL THERAPY 0,000000 66.00 68. 00 06800 SPEECH PATHOLOGY 0,000000 68.00 69. 01 03600 LECETROCARDI OLOGY 0,000000 69.00 69. 01 03160 CARDI OPULMONARY 0,000000 69.00 69. 02 03650 VASCULAR LAB 0,000000 69.00 69. 02 03550 VASCULAR LAB 0,000000 71.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0,000000 72.00 73. 01 03480 ONCOLOGY 0,000000 73.00 73. 01 03480 ONCOLOGY 0,000000 73.00 78. 00 00 000000 73.00 79. 00 07000 ALLOGENEIC HSCT ACQUISITION 0,000000 73.00 79. 00 07000 ALLOGENEIC HSCT ACQUISITION 0,000000 77.00 <tr< td=""><td></td><td></td><td></td><td></td><td></td></tr<>					
59. 00 05900 CARDI AC CATHETERIZATION 0.000000 59.00 60. 00 06000 LABORATORY 0.000000 60.00 60. 01 06001 BLOOD LABORATORY 0.000000 60.01 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 65. 00 06500 RESPIRATORY THERAPY 0.000000 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 68.00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68.00 69. 01 03160 CARDI OPULMONARY 0.000000 69.00 69. 02 03550 VASCULAR LAB 0.000000 69.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 73. 00 07300 IPLL DEV. CHARGED TO PATI ENTS 0.000000 73.00 73. 00 07300 IPLL DEV. CHARGED TO PATI ENTS 0.000000 73.00 73. 00 07300 IPL DEV. CHARGED TO PATI ENTS 0.000000 73.00 73. 00 07300 ONSON DRUGS CHARGED TO PATI ENTS 0.000000 73.00 73. 00 07300 ONSON DRUGS CHARGED TO PATI ENTS 0.000000 73.00 89. 00 08800 DRURAL HEALTH CLINIC 0.000000 78.00 <td< td=""><td></td><td></td><td></td><td></td><td></td></td<>					
60. 00 06000 LABORATORY 0. 000000 60. 01 06001 BLOOD LABORATORY 0. 000000 60. 01 06001 BLOOD LABORATORY 0. 000000 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 06500 06000 RESPI RATORY THERAPY 0. 000000 06500 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 0600000 0600000 06000000 0600000 0600000 0600000 06000000 06000000 0600000000					
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62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 65.00 65.00 65500 RESPIRATORY THERAPY 0.000000 66.00 66.00 66.00 66.00 CALT SCAL THERAPY 0.000000 66.00 66.00 66.00 CALT SCAL THERAPY 0.000000 67.00 68.00	1 I	1			
65. 00 06500 RESPIRATORY THERAPY 0.000000 66. 00 66.00 06600 PHYSI CAL THERAPY 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 68. 00 06800 SPECH PATHOLOGY 0.000000 68. 00 06900 ELCTROCARDI OLOGY 0.000000 69. 00 06900 ELCTROCARDI OLOGY 0.000000 69. 00 06900 SPECH PATHOLOGY 0.000000 69. 00 06900 SUSCULAR LAB 0.00000000					
66. 00 06600 PHYSI CAL THERAPY 0. 000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 69. 01 03160 CARDI OPULMONARY 0. 000000 69. 00 69. 02 03650 VASCULAR LAB 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 00 73. 01 03480 ONCOLOGY 0. 000000 73. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07900 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07900 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07900 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07900 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07900 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07900 CAR T-CELL IMMUNOTHERAPY 0. 000000 77. 00 70. 00 07900 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 000000 70. 00 0. 000000 0. 000000 0. 0000000 70. 00 0. 0000000 0. 0000000 0. 000000 70. 00 0. 0000000 0. 0000000 0. 000000 70. 00 0. 0000000 0. 00000000 0. 000000 70. 00 0. 0000000 0. 0000000 0. 0000000 70. 00 0. 0000000 0. 0000000 0. 0000000 0. 0000000 70. 00 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00		1			
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 69. 01 03160 CARDI OPULMONARY 0. 000000 69. 00 69. 02 03650 VASCULAR LAB 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 73. 01 03480 0NCOLOGY 0. 000000 73. 01 73. 01 03480 ONCOLOGY 0. 000000 73. 01 75. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 78. 00 88. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 78. 00 99. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 78. 00 91. 00 09100 EMERGENCY 0. 000000 91. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000 91. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000 0. 000000 0. 000000 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 0000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000					
68. 00		1			
69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 69. 01 03160 CARDI OPULMONARY 0.000000 69. 00 69. 02 03650 VASCULAR LAB 0.000000 69. 02 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 73. 01 03480 ONCOLOGY 0.000000 73. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0.000000 91. 00 91. 00 09100 EMERGENCY 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 91. 00 91. 00 010200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 201. 00 Less Observation Beds 201. 00 201. 00 Car to the total care		1			
69. 01		1			
69. 02 03650 VASCULAR LAB		1			
71. 00		1			
72. 00		1			
73. 00		1			
73. 01		1			
77. 00					
78. 00					
SECOND SUBSTRATE SUBSTRA		1			
88. 00		0. 000000			78. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 91. 00 91. 00 91. 00 92. 00 92.00 09200 095ERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 07100					
91. 00					
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 0000000 92. 00 0THER REI MBURSABLE COST CENTERS 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					89.00
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					91.00
102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 130		0. 000000			92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
113.00 11300 NTEREST EXPENSE					102. 00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 200.00	SPECIAL PURPOSE COST CENTERS				
201.00 Less Observation Beds 201.00					113. 00
	200.00 Subtotal (see instructions)				200.00
202.00 Total (see instructions)	201.00 Less Observation Beds				201. 00
	202.00 Total (see instructions)				202.00

Health Financial Systems (OSF SAINT LUKE N	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der CO		Peri od: From 10/01/2022 To 09/30/2023	Worksheet D Part II Date/Time Pre 2/24/2024 6:3	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
·	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	439, 535	4, 132, 070			0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	9, 155	822, 927	0. 01112	25 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	162, 936	3, 809, 688	0. 04276	9 21, 140	904	54.00
54. 01 03440 MAMMOGRAPHY	4, 885	1, 078, 666	0. 00452	.9 0	0	54. 01
56. 00 05600 RADI OI SOTOPE	7, 080	1, 462, 993	0. 00483	14, 789	72	56.00
56. 01 03630 ULTRA SOUND	8, 061	2, 075, 506	0. 00388	8, 354	32	56. 01
57.00 05700 CT SCAN	13, 099	16, 303, 131	0. 00080	63, 091	51	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	38, 476	5, 797, 886	0. 00663	18, 533	123	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000	0 0	0	59.00
60. 00 06000 LABORATORY	159, 941	22, 636, 992	0. 00706	5 304, 404	2, 151	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 953	305, 390	0. 01294	16, 734	217	62.00
65. 00 06500 RESPIRATORY THERAPY	36, 626	2, 052, 245	0. 01784	7 152, 879	2, 728	65.00
66. 00 06600 PHYSI CAL THERAPY	80, 791	2, 800, 170	0. 02885	68, 975	1, 990	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	7, 634	694, 131	0. 01099	43, 485	478	67.00
68.00 06800 SPEECH PATHOLOGY	3, 762	127, 555	0. 02949	6, 219	183	68.00
69. 00 06900 ELECTROCARDI OLOGY	O	0	0. 00000	0 0	0	69.00
69. 01 03160 CARDI OPULMONARY	71, 206	4, 451, 623			1, 363	69. 01
69. 02 03650 VASCULAR LAB	2, 160	842, 625	0. 00256	8, 115	21	69. 02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0. 00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	378	361, 017	0. 00104	·7	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	97, 689	6, 978, 321	0. 01399	9 305, 905	4, 282	73.00
73. 01 03480 ONCOLOGY	o	0	0. 00000	0 0	0	73. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	0	0. 00000	0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	o	0	0. 00000	0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS						1
88. 00 08800 RURAL HEALTH CLINIC	288, 498	12, 634, 815	0. 02283	34 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	00	0	89.00
91. 00 09100 EMERGENCY	205, 833	14, 506, 288	0. 01418	10, 874	154	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	142, 814	337, 962	0. 42257	1, 389	587	92.00
200.00 Total (lines 50 through 199)	1, 784, 512	104, 212, 001		1, 130, 076	15, 336	200.00

| Peri od: | Worksheet D | From 10/01/2022 | Part IV | To | 09/30/2023 | Date/Time | Prepared: THROUGH COSTS

					07/30/2020	2/24/2024 6: 3	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
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	03440 MAMMOGRAPHY	0	0		0	0	54. 01
56.00		0	0		0	0	56.00
56. 01	03630 ULTRA SOUND	0	0		0 0	0	56. 01
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
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
65.00		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
69. 01	03160 CARDI OPULMONARY	0	0		0	0	69. 01
69. 02	03650 VASCULAR LAB	0	0		0	0	69. 02
71.00		0	0		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00		0	0		0	0	73.00
73. 01	03480 ONCOLOGY	0	0		0 0	0	73. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 (0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
91.00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0	0	200. 00

Heal th Financial Systems OSF SAINT LUKE MEDICAL CENTER

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1325 | Peri od: | Worksheet D | From 10/01/2022 | Part IV | To | 09/30/2023 | Date/Time | Prepared: THROUGH COSTS

				10 07/30/2023	2/24/2024 6: 3	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	1	4, 132, 070		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		822, 927	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		3, 809, 688		54.00
54. 01 03440 MAMMOGRAPHY	0	0		1, 078, 666		54. 01
56. 00 05600 RADI OI SOTOPE	0	0		1, 462, 993		56.00
56. 01 03630 ULTRA SOUND	0	0		2, 075, 506		56. 01
57. 00 05700 CT SCAN	0	0		16, 303, 131	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		5, 797, 886		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0.000000	59.00
60. 00 06000 LABORATORY	0	0		22, 636, 992	0.000000	60.00
60. 01 06001 BL00D LABORATORY	0	0		0	0.000000	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		305, 390	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		2, 052, 245	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 800, 170	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		694, 131	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		127, 555	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0.000000	69.00
69. 01 03160 CARDI OPULMONARY	0	0		4, 451, 623	0.000000	69. 01
69. 02 03650 VASCULAR LAB	0	0		842, 625	0.000000	69. 02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		361, 017	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		6, 978, 321	0.000000	73.00
73. 01 03480 ONCOLOGY	0	0		0	0.000000	73. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0		12, 634, 815	0.000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	89. 00
91. 00 09100 EMERGENCY	0	0		14, 506, 288	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		337, 962	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0		104, 212, 001		200. 00
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| Peri od: | Worksheet D | From 10/01/2022 | Part IV | To | 09/30/2023 | Date/Time Prepared: THROUGH COSTS

