Health Financia	al Syste	ems	LUTHERAN HOSPITAL O	F INDIANA			In Lie	u of Form	CMS-2	2552-10
This report is	requi r	ed by law (42 USC 1395)	g; 42 CFR 413.20(b)). Failu	re to report can i	resul t	in all	interim	FORM APPR	OVED	
payments made :	since t	he beginning of the co	st reporting period being o	leemed overpayments	s (42	USC 1395	g).	OMB NO. O	938-0	0050
HOSPITAL AND H	OSPI TAL	HEALTH CARE COMPLEX CO	OST REPORT CERTIFICATION	Provi der CCN: 150		Peri od:		Worksheet		
AND SETTLEMENT	SUMMAR	Υ						Parts I-I		
						To 06/	30/2014	Date/Time		
								12/1/2014	1: 18	3 pm
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	12/1/20	14 Timo	e: 1	:18 pm
use only	2. [] Manually submitted co	st report							
			report enter the number of		ler res	submitted	l this co	ost report		
	4. [F] Medicare Utilization.	Enter "F" for full or "L"	for low.						
Contractor	5. [1	1Cost Report Status	6. Date Received:		10. NF	PR Date:				
use only	(1)	Ás Submitted	7. Contractor No.		11. Cc	ontractor	's Vendo	or Code:		4
	(2)	Settled without Audit	8. [N] Initial Report for	this Provider CCN	l 12. [0]If lii	ne 5, co	lumn 1 is	4: Er	nter
		Settled with Audit	9. N Final Report for the	nis Provider CCN				es reopene		
	(-)	Reopened								

PART II - CERTIFICATION

(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 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 the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN HOSPITAL OF INDIANA (150017) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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.

(Si gned)				
	Officer o	r Administrator	of Provider(s)	
Title				
Date				

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	630, 339	-150, 640	77, 759	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing bed - SNF	0	0	0		0	5. 00
6.00 Swing bed - NF	0				0	6.00
200. 00 Total	0	630, 339	-150, 640	77, 759	0	200. 00
The above amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above compl	ex indicated.	

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

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150017 Peri od: Worksheet S-2 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7950 WEST JEFFERSON BLVD 1.00 PO Box: 1.00 State: IN 2.00 City: FT WAYNE Zip Code: 46804 County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 LUTHERAN HOSPITAL OF 150017 23060 1 07/01/1966 Ν 0 3.00 NDI ANA Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2013 06/30/2014 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for ves or "N" for no In-State In-State Out-of Out-of Medicai d Other Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2. 00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 6, 455 2,066 216 63 8,064 24 00 in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state 0 0 0 0 0 25.00 Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27.00 enter the effective date of the geographic reclassification in column 2.

If this is a sole community hospital (SCH), enter the number of periods SCH status in

35.00

effect in the cost reporting period.