				10 09/30/2023	Date/lime Pre 2/24/2024 6:3	
		Title	XVIII	Hospi tal	Cost	7 PIII
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	J	Costs (col. 8		Costs (col. 9	
	col. 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	0		0	0	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	21, 140		0	0	54.00
54. 01 03440 MAMMOGRAPHY	0. 000000	0		0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	14, 789		0	0	56.00
56. 01 03630 ULTRA SOUND	0. 000000	8, 354		0	0	56. 01
57. 00 05700 CT SCAN	0. 000000	63, 091		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	18, 533		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	304, 404		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	16, 734		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	152, 879		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	68, 975		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	43, 485		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	6, 219		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
69. 01 03160 CARDI OPULMONARY	0. 000000	85, 190		0 0	0	69. 01
69. 02 03650 VASCULAR LAB	0. 000000	8, 115		0 0	0	69. 02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	305, 905		0 0	0	73.00
73. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	73. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			•		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89. 00
91. 00 09100 EMERGENCY	0. 000000	10, 874		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 389		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 130, 076		0 0	0	200. 00

Hear th	Financiai Systems 0	SF SAINT LUKE	MEDICAL CENTER		In Lie	u or form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		eri od:	Worksheet D	
					rom 10/01/2022	Part V	
				T	o 09/30/2023	Date/Time Pre 2/24/2024 6:3	pared:
						2/24/2024 6: 3	9 pm
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	pro-	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not	(000 111011)	
		Worksheet C.	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins.	Ded. & Coins.		
		9					
			2.00	(see inst.)	(see inst.)	Г 00	
	ANOLILABY OFFICE OFFICE	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		1		_	_	4
	05000 OPERATING ROOM	0. 564950				0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 029105	0	222, 564	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 474961	0	803, 765	0	0	54.00
54. 01	03440 MAMMOGRAPHY	0. 192372	0	188, 051	0	0	54. 01
	05600 RADI OI SOTOPE	0. 197812		473, 296		0	56.00
	03630 ULTRA SOUND	0. 200365		240, 970		0	56.01
57. 00	05700 CT SCAN	0. 032196				0	57.00
	l l			4, 536, 387		_	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 071850	l .	1, 313, 434		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	l .		0	0	59.00
	06000 LABORATORY	0. 144188	l .	5, 595, 108		0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	C	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 350699	0	117, 000	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 303878	0	328, 118	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 493113	0	534, 330	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 372943	l .	72, 089		0	67.00
	06800 SPEECH PATHOLOGY	0. 780816	l .	40, 041		0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	l .	10,011	0	0	69.00
	03160 CARDI OPULMONARY	0. 140550	l .	1 222 200	1	0	69. 01
	l l			1, 332, 290		0	
69. 02	03650 VASCULAR LAB	0. 018242		282, 736		0	69.02
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000		C	_	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 118166	l .	126, 696		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 300547	l .	2, 940, 749	4, 203	0	73.00
73. 01	03480 ONCOLOGY	0. 000000	0	C	0	0	73. 01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	C	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	l	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS	•		•	•		1
88. 00	08800 RURAL HEALTH CLINIC						88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
	09100 EMERGENCY	0. 374801	0	2, 832, 269	558	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3. 844622				0	
	1 1	3. 044022		73, 451		_	1
200.00	1 1	1		23, 286, 860		0	200.00
201.00					0		201. 00
	Only Charges					_	
202.00	Net Charges (line 200 - line 201)	ļ	0	23, 286, 860	5, 249	0	202.00

| Peri od: | Worksheet D | From 10/01/2022 | Part V | To | 09/30/2023 | Date/Time | Prepared:

				10 09/30/2023	2/24/2024 6:39	
		Title	XVIII	Hospi tal	Cost	<i>у</i> рііі
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	696, 875	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	6, 478	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	381, 757	0				54.00
54. 01 03440 MAMMOGRAPHY	36, 176	0				54. 01
56. 00 05600 RADI 0I SOTOPE	93, 624	0				56.00
56. 01 03630 ULTRA SOUND	48, 282	0				56.00
	1	16	l .			57.00
	146, 054) 94, 370	0				1
	94, 370					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	806, 747	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	1	0				62.00
65. 00 06500 RESPI RATORY THERAPY	99, 708	0				65.00
66. 00 06600 PHYSI CAL THERAPY	263, 485	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	26, 885	0				67.00
68.00 06800 SPEECH PATHOLOGY	31, 265	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 03160 CARDI OPULMONARY	187, 253	0				69. 01
69. 02 03650 VASCULAR LAB	5, 158	0				69. 02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENTS 0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 971	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	883, 833	1, 263				73.00
73. 01 03480 ONCOLOGY	0	0				73. 01
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	ام	0				77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0				78.00
OUTPATIENT SERVICE COST CENTERS		<u> </u>				70.00
88. 00 08800 RURAL HEALTH CLINIC						88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENT	FR					89.00
91. 00 09100 EMERGENCY	1, 061, 537	209				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT)		209				92.00
200.00 Subtotal (see instructions)	5, 207, 881	1, 488				200.00
201.00 Less PBP Clinic Lab. Services-P		1, 488				200.00
Only Charges	i ogi aiii					201.00
202.00 Net Charges (line 200 - line 20	1) 5, 207, 881	1, 488				202. 00
202.00 Net Charges (Time 200 - Time 20	1) 5,207,881	1, 488	l		l	1202. UU

Health Financial Systems C	SF SAINT LUKE !	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2022		
				To 09/30/2023	Date/Time Pre 2/24/2024 6:3	
		Ti tl	e XIX	Hospi tal	Cost	7 PIII
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	576, 265	152, 818	423, 447	1, 258	336. 60	30.00
31.00 INTENSIVE CARE UNIT	45, 912		45, 912	2 16	2, 869. 50	31.00
200.00 Total (lines 30 through 199)	622, 177		469, 359	1, 274		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	9	3, 029				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
200.00 Total (lines 30 through 199)	9	3, 029				200.00

	OSF SAINT LUKE !			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet D Part II Date/Time Pre 2/24/2024 6:3	epared:
			e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	439, 535	4, 132, 070			0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0.00000	00	0	52.00
53. 00 05300 ANESTHESI OLOGY	9, 155	822, 927	0. 01112	25 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	162, 936	3, 809, 688	0. 04276	0	0	54.00
54. 01 03440 MAMMOGRAPHY	4, 885	1, 078, 666	0. 00452	29 0	0	54.01
56. 00 05600 RADI 01 SOTOPE	7, 080	1, 462, 993	0. 00483	39 0	0	56.00
56. 01 03630 ULTRA SOUND	8, 061	2, 075, 506	0. 00388	0	0	56. 01
57. 00 05700 CT SCAN	13, 099	16, 303, 131	0.00080	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	38, 476	5, 797, 886	0. 00663	86 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000	00	0	59.00
60. 00 06000 LABORATORY	159, 941	22, 636, 992	0. 00706	5 0	0	60.00
60. 01 06001 BL00D LABORATORY	0	0	0. 00000	00	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 953	305, 390	0. 01294	14 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	36, 626				0	65.00
66. 00 06600 PHYSI CAL THERAPY	80, 791	2, 800, 170			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	7, 634		•		0	67.00
68. 00 06800 SPEECH PATHOLOGY	3, 762	127, 555	•		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0,152	0			0	69.00
69. 01 03160 CARDI OPULMONARY	71, 206	4, 451, 623			0	1
69. 02 03650 VASCULAR LAB	2, 160	1			0	69. 02
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0.2,020	1		0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	378	361, 017	•		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	97, 689				o o	73.00
73. 01 03480 0NC0L0GY	0	0, 7,0, 321			Ö	1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0			0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	١	0. 00000		0	78.00
OUTPATIENT SERVICE COST CENTERS			0.00000	0		70.00
88. 00 08800 RURAL HEALTH CLINIC	288, 498	12, 634, 815	0. 02283	34 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1		Ō	1
91. 00 09100 EMERGENCY	205, 833	14, 506, 288			0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	142, 814				Ō	1
200.00 Total (lines 50 through 199)	1, 784, 512	•		0	0	200.00

Health Financial Systems	OSF SAINT LUKE M	EDI CAL CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COST	TS Provider C	F	Period: From 10/01/2022 To 09/30/2023		epared:
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0		0	0	31.00
200.00 Total (lines 30 through 199)	ol	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
· ·	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4. 00	5. 00	6.00	7.00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 258	0.00	9	30.00
31.00 03100 INTENSIVE CARE UNIT		0	16	0.00	0	31.00
200.00 Total (lines 30 through 199)		0	1, 274			200.00
Cost Center Description	Inpatient					
	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	l ol					31.00
200.00 Total (lines 30 through 199)	o					200.00
	- 1					

| Peri od: | Worksheet D | From 10/01/2022 | Part IV | To | 09/30/2023 | Date/Time | Prepared: THROUGH COSTS

					10 09/30/2023	2/24/2024 6: 3	
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	T	1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			1		_	
	05000 OPERATING ROOM	0	C	1	0	1	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	1	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	C	1	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	1	0	0	54.00
54. 01	03440 MAMMOGRAPHY	0	C	1	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	C	1	0	0	56.00
56. 01	03630 ULTRA SOUND	0	C	1	0	0	56. 01
57. 00	05700 CT SCAN	0	C	1	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0	0	59.00
60.00	06000 LABORATORY	0	C		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C		0	0	60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	C	1		0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C	1	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	1	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C	1		0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C	1		0	69.00
69. 01	03160 CARDI OPULMONARY	0	C	1		0	69. 01
69. 02	03650 VASCULAR LAB	0	C	1		0	69. 02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C			0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C			0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	C			0	73.00
73. 01 77. 00	03480 ONCOLOGY	0	C			0	73. 01
	07700 ALLOGENEIC HSCT ACQUISITION	0	C	1		0	77. 00
78. 00	07800 CAR T-CELL I MMUNOTHERAPY	U	<u> </u>		0 0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC			ı		0	00 00
88. 00		0	C	1	0	1	88. 00
89. 00 91. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			1		0	89.00
	09100 EMERGENCY		C	Ί		0	91. 00 92. 00
92. 00 200. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	0	92.00 200.00
200.00	Total (lines 50 through 199)	ı o	C	T .	0 0	,i O	200.00

| Peri od: | Worksheet D | From 10/01/2022 | Part IV | To 09/30/2023 | Date/Time Prepared: Health Financial Systems

OSF SAINT LUKE MEDICAL CENTER

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1325 THROUGH COSTS

				10 09/30/2023	2/24/2024 6: 3	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		4, 132, 070		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		822, 927	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		3, 809, 688		
54. 01 03440 MAMMOGRAPHY	0	0		1, 078, 666		
56. 00 05600 RADI 0I SOTOPE	0	0		1, 462, 993		
56. 01 03630 ULTRA SOUND	0	0		2, 075, 506		
57.00 05700 CT SCAN	0	0		16, 303, 131	0.000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		5, 797, 886	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0.000000	59. 00
60. 00 06000 LABORATORY	0	0		22, 636, 992	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	0.000000	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		305, 390	0.000000	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		2, 052, 245	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 800, 170	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		694, 131	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		127, 555	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0.000000	69. 00
69. 01 03160 CARDI OPULMONARY	0	0		4, 451, 623	0.000000	69. 01
69. 02 03650 VASCULAR LAB	0	0		842, 625	0.000000	69. 02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		361, 017	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		6, 978, 321	0.000000	73. 00
73. 01 03480 ONCOLOGY	0	0		0	0.000000	73. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	(12, 634, 815	0.000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	89. 00
91. 00 09100 EMERGENCY	0	0		14, 506, 288	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		337, 962	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0		104, 212, 001		200. 00
•						

| Peri od: | Worksheet D | From 10/01/2022 | Part IV | To | 09/30/2023 | Date/Time Prepared: THROUGH COSTS

				10 09/30/2023	Date/lime Pre 2/24/2024 6:3	
		Ti tl	e XIX	Hospi tal	Cost	7 PIII
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
· ·	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	J	Costs (col.		Costs (col. 9	
	col. 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	0		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
54. 01 03440 MAMMOGRAPHY	0. 000000	0		0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
56. 01 03630 ULTRA SOUND	0. 000000	0		0 0	0	56. 01
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	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
69. 01 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	69. 01
69. 02 03650 VASCULAR LAB	0. 000000	0		0 0	0	69. 02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
73. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	73. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	·		<u>'</u>			
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89. 00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		0		0 0	0	200. 00
	•		-	*		

Health Financial Systems	OSF SAINT LUKE MEDIC	CAL CENTER	In Lieu	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1325	Peri od: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Pre 2/24/2024 6:3	
		Title XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	·				
				1. 00	

		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day			1, 755	
2.00	Inpatient days (including private room days, excluding swing-			1, 258	2.00
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		833	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	114	5.00
	reporting period	3 7			
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	340	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through Docombor	21 of the cost	11	7. 00
7.00	reporting period	iii days) tili odgir beceilber	31 Of the cost	1.1	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	32	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	388	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	nom days)	62	10.00
10.00	through December 31 of the cost reporting period (see instruc		com days)	02	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days) after	184	11. 00
	December 31 of the cost reporting period (if calendar year, e			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
.0.00	after December 31 of the cost reporting period (if calendar y	ear, enter O on this lin	ie)	· ·	10.00
14.00	Medically necessary private room days applicable to the Progr	am (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) SWING BED ADJUSTMENT			0	16. 00
17 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost		17. 00
17.00	reporting period	es in ough becomber or e	in the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period			004 5/	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	201. 56	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	208. 70	20.00
	reporting period				
21.00				5, 242, 918	•
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na period (line A	0	23. 00
20.00	x line 18)	or or the cost reportin	ig perrod (irric o	G	20.00
24.00		r 31 of the cost reporti	ng period (line	2, 217	24.00
05.00	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	6, 678	25. 00
26. 00				1, 396, 891	26. 00
27. 00		(line 21 minus line 26)		3, 846, 027	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	•
34.00	Average per diem private room charge differential (line 32 mi	, ,	tions)	0. 00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 846, 027	37.00
57.00	27 minus line 36)	p		5, 515, 527	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00				3, 057. 26	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			1, 186, 217 0	39.00 40.00
	Total Program general inpatient routine service cost (line 39			1, 186, 217	
	3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,	'	,,	

IVIPU	Financial Systems 0 ATION OF INPATIENT OPERATING COST	SF SAINT LUKE N		CCN: 14-1325	Peri od: From 10/01/2022 To 09/30/2023	u of Form CMS-: Worksheet D-1 Date/Time Pre 2/24/2024 6:3	epar
	Cost Center Description	Total I npati ent Cost	Titl Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only)						42
. 00	Intensive Care Type Inpatient Hospital Units	219, 706	1	13, 731.	63 12	164, 780	43
. 00	CORONARY CARE UNIT	217, 700		13, 731.	12	104, 700	44
. 00							45
. 00	1						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wk	est D 2 col 3) line 200)			1. 00 282, 781	10
01	Program inpatient cellular therapy acquisiti			III line 10) column 1)	202, 701	
	Total Program inpatient costs (sum of lines				o, corumin i)	1, 633, 778	
	PASS THROUGH COST ADJUSTMENTS	Tr till dagir for t	11) (000 1110111	.0 (1 01.0)		1, 000, 110	1 .,
00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	ım of Parts I and	0	50
	[111]						
00	Pass through costs applicable to Program inp	atient ancillar	ry services (1	from Wkst. D,	sum of Parts II	0	51
00	and IV) Total Program excludable cost (sum of lines	EO and E1)				0	52
. 00	Total Program inpatient operating cost exclu		lated non-nh	weician anget	hatist and	0	
. 00	medical education costs (line 49 minus line	9 1	rateu, non-pi	iysi ci aii ailesi	inetist, and	0	
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
. 00						0	54
. 00	Target amount per discharge					0. 00	
. 01	, ,					0. 00	
. 02	Adjustment amount per discharge (contractor					0.00	
. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			Tipo E4 minus	Lino E2)	0	
. 00	Bonus payment (see instructions)	ing cost and ta	inget amount i	Title 56 III llus	5 Title 55)	0	
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost re	ortina period	l endina 1996.	0.00	
	updated and compounded by the market basket)						
. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year	cost report,	updated by the	0. 00	60
. 00	market basket) Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les	ser of 50% of t	the amount by	which operati	ng costs (line	0	61
	53) are less than expected costs (lines 54 x	: 60), or 1 % of	the target a	amount (line 5	66), otherwise		
. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	10112 (000 111011)	.01.01.0)				"
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost report	ing period (See	189, 550	64
	instructions)(title XVIII only)						١
. 00	Medicare swing-bed SNF inpatient routine cos	its after Decemb	er 31 of the	cost reportir	ng period (See	562, 536	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	na costs (lina	64 nlus line	65)(title YVI	II only): for	752, 086	6
. 00	CAH, see instructions	ne costs (Title	04 prus rine	os) (ti ti e xvi	Tr only), roi	732,000	"
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	reporting period	0	67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [ecember 31 of	the cost rep	orting period	0	68
. 00	(line 13 x line 20)	routing costs (lino 47 . lir	20 40)		0	69
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					U	1 05
. 00	Skilled nursing facility/other nursing facil				')		70
00	Adjusted general inpatient routine service of	-		•	,		71
00	Program routine service cost (line 9 x line	,					72
00	1 3 1						73
00	Total Program general inpatient routine serv	•		,	D		74
00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksneet B,	Part II, column		75
00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital -related costs (line 9 x line						7
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces						79
00	Total Program routine service costs for comp		ost limitatio	on (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem limi		`				81
.00	Inpatient routine service cost limitation (I		* .				82
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				83
	Utilization review - physician compensation		ons)				85
. 00							1
. 00	Total Program inpatient operating costs (sum	•	,				86
00	. ,	of lines 83 th S THROUGH COST	,			425	

Health Financial Systems 05	SF SAINT LUKE N	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023		pared: 9 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 299, 336	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	576, 265	5, 242, 918	0. 10991	3 1, 299, 336	142, 814	90.00
91.00 Nursing Program cost	0	5, 242, 918	0.00000	0 1, 299, 336	0	91.00
92.00 Allied health cost	0	5, 242, 918	0.00000	0 1, 299, 336	0	92.00
93.00 All other Medical Education	o	5, 242, 918	0. 00000	0 1, 299, 336	0	93.00

m CMS-25	In Lieu of I	CAL CENTER	OSF SAINT LUKE MED	Health Financial Systems
eet D-1	From 10/01/2022	Provider CCN: 14-1325		COMPUTATION OF INPATIENT OPERATING COST
ime Prepa 024 6:39	To 09/30/2023 Date 2/24			
Cost	Hospi tal	Title XIX		
			<u> </u>	Cost Center Description
00				
)()				DADT I ALL DROWLDED COMPONENTS

		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		1, 755	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 258	
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		833	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	114	5.00
	reporting period	3 .			
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	340	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	11	7.00
7.00	reporting period	iii days) trii ougii beceiibei	31 of the cost	11	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	32	8. 00
	reporting period (if calendar year, enter 0 on this line)	5			
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	swing-bed and	9	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc	tions)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	X only (Therearing private	ic room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
44.00	after December 31 of the cost reporting period (if calendar y			0	44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost		17.00
18 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. 00
10.00	reporting period	es arter becomber 51 or	the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	o often December 21 of t	·ho coot	0.00	20.00
20.00	reporting period	s arter becember 31 or t	THE COST	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	s)		5, 242, 918	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na period (line A	0	23.00
20.00	x line 18)	or or the cost reportin	ig perred (irrie d	· ·	20.00
24.00		r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	noried (line 9	0	25. 00
25.00	x line 20)	31 of the cost reporting	perrod (Trile 6	U	25.00
26.00				1, 390, 352	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 852, 566	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had ch	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)	d and observation bed er	idi ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nue lina 33)(saa instruc	rtions)	0. 00 0. 00	1
35.00	Average per diem private room cost differential (line 34 x li		, (1 0113)	0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 852, 566	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			3, 062. 45	38.00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		27, 562	1
40.00	Medically necessary private room cost applicable to the Progr			0	•
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	ļ	27, 562	41.00