1.00 2.00	OSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	F	Period: From 07/01 To 06/30 Beginni	/2014	Workshe Part I Date/Ti 12/1/20 Endi	me Pre	epared:
0. Oil Fith is a Medicare dependent hospital (DMH), enter the number of periods MDH status in refrect in the cost reporting period. 1. Oil Fith is as Medicare dependent hospital (DMH), enter the number of periods MDH status. 1. Oil Fith is as Medicare dependent hospital states of MDH status. Subscript line 38 for number of periods. In the cost reporting period of the periods o										
7.00 If this is a Medicare dependent hospital (M6H), enter the number of periods MBH status in effect in the cost reporting period. 8.00 Enter applicable beginning and ending dates of MBH status. Subscript line 38 for number of periods in excess of view and enter subsequent dates. 9.00 Dees this Facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 1 "Y" for yes or "N" for no. Does the facility meet the all-eage regularements in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 1 "Y" for yes or "N" for no. Does the facility meet the all-eage regularements in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 2 "Y" for yes or "N" for no. (See Instructions) 9.00 Prospective Payment System (PPS) -Capital Deplied to the subscript of	6. 00			Subscript line	36 for number					36. 0
1.00 Cheen and period bids period in excess of fore and enter subsequent dates of MRH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates. Y/N	. 00			umber of period	ds MDH status		0			37. 0
of periods in excess of one and enter subsequent dates. Y/N				Cubaarint lina	20 for number					20.0
9.00 Does this facility qualify for the Inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CRR \$412.1016()(2)(11)? Inter in column 1 'Y' for yes or 'N' for no. Does the facility medited the mileage requirements in accordance with 42 CRR \$412.1016()(2)(11)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility medited facility medited facility medited facility medited facility medited facility of the facility of th	8.00			Subscript line	38 FOR number					38. 0
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Prespective Payment System (PPS)-Capital 5.00 Does this Facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.300? (see instructions) 6.00 Is this Facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.300? (see instructions) 7.00 Is this racility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no. 8.00 Is the facility electing full rederal capital payment? Enter "Y for yes or "N" for no. 9.01 Is the facility electing full rederal capital payment? Enter "Y" for yes or "N" for no. 10.02 Is this a new hospital involved in training residents in approved GME programs rained at this facility? Enter "Y" for yes or "N" for no. 10.03 Is the facility electing full rederal capital payment? Enter "Y" for yes or "N" for no. 10.04 If I line 56 is yes, sit start training in the first month or this cost reporting period? Enter "Y" for yes or "N" for no in column 1. I'r column 1 is "Y" did residents start training in the first month or this cost reporting period? Enter "Y" for yes or "N" for no in column 2. I'r column 2 is "Y" complete Worksheet E-4. I'r column 2 is "N" for so is 1 yes, add this facility elect cost relebursement for physicians services a defined in CMS PNB. 15-1, section 2148? If yes, complete Worksheet D-2, Part I. 10.00 OA Are you claiming nursing school and/or allied heal th costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) 10.00 OA Expects claimed on this Pacility elect cost relebursement for "N" for no. (see instructions) 10.01 OA your hospital receive FFE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 10.01 OA your hospital receive for sold particles of the surface	9. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req)? Ente Jui remen	er in column 1 nts in accordar	"Y" for yes nce with 42	_				39. 0
Prospective Payment System (PPS)-Capital										1
with 42 CFR Section \$412,3207 (see instructions) 0		Prospective Payment System (PPS)-Capital					1.00	7 2.00	3.00	
Statis facility eligible for additional payment exception for extraordinary circumstances oursunt to 42 CFR \$412.346(F)? If yes, complete Worksheet I, Part III and L-I, Parts I through III.	5. 00		it for (di sproporti onat	te share in ac	cordance	N	Y	N	45. 0
8.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	6. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Work			,		N	N	N	46. 0
Sthis a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. Or "N" for no. Till films 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "N", complete Worksheet E4. If column 2 is "N", complete Worksheet D4. If column 2 is "N, column 2 is "N, column 2 is "N, column 2 is "N, column 2		Is the facility electing full federal capital payment							1	47. C 48. C
1.00 If	5. 00	Is this a hospital involved in training residents in	approve	ed GME programs	s? Enter "Y"	for yes	Y			56.0
GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "N", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III, & IV and D-2, Part II, if applicable. 3.00 If fline 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5. 9.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-5. 9.00 Are coulcialming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) 1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care enter the average number of unweighted primary care enter the average number of unweighted primary care enter cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the current year total unweighted primary care endor general surgery residents, which is used for determining compilance with the 75% test. (see instructions) 1.04 Enter the difference between the baseline primary and/or general surgery residents, which is used for determining compilance with the 75% test. (see instructions) 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs that are nonprimary care entered by a primary	7. 00		eriod o	durina which re	esidents in ap	proved	N			57.0
2.00 Are costs claimed on line 100 of Worksheet Å? If yes, complete Worksheet D-2, Part I. 2.00 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) 1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.00 Enter the average number of unweighted primary care FTEs from the hospital is 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding 08/GVN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current year the difference between the baseline primary and/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs that are nonprimary care or general surgery. (see instructions) 1.06 Enter the difference between the baseline primary and/or general surgery. (see instructions) 1.00 Fine FTEs in line 61.05, specify each new program proved the section of the FTE count proved the program of th		GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y"N", complete Worksheet D, Part III & IV and D-2, Par If line 56 is yes, did this facility elect cost reimb	yes on the second of the secon	r "N" for no ir his cost report plete Worksheet if applicable. nt for physicia	n column 1. If ting period? t E-4. If colu	column 1 Enter "Y" mn 2 is	N			58. (
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Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 1. 05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61. 04 minus line 61. 03). (see instructions) 1. 06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME FTE Count 1. 00 2. 00 3. 00 4. 00 1. 10 Of the FTEs in line 61. 05, specify each new program specialty, if any, and the number of FTE residents	. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.0	o				61. (
.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) .06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents	. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	d				61. (
.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME FTE Count 1.00 2.00 3.00 4.00 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents	. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.0	o				61.
Program Name Program Code Unweighted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents	. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary		0.00	0.0	o				61. (
.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents		g., (Pr			FTE Co	ount	Direct (Cou	GME FTE	-
column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE	. 10	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the		1.00	2.00	3.00				61.