Cost Center Description Total Total New York (111e V & XIX only) 2.00 NURSERY (111e V & XIX only) 1.00	'UTA	TION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 10/01/2022	Worksheet D-1	
Cost Center Description Total Inpatt ent Description Total							Date/Time Prepa 2/24/2024 6:39	
Injustient Injustient Injustient Diem (col. 1 Col. 3 Col. 3 Col. 3 Col. 4 Col. 5 C		Cost Contor Decement on	Total				Cost	
Intensive Care Type Input ent Hospital Unit is 219,706 16 13,731.63 0		Cost Center Description	Inpatient Cost	Inpatient Days	Diem (col. 1 + col. 2)	1	(col. 3 x col. 4)	
Intensive Care Type Inpatient Hospital Units 219,706 16 13,731.63 0 0 0 0 0 0 0 0 0	0 1	UIRSERY (title V & XIX only)	1. 00	2.00	3. 00	4.00	5. 00	42
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CAH, see instructions OTITIE V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital-related costs (line 75 + line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine services (see instructions) Program inpatient ancillary services (see instructions)	i	nstructions)(title XVIII only)			·		_	
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Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)	- 1	•	,					7
On Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)	- 1			orovi der recor	ds)			7
ON Inpatient routine service cost limitation (line 9 x line 81) ON Reasonable inpatient routine service costs (see instructions) ON Program inpatient ancillary services (see instructions)	ОΙ	otal Program routine service costs for compa	parison to the o			nus line 79)		8
00 Reasonable inpatient routine service costs (see instructions) 00 Program inpatient ancillary services (see instructions)	- 1	·		1)				8
	4	•		•				8
ou julifization review - physician compensation (see instructions)	4			200)				8
00 Total Program inpatient operating costs (sum of lines 83 through 85)	4	. ,	•	,				8
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	_							1

Health Financial Systems	OSF SAINT LUKE N	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (s	ee instructions)			1, 301, 541	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	576, 265	5, 242, 918	0. 10991	3 1, 301, 541	143, 056	90.00
91.00 Nursing Program cost	0	5, 242, 918	0. 00000	0 1, 301, 541	0	91.00
92.00 Allied health cost	0	5, 242, 918	0. 00000	0 1, 301, 541	0	92.00
93.00 All other Medical Education	0	5, 242, 918	0. 00000	0 1, 301, 541	0	93.00

Health Financial Systems OSF SAINT INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	LUKE MEDICAL CENTER Provider C	CN: 14_1325	Peri od:	u of Form CMS-2 Worksheet D-3	
INFAITENT ANGIELART SERVICE COST AFFORTIONWENT	Flovidei		From 10/01/2022)
			To 09/30/2023	Date/Time Pre	
	Ti +Lo	: XVIII	Hospi tal	2/24/2024 6: 3 Cost	39 pm
Cost Center Description		Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col . 1 x	
			Charges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			625, 638		30.00
31.00 03100 INTENSIVE CARE UNIT			45, 480		31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 56495	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	00	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 02910	05	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 47496	21, 140	10, 041	
54. 01 03440 MAMMOGRAPHY		0. 19237		0	
56. 00 05600 RADI OI SOTOPE		0. 19781	2 14, 789	2, 925	
56. 01 03630 ULTRA SOUND		0. 20036		1, 674	
57. 00 05700 CT SCAN		0. 03219		2, 031	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07185			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	
60. 00 06000 LABORATORY		0. 14418		43, 891	
60. 01 06001 BLOOD LABORATORY		0. 00000		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 35069		5, 869	
65. 00 06500 RESPI RATORY THERAPY		0. 30387			
66. 00 06600 PHYSI CAL THERAPY		0. 49311			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37294			
68. 00 06800 SPEECH PATHOLOGY		0. 78081	·	l .	
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
69. 01 03160 CARDI OPULMONARY		0. 14055		l .	
69. 02 03650 VASCULAR LAB		0. 01824		l	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	
		0. 11816			
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 03480 ONCOLOGY		0. 30054		1	
73. 01 03480 ONCOLOGY 77. 00 07700 ALLOGENET C HSCT ACQUISITION		0. 00000 0. 00000		0	
78. 00 07/00 ALLOGENETC HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000		1	
OUTPATIENT SERVICE COST CENTERS		U. 00000	0	<u> </u>	1 /8.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	10	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
01 00 00100 EMERCENCY		0.00000		1 076	

0.374801

3. 844622

10, 874 1, 389

1, 130, 076

1, 130, 076

91.00

92.00 200. 00 201. 00

202.00

4, 076

5, 340

282, 781

202.00

91. 00 09100 EMERGENCY

97.00 O9200 EMERGENCY
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

Health Financial Systems OSF SAINT LUKE	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC	CN: 14-1325	Peri od:	Worksheet D-3	
			From 10/01/2022		
	Component (CCN: 14-Z325	To 09/30/2023	Date/Time Pre 2/24/2024 6:3	
	Title	XVIII	Swing Beds - SNF		7 pili
Cost Center Description		Ratio of Cos		I npati ent	
555t 55.1ts. 55551 Ft. 5.1		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			3	col . 2)	
	ĺ	1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 INTENSIVE CARE UNIT					31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 56495		1, 207	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 02910		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 47496		800	54.00
54. 01 03440 MAMMOGRAPHY		0. 19237		0	54.01
56. 00 05600 RADI 0I SOTOPE		0. 19781		0	56.00
56. 01 03630 ULTRA SOUND		0. 20036		0	56. 01
57. 00 05700 CT SCAN		0. 03219		202	57.00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)		0. 07185		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY		0.00000		0	59. 00 60. 00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 14418 0. 00000		5, 781 0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 35069		1, 110	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 30387		3, 564	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 49311		33, 697	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37294		21, 860	
68. 00 06800 SPEECH PATHOLOGY		0. 78081		2, 794	
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		2, , , 1	69.00
69. 01 03160 CARDI OPULMONARY		0. 14055		145	69. 01
69. 02 03650 VASCULAR LAB		0. 01824		24	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 11816		0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	İ	0. 30054		16, 761	73.00
73. 01 03480 ONCOLOGY		0. 00000		0	73. 01
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0 0	0	78. 00
OUTDATIENT SERVICE COST CENTERS					Ī

0.000000

0.000000

0.374801

3. 844622

253, 712

253, 712

88.00

91.00 0

92.00 0 87, 945 200. 00

201.00

202.00

0

0 89.00

OUTPATIENT SERVICE COST CENTERS
08800 RURAL HEALTH CLINIC

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

88.00

201.00

202.00

91. 00 09100 EMERGENCY

Health Financial Systems OSF SAINT INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	LUKE MEDICAL CENTER Provi der CCN		Peri od:	u of Form CMS-2 Worksheet D-3	
			From 10/01/2022 To 09/30/2023		
				2/24/2024 6: 3	9 pm
	Title		Hospi tal	Cost	1
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
	-	1. 00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		1 30. oc
31.00 03100 INTENSIVE CARE UNIT			0		31.00
ANCILLARY SERVICE COST CENTERS	<u> </u>				
50. 00 05000 OPERATING ROOM		0. 56495	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 02910	05	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 47496	0	0	54.00
54. 01 03440 MAMMOGRAPHY		0. 19237	2 0	0	54.01
56. 00 05600 RADI OI SOTOPE		0. 19781	2 0	0	56.00
56. 01 03630 ULTRA SOUND		0. 20036		0	56. 01
57. 00 05700 CT SCAN		0. 03219		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07185	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60. 00 06000 LABORATORY		0. 14418		0	
60. 01 06001 BL00D LABORATORY		0.00000		0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 35069		0	02.00
65. 00 06500 RESPIRATORY THERAPY		0. 30387		0	
66. 00 06600 PHYSI CAL THERAPY		0. 49311		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37294		0	
68. 00 06800 SPEECH PATHOLOGY		0. 78081		0	00.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
69. 01 03160 CARDI OPULMONARY		0. 14055		0	
69. 02 03650 VASCULAR LAB		0. 01824		0	0 / 1 02
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 11816		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 30054		0	1 , 0, 00
73. 01 03480 0NC0L0GY		0.00000		0	,
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00 0	0	78.00
OUTPATIENT SERVICE COST CENTERS			_1		
88. 00 08800 RURAL HEALTH CLINIC		0. 89070		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0 0	0	89.00

0.000000

0.374801

3. 844622

0 89.00

0 91.00

0

92.00

201.00

202.00

0 200.00

08900 FEDERALLY QUALIFIED HEALTH CENTER

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

89.00

200.00

201.00

202.00

91. 00 09100 EMERGENCY

Health Financial Systems	OSF SAINT LUKE MEDI	CAL CENTER	In Lieu of Form CMS-2552		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-1325	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/24/2024 6:39 pm	

	THE WILL	2/24/2024 6: 3	9 pm
	Title XVIII Hospital	Cost	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5, 209, 369	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)	0	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)	0	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	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 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	5, 209, 369	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	3, 207, 307	11.00
	Reasonabl e charges		
	Ancillary service charges	0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
	Amounts that would have been realized from patients liable for payment for services on a chargebasis		16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
	Total customary charges (see instructions)	0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
20.00	instructions)		20.00
21. 00	Lesser of cost or charges (see instructions)	5, 261, 463	21.00
	Interns and residents (see instructions)	0	•
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	47.750	25 00
26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	47, 753 3, 378, 890	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 834, 820	
27.00	instructions)	1,001,020	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
	REH facility payment amount		28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments	1, 834, 820 541	1
	Subtotal (line 30 minus line 31)	1, 834, 279	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1,001,277	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	326, 616	34.00
	Adjusted reimbursable bad debts (see instructions)	212, 300	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	287, 480	1
	Subtotal (see instructions)	2, 046, 579	
39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		38. 00 39. 00
	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39. 75	N95 respirator payment adjustment (see instructions)	0	39. 75
	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
	Subtotal (see instructions)	2, 046, 579	
40. 01	Sequestration adjustment (see instructions)	40, 932	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs	0	40. 02 40. 03
	Interim payments	2, 309, 948	
	Interim payments	2,007,740	41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
	Tentative settlement-PARHM (for contractor use only)		42. 01
43.00	Balance due provider/program (see instructions)	-304, 301	43.00
43. 01	Balance due provider/program-PARHM (see instructions)	8: 15-	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	24, 122	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	91.00
	The rate used to calculate the Time Value of Money	0.00	
93.00		0	
94.00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems	OSF SAINT LUKE MEDICAL CENTER In Lieu			of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1325	Peri od:	Worksheet E	
			From 10/01/2022 To 09/30/2023	Part B Date/Time Pr	onarad.
			10 09/30/2023	2/24/2024 6:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1325 Peri od: Worksheet E-1 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 4. 00 1.00 2.00 3.00 1.00 Total interim payments paid to provider 1, 107, 771 2, 523, 672 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate 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 06/08/2023 257, 079 3.01 3.02 09/14/2023 43.024 0 3.02 3 03 0 0 3 03 3.04 0 0 3.04 3.05 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 06/08/2023 182, 016 3.50 09/14/2023 3.51 3.51 0 31,708 0 3.52 0 3.52 3 53 0 0 3 53 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 300, 103 -213, 724 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1, 407, 874 2, 309, 948 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, write "NONE" or enter a zero. (1) $\,$ Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 5.02 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 5.50 0 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 the cost report. (1)

6.01

6.02

7.00

8.00

0

304, 301

2, 005, 647

NPR Date

(Mo/Day/Yr)

2.00

40, 694

Contractor

Number

1.00

1, 448, 568

6.01

6.02

7.00

SETTLEMENT TO PROVIDER

Total Medicare program liability (see instructions)

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Health Financial Systems OSF SAI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	0014. 11 2020	09/30/2023	2/24/2024 6: 39	
		Title	XVIII Sw	ving Beds - SNF		
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Total interim payments and to provider	1.00	2.00	3. 00	4. 00	1 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		688, 205 0		0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for		U		ا	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	06/08/2023	136, 787		0	3. 01
3. 02		09/14/2023	23, 612		0	3. 02
3. 03			0		0	3. 03
3. 04 3. 05			0		0	3. 04 3. 05
3.05	Dravider to Dragram		U		U	3.05
3. 50	Provi der to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADJUSTIMENTS TO TROUTONIA		0		o o	3. 51
3. 52			Ö		Ö	3. 52
3. 53			0		ol	3. 53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		160, 399		o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		848, 604		0	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	Γ				5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5.03			0		0	5.03
	Provider to Program					
5. 50	TENTATIVE 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 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		18, 710		0	6. 02
7. 00	Total Medicare program liability (see instructions)		829, 894		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor	l				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1325 From 10/01/2022 To 09/30/2023 Date/Time Prepare 2/24/2024 6: 39 pt					
To 09/30/2023 Date/Time Prepare 2/24/2024 6: 39 pt					
	ed:				
Title XVIII Hospital Cost					
TO DE COMPLETED BY CONTRACTOR FOR MONOTANIBADE COST. REPORTS					
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
	.00				
	. 00				
	. 00				
	. 00				
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	. 00				
	. 00				
	. 00				
line 168	00				
	. 00				
	. 00				
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	. 00				
	. 00				
2.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)					

Health Financial Systems	OSF SA	AINT LUKE MEDICAL CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14	4-1325 Period: From 10/01/2022	Worksheet E-2
		Component CCN: 1	14-Z325 To 09/30/2023	

Title XVIII Sating Body = SMF Cost			Component CCN: 14-Z325	To 09/30/2023	Date/Time Pre 2/24/2024 6:3	
1.00 2.00			Title XVIII	Swing Beds - SNF		7 рііі
COMMUNITATION OF MICROST OF COMPRED SERVICES 1.00 Imputitive routine services - swing bed-WF (see instructions) 759,607 0.1.00 1.00 Imputitive routine services - swing hed-WF (see instructions) 759,607 0.1.00 1.00						
1.00 Inpatient routine services - seing bed-SWF (see instructions) 759,607 0 1.00		COMPUTATION OF NET COOT OF CONFERENCES		1. 00	2. 00	
2.00 Impattent routine services - swing bod-WF (see instructions) 2.00 3.00 Ancil Irany services (from Mist. 1-3., co. 1.3. Iline 2002, for Part A, and sum of Wist. D, 88,824 0.3.00 3.00 Ancil Irany services (from Mist. 1-3., co. 1.3. Iline 2002, for Part B) (for CAN and sulng-bed pass-through, see 3.00	1 00			750 (07	0	1 00
0.00 Ancil Hary services (From West. D-3, col. 3, il ine 200, for Part A, and sum of West. D. 88,824 0.3, 0.0				/59, 60/	Ü	
Part V. Cols. 6 and 7, Ilne 202, for Part 8) (For CAH and swing-bed pass-through, see instructions) 3.01			t A and sum of Wkst D	88 824	0	
1	0.00				O	0.00
4.00 Per dien cost for Interns and residents not in approved teaching program (see Instructions) 246 0.50			3 · · · · · · · · · · · · · · · · · · ·			
Instructions	3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
Program days 246	4.00		ing program (see		0.00	4.00
1. Interns and residents not in approved teaching program (see instructions)	F 00	,		0.47	0	- 00
1.00			actructions)	246		
Subtotal (sum of lines inthrough 3 plus lines 6 and 7) 84, 431 0 8.00					U	
Primary payer payments (see instructions) 0 0 0 0 0 0 0 0 0			thou only	848 431	0	
10.00 Subtotal (line 8 minus line 9) 848, 431 0 10.00 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00	9. 00			0 0	-	
Deductibles billed to program patients (exclude amounts applicable to physician professional services) Subtotal (line 10 minus line 11) Subtotal (line 11) Subtota	10.00			848, 431		
12.00 Subtotal (line 10 minus line 11) 12.00 12.00 13.00 1	11.00		cable to physician	0	0	11.00
13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for prophysician professional services) 14.00 80% of Part B costs (line 12 x 80%) 014.01 15.00						
for physician professional services						
14. 00 80% of Part B costs (line 12 x 80%) 0 14. 00	13. 00) (exclude coinsurance	1, 600	0	13.00
15.00 Subtotal (see instructions) 15.00 10.00	14.00				0	14 00
16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 16.00 16.50 16.55 Proper ACO demonstration payment adjustment (see instructions) 16.55 Rural community hospital demonstration project (\$410A Demonstration) payment 0 16.56 adjustment (see instructions) 0 0 16.50 16.55 adjustment (see instructions) 0 0 17.00 All towable bad debts (see instructions) 0 0 17.00 All towable bad debts (see instructions) 0 0 17.00 All towable bad debts for dual eligible beneficiaries (see instructions) 0 0 18.00 10.00		· · · · · · · · · · · · · · · · · · ·		044 021		
16.50 Ploneer ACO demonstration payment adjustment (see instructions) 16.55				840, 831	-	
16.55 Rural community hospital demonstration project (\$410A Demonstration) payment a giustment (see instructions) 0 16.55		, , , , ,	s)		U	
adjustment (see instructions) 10 0 0 16.99 17.00 Allowable bad debts (see instructions) 17.01 Al gusted reimbursable bad debts (see instructions) 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.01 Total (see instructions) 19.01 Sequestration adjustment (see instructions) 19.02 Demonstration payment adjustment amount after sequestration) 19.03 Sequestration adjustment amount after sequestration) 19.03 Sequestration adjustment amount after sequestrations 19.05 Sequestration adjustment amount after sequestrations 19.06 Sequestration payment adjustment amount after sequestrations 19.07 Sequestration payments adjustment amount after sequestrations 19.08 Sequestration for non-claims based amounts (see instructions) 19.09 Sequestration for non-claims based amounts (see instructions) 19.00 Interim payments 19.00 Sequestration for non-claims based amounts (see instructions) 19.01 Sequestration for non-claims based amounts (see instructions) 19.02 Sequestration for non-claims based amounts (see instructions) 19.03 Sequestration for non-claims based amounts (see instructions) 19.04 Sequestration for non-claims based amounts (see instructions) 19.05 Sequestration for non-claims based amounts (see instructions) 19.06 Sequestration for non-claims based amounts (see instructions) 19.07 Sequestration for non-claims based amounts (see instructions) 19.08 Sequestration for non-claims based amounts (see instructions) 19.09 Sequestration for non-claims based amounts (see instructions) 19.00 Sequestration for non-claims based amounts (see instructions) 19.00 Sequestration for non-claims based amounts (see instructions) 19.00 Sequestration for payments-PARHM (see instructions) 19.00 Sequestration for payments-PARHM (see instructions) 19.00 Sequestration for payments-PARHM (see instructions) 19.00 Sequestration for payments-PARHM (see instructions) 19.00 Sequestration for payments-PARHM (see instructions) 19.00 Sequestration f				0		16. 55
17.00			, р			
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215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00	20					1
	215.00		209 plus line 210) (see			215. 00
		instructions)				

Health Financial Systems	OSF SAINT LUKE MED	ICAL CENTER	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-1325	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/24/2024 6:39 pm	
		Title XVIII	Hosni tal	Cost	

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR WEDICARE PART A SERVICES - COST REIMBURSEMENT 1.00		Title XVIII Hospital	2/24/2024 6: 3 Cost	9 pm
PART V . CALCULATION OF RETMBURSMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETMBURSMENT 1,633,778 1,00 1,633,778 1,00 0 0 0 0 0 0 0 0 0			1.00	
Inpatient services 1,633.778 1,00 2,00 1,633.778 1,00 2,00 1,00 2,00 1,00 2,00 1,00		DART V _ CALCULATION OF RELARRIDSEMENT SETTLEMENT FOR MEDICARE DART A SERVICES _ COST RELARRIDSEMENT		
2.00	1 00		_	1 00
3.00 Collar therapy acquisition cost (see instructions)				
4.00 Subtotal (sum of lines 1 through 3.01) 1,633,778 4.00 0.500 0.00 0.0000 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 0.0000 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 0.0000 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 0.0000 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 0.0000 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 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000	3.00		0	3. 00
Primary payer payments	3. 01	Cellular therapy acquisition cost (see instructions)	0	3. 01
Total Cost (Liné 4 Less Line 5). For CAH (see instructions) 1,650,116 6.00	4.00	Subtotal (sum of lines 1 through 3.01)	1, 633, 778	4.00
COMPUTATION OF LESSER OF COST OR CHARGES	5.00	Primary payer payments	0	5.00
Reasonable charges	6.00		1, 650, 116	6. 00
Routine service charges 0 7.00				
8. 00 Ancillary service charges 0 8. 00 0 0. 00 Total reasonable charges 0 9. 00 0. 00 Total reasonable charges 0 0. 00 0.	7 00	5		7.00
9.00 Organ acquisition charges, net of revenue 0 9.00 0.00 Total reasonable charges 0 10.00 Total reasonable charges 0 10.00 1				
10. 00 Total reasonable charges				
Customary charges				
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 12.00 Namounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 Namounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 Namounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 Namounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 Namounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 Namounts that would have been realized from payment for services on a charge basis 0 12.00 Namounts that would have been realized from payment for services on a charge basis 0 14.00 Namounts that would have been realized from payments (see instructions) 0 14.00 14.00 Namounts 14.00 Namo	10.00	· ·	<u> </u>	10.00
12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 13.00 10.00	11 00			11 00
had such payment been made in accordance with 42 CFR 413.13(e)				
14.00 Total customary charges (see instructions) 14.00 15.00				
15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 19.0	13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 0 16.00 16.00 17.00 17.00 17.00 18.00 18.00 19.00	14.00	Total customary charges (see instructions)		14.00
16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 17.00 17.00 17.00 18.00 18.00 18.00 19.0	15.00		0	15.00
Instructions Cost of physicians' services in a teaching hospital (see instructions) 17. 00 17. 00 17. 00 17. 00 17. 00 18. 00 19.				
17. 00	16. 00		0	16. 00
18.00	17 00			17 00
18. 00	17.00		1 0	17.00
19. 00 Cost of covered services (sum of lines 6, 17 and 18) 1,650, 116 19. 20. 00 20. 00 Deductibles (excl ude professional component) 190, 284 20. 00 21. 00 Excess reasonable cost (from line 16) 0 21. 00 22. 00 Subtotal (line 19 minus line 20 and 21) 1,459, 832 22. 00 23. 00 Coln surance 1,459, 832 22. 00 24. 00 Subtotal (line 22 minus line 23) 1,459, 832 24. 00 25. 00 All owable bad debts (exclude bad debts for professional services) (see instructions) 28, 152 25. 00 26. 00 Adj usted reimbursable bad debts (see instructions) 18, 299 26. 00 27. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 18, 299 26. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1, 478, 131 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 98 Recovery of accelerated depreciation. 0 29. 50 29. 99 Demonstration payment adj ustment (see instructions) 1, 478, 131 30. 00 30. 01 Sequestration adj ustment (see instructions) 29. 50 30. 01 </td <td>18 00</td> <td></td> <td>1</td> <td>18 00</td>	18 00		1	18 00
20. 00 Deductibles (exclude professional component) 190, 284 20. 00 21. 00 Excess reasonable cost (from line 16) 0 21. 00 22. 00 Subtotal (line 19 minus line 20 and 21) 1, 459, 832 22. 00 23. 00 Coinsurance 0 23. 00 24. 00 Subtotal (line 22 minus line 23) 1, 459, 832 24. 00 25. 00 All lowable bad debts (exclude bad debts for professional services) (see instructions) 18, 299 26. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 18, 299 26. 00 27. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 26, 596 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1, 478, 131 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 90 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 29. 99 Recovery of accelerated depreciation. 0 29. 98 29. 99 Subtotal (see instructions) 29. 50 29. 98 30. 01 Sequestration adjustment amount after sequestration 29. 50				
21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 Subtotal (line 19 minus line 20 and 21) 1,459,832 22.00 23.00 20.00 24.00 Subtotal (line 22 minus line 23) 1,459,832 24.00 25.00 All lowable bad debts (exclude bad debts for professional services) (see instructions) 28,152 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 18,299 26.00 27.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 26,596 27.00 27.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 26,596 27.00 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.50 29.50 29.50 29.90 29.50 29.90 29.50 29.90 29.50 29.90 29.				
22. 00 Subtotal (line 19 minus line 20 and 21) 1, 459, 832 22. 00 23. 00 Coinsurance 0 23.00 24. 00 Subtotal (line 22 minus line 23) 1, 459, 832 24. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 28, 152 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 18, 299 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 26, 596 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1, 478, 131 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 98 Recovery of accelerated depreciation. 0 29. 90 29. 98 Recovery of accelerated depreciation adjustment (see instructions) 0 29. 98 29. 99 Subtotal (see instructions) 1, 478, 131 30. 00 30. 01 Sequestration payment adjustment amount before sequestration 29. 98 30. 02 Demonstration payment adjustment amount after sequestration 29. 98 30. 03 Sequestration adjustment-PARHM 30. 03 31. 01 <td></td> <td></td> <td></td> <td></td>				
24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.01 Interim payments 31.01 Interim payments 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.03 Jaccordance vices instructions (see instructions) 32.40 Jaccordance vices instructions) 32.40 Jaccordance vices instructions 32.40 Jaccordance vices ins				
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment (see instructions) 30. 01 Interim payments 31. 01 Interim payments 31. 01 Interim payments 31. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	23.00	Coinsurance	0	23.00
26. 00 Adj usted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	24.00	Subtotal (line 22 minus line 23)	1, 459, 832	24.00
27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 26,596 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1,478,131 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 29. 99 Recovery of accelerated depreciation. 0 29. 98 29. 99 Demonstration payment adjustment amount before sequestration 0 29. 99 30. 01 Subtotal (see instructions) 1,478,131 30. 00 30. 02 Subtotal in adjustment (see instructions) 29. 96 30. 01 30. 02 Superstration adjustment (see instructions) 29. 56 30. 01 30. 02 Sequestration payment adjustment amount after sequestration 0 30. 02 31. 00 Interim payments 1,407,874 31. 00 31. 01 Interim payments 1,407,874 31. 00 31. 01 Tentative settlement (for contractor use only) 31. 01 32. 01 33. 01 33. 01 32. 01 33. 01 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01	25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28, 152	25.00
28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment (see instructions) 30. 04 Sequestration adjustment amount after sequestration 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement (for contractor use only) 33. 01 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3, 063 34. 00	26.00	Adjusted reimbursable bad debts (see instructions)	18, 299	26.00
29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pi oneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.01 Subtotal (see instructions) 30.02 Demonstration payment adjustment (see instructions) 30.03 Sequestration adjustment (see instructions) 30.04 Demonstration payment adjustment amount after sequestration 30.05 Sequestration adjustment amount after sequestration 30.06 Sequestration adjustment-PARHM 30.07 Interim payments 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3,063 34.00	27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26, 596	27.00
Pi oneer ACO demonstration payment adjustment (see instructions) Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Sequestration payment adjustment amount after sequestration Sequestration adjustment (see instructions) Sequestration adjustment amount after sequestration Sequestration adjustment -PARHM Interim payments Interim payments Tentative settlement (for contractor use only) Tentative settlement (for contractor use only) Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3 29, 50 29, 98 1, 478, 131 30. 00 29, 563 30. 01 30. 02 30. 03 31. 01 30. 02 30. 03 31. 01 32. 05 32. 06 33. 00 34. 00			· · ·	
29. 98 Recovery of accelerated depreciation. 29. 98 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment - PARHM 30. 03 31. 00 Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3 29. 98 0 29. 99 1, 478, 131 30. 00 29, 563 30. 01 30. 02 30. 03 31. 01 31. 407, 874 31. 00 31. 01 32. 00 31. 01 32. 00 32. 00 33. 01 34. 00 35. 01 36. 02 37. 04 38. 063 38. 01 39. 02 39. 02 30. 03 30. 03 31. 01 32. 01 33. 01 34. 00				
29. 99 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 04 Sequestration adjustment amount after sequestration 30. 05 Sequestration adjustment amount after sequestration 30. 06 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30. 02 30. 03 30. 04 30. 05 30. 05 30. 07 30. 08 30. 09 30.				
30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 32.01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.00 29, 563 30.01 30.02 30.02 30.03 31.00 31.00 30.02 31.00 31				
30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments Interim payments-PARHM 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.01 30.02 30.03 1, 407, 874 31.00 31.01 31.01 31.01 31.01 31.01 31.01 31.01 31.01 31.01 31.01 31.01 31.01 31.01 31.01 32.01 32.01 33				
30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.02 30.03 31.00 31.01 31.00 31.01 32.00 32.00 32.00 33.01 33.01 34.00				
30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 Interim payments 1, 407, 874 31. 00 31. 01 Interim payments-PARHM 31. 01 Tentative settlement (for contractor use only) 0 32. 00 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 40, 694 33. 00 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3, 063 34. 00				
31.00 Interim payments 1,407,874 31.00 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 0 32.00 32.01 Tentative settlement-PARHM (for contractor use only) 0 32.00 33.01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 40,694 33.00 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33.00 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3,063 34.00		, , , , , , , , , , , , , , , , , , , ,	١	
31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3,063 34.00		, '	1 407 874	
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3,063 34.00			1,407,074	
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3,063 34.00			0	
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 40,694 33.00 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3,063 34.00				
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3,063 34.00		1	40, 694	
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 3,063 34.00	33. 01			
§115. 2	34.00	Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	3, 063	34.00
		§115. 2		

Health Financial Systems OSF SAINT LUK
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 14-1325

oni y)				077 007 2020	2/24/2024 6: 3	9 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-732, 193	1	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	9, 985, 299	0	0	0	3. 00 4. 00
5. 00	Other recei vable	485, 099	1	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	1	1	0	Ö	
7.00	Inventory	377, 821	0	0	0	7.00
8. 00	Prepai d expenses	0	0	0	0	1
9.00	Other current assets	62, 995, 698	1	0	0	9.00
10. 00 11. 00	Due from other funds	0 67, 590, 358	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	07, 390, 336	U U	0	U] 11.00
12. 00	Land	1, 712, 018	0	0	0	12.00
13.00	Land improvements	1, 390, 342		0	0	
14.00	Accumul ated depreciation	-1, 097, 790	0	0	0	14.00
15. 00	Bui I di ngs	22, 045, 313	1	0	0	15.00
16.00	Accumulated depreciation	-13, 483, 709	1	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	0	0	0	0	17. 00 18. 00
19. 00	Fi xed equipment	0		0	0	19.00
20. 00	Accumulated depreciation	Ö	ő	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	17, 724, 099	1	0	0	23. 00
24. 00	Accumulated depreciation	-14, 121, 474	1	0	0	24.00
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	0	0	0	0	25. 00 26. 00
27. 00	HIT desi gnated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	ő	0	Ö	28.00
29. 00	Mi nor equi pment-nondepreci abl e	334, 878	0	0	0	
30.00	Total fixed assets (sum of lines 12-29)	14, 503, 677	0	0	0	30.00
04 00	OTHER ASSETS		1			
31. 00 32. 00	Investments Penerits on Leases	638, 104	0	0	0	31.00
33. 00	Deposits on leases Due from owners/officers	0	0	0	0	33.00
34. 00	Other assets	916, 316	_	0	Ö	34.00
35.00	Total other assets (sum of lines 31-34)	1, 554, 420	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	83, 648, 455	0	0	0	36.00
07.00	CURRENT LIABILITIES		1			
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	446, 382 158, 941	0	0	0	37. 00 38. 00
39. 00	Payroll taxes payable	130, 941	0	0	0	39.00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00	Deferred income	Ö	O	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	
44.00	Other current liabilities	-289, 082		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	316, 241	0	0	0	45.00
46. 00	Mortgage payable	0	0	0	0	46.00
47. 00	Notes payable	Ö		0	Ö	
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	462, 462	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	462, 462	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	778, 703	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	82, 869, 752				52.00
53. 00	Specific purpose fund	02,007,732	0			53.00
54. 00	Donor created - endowment fund balance - restricted		Ĭ	0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	82, 869, 752	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	83, 648, 455	1	0	0	
	59)			9		
			· ·			

16. 00 17. 00

18.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 14-1325 Peri od: Worksheet G-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 3. 00 4.00 2.00 1.00 Fund balances at beginning of period 73, 453, 469 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 9, 410, 247 2.00 2.00 3.00 Total (sum of line 1 and line 2) 82, 863, 716 ol 3.00 4.00 **TRANSFERS** 6,036 0 4.00 5.00 0 5.00 0 6.00 0 0 0 0 6.00 0 7. 00 0 7.00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 6,036 0 10.00 82, 869, 752 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 000000 13.00 0 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 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 82, 869, 752 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 0 0 3.00 3.00 Total (sum of line 1 and line 2) 4.00 **TRANSFERS** 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00

0

0

0

0

16.00

17.00

18.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

| Peri od: | Worksheet G-2 | From 10/01/2022 | Parts | & II | To | 09/30/2023 | Date/Time | Prepared:
 Heal th Financial Systems
 OSF

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 14-1325

			То	09/30/2023	Date/Time Prep 2/24/2024 6:39	
	Cost Center Description	I npati ent		Outpati ent	Total	, p
		1.00		2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	1, 423, 9	933		1, 423, 933	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF	566, 4	130		566, 430	5.00
6.00	Swing bed - NF	53, 6	549		53, 649	6.00
7.00	SKILLED NURSING FACILITY					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)	2, 044, 0)12		2, 044, 012	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	60, 6	555		60, 655	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	s 60, 6	555		60, 655	16.00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 104, 6			2, 104, 667	17.00
18. 00	Ancillary services	4, 053, 7		72, 679, 170	76, 732, 936	18. 00
19. 00	Outpati ent servi ces	356, 8	808	14, 436, 680	14, 793, 488	19. 00
20.00	RURAL HEALTH CLINIC		0	12, 634, 815	12, 634, 815	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY					22.00
23. 00	AMBULANCE SERVICES					23.00
24. 00	CMHC					24.00
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)					25.00
26. 00	HOSPI CE		_			26. 00
27. 00	NRCC		0	681	681	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to We	kst. 6, 515, 2	241	99, 751, 346	106, 266, 587	28. 00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)			20 0/5 215		29. 00
29. 00 30. 00	ADD (SPECIFY)		0	39, 065, 215		29. 00 30. 00
31.00	ADD (SPECIFY)		0			30.00
32.00			0			32.00
33. 00			0			33.00
34.00			0			34. 00
35.00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		U	0		36.00
37. 00	DEDUCT (SPECIFY)		0	٥		37. 00
38. 00	DEDUCT (SI ECTIT)		0			38.00
39. 00			0			39.00
40. 00			0			40.00
41.00			0		ŀ	41.00
42.00	Total deductions (sum of lines 37-41)		U	0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfer		39, 065, 215		43.00
10. 00	to Wkst. G-3, line 4)			37, 000, 210		.0.00
	1,	ı	,	ı	'	

	Financial Systems OSF SAINT LUKE MENT OF REVENUES AND EXPENSES	MEDICAL CENTER Provider CCN: 14-1325	Peri od:	u of Form CMS-2 Worksheet G-3	
			From 10/01/2022 To 09/30/2023		pared:
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,			106, 266, 587	1.00
2. 00	Less contractual allowances and discounts on patients' ac	ccounts		59, 649, 745	
3. 00	Net patient revenues (line 1 minus line 2)			46, 616, 842	3.00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, I			39, 065, 215	•
5. 00	Net income from service to patients (line 3 minus line 4)			7, 551, 627	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			347, 039	6. 00
7. 00	Income from investments			64, 712	
8. 00	Revenues from telephone and other miscellaneous communica	ition services		0	
9. 00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	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			127, 816	1
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to oth	er 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			60	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23.00
24.00	OTHER REVENUE			779, 576	1
24. 01	340B REVENUE			543, 418	
	COVI D-19 PHE Fundi ng			0	24. 50
	Total other income (sum of lines 6-24)			1, 862, 621	
	Total (line 5 plus line 25)			9, 414, 248	1
27.00				•	27. 00
27 01	ROUNDI NG			1	27 01

4, 000 27. 00 1 27. 01

4, 001 28. 00 9, 410, 247 29. 00

27. 01 ROUNDI NG

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

		SF SAINT LUKE N				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Period: From 10/01/2022	Worksheet M-1	
			Component		To 09/30/2023		pared:
						2/24/2024 6: 3	9 pm
					RHC I	Cost	
		Compensation	Other Costs		Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2.00	3. 00	4. 00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1. 00	Physician	1, 473, 164	172, 250	1, 645, 41	-68, 516	1, 576, 898	1.00
2. 00	Physician Assistant	276, 136		276, 13		263, 865	2.00
3. 00	Nurse Practitioner	674, 995	l	674, 99			3.00
4. 00	Visiting Nurse	074, 993	0	074, 77	2,034	077,029	1
5. 00	Other Nurse	2, 108, 480	0	2, 108, 48	٥	2, 134, 682	5.00
6. 00	Clinical Psychologist	2, 100, 400	0	2, 100, 40	0 20, 202		1
7. 00	Clinical Social Worker	51, 771	0	51, 77	٥	1	1
8. 00	Laboratory Technician	31, 771	0	31,77) 019	0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0			0	1
10.00	Subtotal (sum of lines 1 through 9)	4, 584, 546	172, 250	4, 756, 79	٥ -	_	
11. 00	Physician Services Under Agreement	0	0	1,700,77	0 0	0	11.00
12. 00	Physician Supervision Under Agreement	0	0		0	0	1
13. 00	Other Costs Under Agreement	0	Ö		0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	424, 901	424, 90	1 0	424, 901	15. 00
16.00	Transportation (Health Care Staff)	0	11, 368	11, 36	3 0	11, 368	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	17. 00
18.00	Professional Liability Insurance	0	11, 921	11, 92	1 0	11, 921	18. 00
19.00	Other Health Care Costs	0	8, 131	8, 13	1 0	8, 131	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	456, 321	456, 32	1 0	456, 321	21.00
22.00	Total Cost of Health Care Services (sum of	4, 584, 546	628, 571	5, 213, 11	7 -51, 136	5, 161, 981	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FOHC SERVICES			-	-1		
23. 00	Pharmacy	0			0	0	
24. 00	Dental	0	0	1	0	0	24.00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0		49, 548		
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0	1	0	0	26.00
27. 00	Nonallowable GME costs	_	_		40 540	40 540	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	·	49, 548	49, 548	28. 00

547, 393

547, 393

5, 131, 939

151, 917 1, 567, 255

1, 719, 172

6, 930, 701

-750

-1, 206, 609

-1, 207, 359

-1, 208, 947

29.00

30.00

31.00

32.00

152, 667

2, 773, 864

2, 926, 531

8, 139, 648

152, 667

2, 226, 471 2, 379, 138

3, 007, 709

through 27)
FACILITY OVERHEAD
29.00 Facility Costs

31.00

32.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	OSF SAINT LUKE MEDICAL CENTER	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1325	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-344	To 09/30/2023 Date/Time Prepared:

			Component CCN: 14-	-3445 10	09/30/2023	2/24/2024 6:3	
					RHC I	Cost	57 PIII
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS		,				
1. 00	Physi ci an	-2, 746	1, 574, 152				1.00
2.00	Physici an Assistant	0	263, 865				2.00
3.00	Nurse Practitioner	0	677, 629				3.00
4.00	Visiting Nurse	0	ol				4.00
5. 00	Other Nurse	0	2, 134, 682				5.00
6. 00	Clinical Psychologist	0	o				6.00
7. 00	Clinical Social Worker	0	52, 586				7. 00
8. 00	Laboratory Techni ci an	0	o				8. 00
9. 00	Other Facility Health Care Staff Costs	0	o				9.00
10.00	Subtotal (sum of lines 1 through 9)	-2, 746	4, 702, 914				10.00
	Physician Services Under Agreement	0	0				11.00
	Physician Supervision Under Agreement	0	o				12.00
	Other Costs Under Agreement	0	o				13. 00
	Subtotal (sum of lines 11 through 13)	0	Ō				14.00
	Medical Supplies	o o	424, 901				15.00
	Transportation (Health Care Staff)	o o	11, 368				16.00
	Depreciation-Medical Equipment	o o	0				17.00
	Professional Liability Insurance	o o	11, 921				18.00
	Other Health Care Costs	o o	8, 131				19.00
	Allowable GME Costs	J	0, 101				20.00
	Subtotal (sum of lines 15 through 20)	0	456, 321				21.00
	Total Cost of Health Care Services (sum of	-2, 746	5, 159, 235				22. 00
22.00	lines 10, 14, and 21)	2,710	0, 107, 200				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0				23. 00
24. 00	Dental	0	0				24.00
	Optometry	o o	Ö				25. 00
	Tel eheal th	o o	49, 548				25. 01
	Chronic Care Management	o o	0				25. 02
	All other nonreimbursable costs	0	o				26.00
27. 00	Nonallowable GME costs	_					27. 00
28. 00		0	49, 548				28. 00
	through 27)	_	,				
	FACILITY OVERHEAD	L	1				1
29. 00	Facility Costs	0	151, 917				29. 00
30.00	Administrative Costs	-379, 656	1, 187, 599				30.00
	Total Facility Overhead (sum of lines 29 and		1, 339, 516				31.00
2 20	30)	, 555	1, 221, 212				
32.00	Total facility costs (sum of lines 22, 28	-382, 402	6, 548, 299				32.00
	and 31)						
		•					

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC SERVICES Provider CCN: 14-1325 Form 10/01/2020 To 09/30/2023 Date/Time Prepared: 2/24/2024 6:39 pm	Heal th	Financial Systems C	SF SAINT LUKE !	MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
Component CCN: 14-3445 To 09/30/2023 Date/Time Prepared: 2/24/2024 6: 39 pm 27/2024 6: 30 pm 27/	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C			Worksheet M-2	
Number of FTE Personnel Total Visits Productivity Minimum Greater of col. 2 or col. 4				Component				
Personnel Standard (1) Visits (col. col. 2 or col. 4						RHC I		
Note		·	Number of FTE	Total Visits		Mi ni mum	Greater of	
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)	Visits (col.	col. 2 or	
VISITS AND PRODUCTIVITY Positions								
Positions Physician Stroke Stroke Physician Stroke Stroke Stroke Physician Stroke			1. 00	2.00	3. 00	4. 00	5. 00	
1.00								
2.00 Physician Assistant 0.90 5,380 2,100 1,890 3.00 3.00 Nurse Practitioner 4.24 12,837 2,100 8,904 3.00 3				1				
3.00 Nurse Practitioner								
A. 00 Subtotal (sum of lines 1 through 3) 8. 90 34, 830 26, 586 34, 830 4. 00								
5.00 Visiting Nurse								
6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 0 0						26, 586		
7. 00 Clinical Social Worker 0. 46 481 481 7. 00 7. 01 Medical Nutrition Therapist (FOHC only) 0. 00 0 0 7. 01 0. 7. 01 0. 00 0 0 0 0 0 0 0 0							_	
7. 01 Medical Nutrition Therapist (FQHC only)					1		_	
7. 02 Di abetes Sel f Management Training (FOHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				l .	l .			
Solid Soli							_	
8.00 Total FTEs and Visits (sum of lines 4 9.36 35,311 35,311 35,311 8.00 through 7) 9.00 Physician Services Under Agreements 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)	7. 02		0.00	0	1		0	7. 02
through 7) Physician Services Under Agreements 0 9.00				05.044			05.044	
9.00 Physician Services Under Agreements 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 5,159,235 10.00 1.00	8.00		9. 36	35, 311			35, 311	8.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES	0.00							0.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 5, 159, 235 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 49, 548 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 5, 208, 783 12.00 13.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 0, 990488 13.00 14.00 Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1, 339, 516 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 4, 705, 527 15.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 6, 045, 043 18.00 19.00 Overhead applicable to hospital -based RHC/FQHC services (line 13 x line 18) 5, 987, 543 19.00 10.00 Total costs of health care services (line 13 x line 18) 5, 987, 543 19.00 10.00 Total nonreimbursable Costs (from Wkst. M-1, col. 7, line 22) 5, 159, 235 10.00 10.00 0, 90488 12.00 0, 990488 13.00 12.00 0, 990488 13.00 13.30 13.00 13.00 14.00	9.00	Physician Services under Agreements					U	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 5, 159, 235 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 49, 548 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 5, 208, 783 12.00 13.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 0, 990488 13.00 14.00 Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1, 339, 516 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 4, 705, 527 15.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 6, 045, 043 18.00 19.00 Overhead applicable to hospital -based RHC/FQHC services (line 13 x line 18) 5, 987, 543 19.00 10.00 Total costs of health care services (line 13 x line 18) 5, 987, 543 19.00 10.00 Total nonreimbursable Costs (from Wkst. M-1, col. 7, line 22) 5, 159, 235 10.00 10.00 0, 90488 12.00 0, 990488 13.00 12.00 0, 990488 13.00 13.30 13.00 13.00 14.00							1 00	
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 5, 159, 235 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 49, 548 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 5, 208, 783 12.00 13.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 0.990488 13.00 15.00 Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1, 339, 516 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 4, 705, 527 15.00 16.00 Total overhead (sum of lines 14 and 15) 6, 045, 043 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 6, 045, 043 18.00 19.00 Overhead applicable to hospital -based RHC/FQHC services (line 13 x line 18) 5, 987, 543 19.00		DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FOHC SE	RVLCES		11.00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 49,548 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 5,208,783 12.00 13.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 0.990488 13.00 15.00 Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1,339,516 14.00 16.00 Total overhead (sum of lines 14 and 15) 4,705,527 15.00 17.00 Allowable GME overhead (see instructions) 6,045,043 16.00 18.00 Enter the amount from line 16 6,045,043 18.00 19.00 Overhead applicable to hospital -based RHC/FQHC services (line 13 x line 18) 5,987,543 19.00							5, 159, 235	10.00
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 10.090488 13.00 1, 339, 516 14.00 6, 045, 043 16.00 6, 045, 043 18.00 5, 987, 543								
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 10.090488 13.00 1, 339, 516 14.00 6, 045, 043 16.00 6, 045, 043 18.00 5, 987, 543	12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			5, 208, 783	12.00
14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1, 339, 516 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 4, 705, 527 15.00 16.00 Total overhead (sum of lines 14 and 15) 6, 045, 043 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 6, 045, 043 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 5, 987, 543 19.00	13.00							
16.00 Total overhead (sum of lines 14 and 15) 6,045,043 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 6,045,043 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 5,987,543 19.00	14.00				ine 31)		1, 339, 516	14.00
17. 00Allowable GME overhead (see instructions)017. 0018. 00Enter the amount from line 166, 045, 04318. 0019. 00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)5, 987, 54319. 00	15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)	,		4, 705, 527	15.00
18.00 Enter the amount from line 16 6,045,043 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 5,987,543 19.00	16.00	Total overhead (sum of lines 14 and 15)	,	,			6, 045, 043	16.00
18.00 Enter the amount from line 16 6,045,043 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 5,987,543 19.00	17.00	Allowable GME overhead (see instructions)					0	17. 00
	18.00						6, 045, 043	18.00
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 11,146,778 20.00	19.00	Overhead applicable to hospital-based RHC/FC	MC services (I	ine 13 x line	18)		5, 987, 543	19.00
	20.00	Total allowable cost of hospital-based RHC/F	FQHC services (sum of lines 1	0 and 19)		11, 146, 778	20.00

Heal th	Financial Systems OSF SAINT LUKE MED	I CAL CENTER	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1325	Peri od:	Worksheet M-3	
SERVI CE	ES .	Component CCN: 14-3445	From 10/01/2022 To 09/30/2023	Date/Time Pre	nared:
		Component Con. 14 3443	10 077 307 2023	2/24/2024 6: 3	
		Title XVIII	RHC I	Cost	
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		<u> </u>	1. 00	
	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2. line 20)		11, 146, 778	1.00
1	Cost of injections/infusions and their administration (from W			572, 411	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m			10, 574, 367	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			35, 311	4.00
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
1	Total adjusted visits (line 4 plus line 5)			35, 311	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			299. 46	7.00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023)	
0.00	Dor visit normant limit (Fram CNC Dub. 100 04 shantar 0 500) (an wayn contractor)	1.00	2.00	0.00
1	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	o. 6 or your contractor)	328. 05 299. 46	340. 52 299. 46	•
H	CALCULATION OF SETTLEMENT		277. 40	277. 40	9.00
	Program covered visits excluding mental health services (from	contractor records)	1, 610	4, 421	10.00
	Program cost excluding costs for mental health services (line		482, 131	1, 323, 913	
1	Program covered visits for mental health services (from contr	*	21	31	12.00
13.00	Program covered cost from mental health services (line 9 x li	ne 12)	6, 289	9, 283	13.00
14.00	Limit adjustment for mental health services (see instructions	5)	6, 289	9, 283	14.00
1	Graduate Medical Education Pass Through Cost (see instruction	•			15. 00
1	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	1, 821, 616	•
	Total program charges (see instructions)(from contractor's re			1, 767, 742	•
1	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times			25, 128 25, 894	
	Total Program non-preventive costs ((Time 10.02/Time 10.07) times	•		1, 309, 559	
10.04	(Titles V and XIX see instructions.)	of and roy trines . doy		1, 307, 337	10.04
16. 05	Total program cost (see instructions)		0	1, 335, 453	16. 05
1	Primary payer amounts			215	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		158, 773	18. 00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		315, 268	19.00
20. 00	Net Medicare cost excluding vaccines (see instructions)			1, 335, 238	20.00
	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		128, 585	
1	Total reimbursable Program cost (line 20 plus line 21)	,		1, 463, 823	
1	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	•
	Demonstration payment adjustment amount before sequestration			1 4/2 022	1
1	Net reimbursable amount (see instructions)			1, 463, 823	
1	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			29, 276 0	
1	Interim payments			1, 337, 668	
1	Tentative settlement (for contractor use only)			1, 337, 000	28.00
1	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		96, 879	
	Protested amounts (nonallowable cost report items) in accorda		,	0	30.00
30. 00 j			1		

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC		Peri od:	Worksheet M-4	
		Component (From 10/01/2022 To 09/30/2023	Date/Time Pre 2/24/2024 6:3	
		Title		RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4, 702, 914	4, 702, 91	4 4, 702, 914	4, 702, 914	1.0
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 002233	0. 00669	0. 001740	0.000000	2.0
. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	10, 502	31, 46	7 8, 183	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	158, 562	56, 22	5 0	0	4.0
. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	169, 064 5, 159, 235	87, 69 5, 159, 23			
. 00 . 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	5, 987, 543 0. 032769	5, 987, 54 0. 01699			
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	196, 206 365, 270	101, 77 189, 46			
1. 00	Total number of injections/infusions (from your records)	761	2, 28	0 593	0	11. (
2. 00	Cost per injection/infusion (line 10/line 11)	479. 99	83. 1	0 29. 81	0.00	12. (
3. 00	Number of injection/infusion administered to Program beneficiaries	155	57	1 226	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	74, 398	47, 45	0 6, 737	0	14.
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
				1. 00	2.00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,	1.00	572, 411	15.
, 00	Total Program cost of injections/infusions and their admin				128, 585	14

Health Financial Systems	OSF SAINT LUKE MEDI	ICAL CENTER	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 14-1325 Component CCN: 14-3445	Peri od: From 10/01/2022 To 09/30/2023	

		Component CCN: 14-3445	10 09/30/2023	2/24/2024 6: 39	
			RHC I	Cost	
	· · · · · · · · · · · · · · · · · · ·		Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			1, 337, 668	1. 0
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. (
. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. (
. 01	Frogram to Frovider			0	3. (
. 02					3.
. 02					3.
. 03					3.
. 05					3.
00	Provider to Program			0	٥.
50	Trovidor to frogram			0	3.
51				ا ا	3.
52				l ol	3.
53				ا آ	3.
54				l ol	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		ا	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	•	е	1, 337, 668	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5.
	Program to Provider				
01				0	5.
02				0	5.
03				0	5.
	Provi der to Program				_
50				0	5.
51				0	5.
52		00)		0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.
00	Determined net settlement amount (balance due) based on the	e cost report. (1)		0, 272	6.
	SETTLEMENT TO PROVIDER			96, 879	6.
	SETTLEMENT TO PROGRAM			0	6.
02					
02	Total Medicare program liability (see instructions)		0 1 1	1, 434, 547	/.
02			Contractor	NPR Date	7.
. 01 . 02 . 00		0	Contractor Number 1.00		7.