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150017 Peri od: Worksheet S-2 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am Program Code Unweighted IME Program Name Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Non-Provider Settings 63.00 Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) N 63.00 Unwei ghted Unwei ghted Ratio (col. 1/ FTEs in FTES (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident 0. 00 0. 00 0.000000 66.00

FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

	instructions) Enter "Y" for yes or "N" for no in the applicable column.			
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter	N	N	93. 00
	"Y" for yes or "N" for no in the applicable column.			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00
	applicable column.			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N	N	96. 00
	applicable column.			
97. 00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0. 00	97. 00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105. 00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment			106. 00
	for outpatient services? (see instructions)			

Health Financial Systems LUTHERAN HOSPIT. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150017	Period: From 07/01 To 06/30	/2013	w of For Workshoper Part I Date/Ti 12/1/20	et S-: me Pro	2 epared:
			1. 00	`	XI		4
107.00 Column 1: If this facility qualifies as a CAH, is it eligil for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on We 25 and the program would be cost reimbursed. If yes complete Column 2: If this facility is a CAH, do I&Rs in an approved train in the CAH's excluded IPF and/or IRF unit? Enter "Y' column 2. (see instructions)	o in column 1. Orksheet B, Pa e Worksheet D- d medical educa " for yes or "I	(see rt I, column 2, Part II. ation program N" for no in		J	2.(<u>JU</u>	107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				a b	Docni r	atony	108. 00
	Physi cal 1.00	Occupationa 2.00	3. 00		Respir 4.		+
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.							109.00
				1. 00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of enter the method used (A, B, or E only) in column 2. If column it is in the provider "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital providers 15-1. \$2208.1.	umn 2 is "E", e for long term	enter in colu care (includ	mn 3 les	N		0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insulan			"N" for	N N			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i			1			118. 00
		Premiums	Losse	es	Insur	ance	
		1. 00	2.00)	3. (00	
118.01 List amounts of malpractice premiums and paid losses:		617, 3	74 18	39, 118			0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.			1. 00 N)	2. (00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies the Hold Harmless provision in ACA §3121 and applicable amendments.	n column 1 "Y" ualifies for tl	for yes or he Outpatient			N	I	119. 00 120. 00
Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y				121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	for yes and "N"	for no. If	Y				125. 00
			14 (05 (2008			126. 00
yes, enter certification date(s) (mm/dd/yyyy) below.		fication date					
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2	2. ter the certifi 2.	ication date	02/16/1				
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ender in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, ender in column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, ender in column 1 and termination date, if applicable, in column 1	 ter the certifi ter the certifi . 	ication date	02/16/1				128. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, entocolumn 1 and termination date, if applicable, in column 2.130.00 If this is a Medicare certified pancreas transplant center,	2. ter the certifi 2. ter the certifi 2. er the certifi enter the certifi	ication date ication date cation date i	02/16/1				128. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.	2. ter the certifi 2. ter the certifi 2. er the certifi enter the certifi tumn 2. r, enter the certifi	ication date ication date cation date i tification	02/16/1				128. 00 129. 00 130. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, entecolumn 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 1.	2. ter the certification the certification the certification the certification the certification that the certification the certification that the certification	ication date ication date cation date itification date itification	02/16/1				128. 00 129. 00 130. 00 131. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified lung transplant center, enticolumn 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, and termination date, and termination	2. ter the certifi 2. ter the certifi 2. er the certifi enter the certifi umn 2. r, enter the certifi 1umn 2. ter the certifi 2. ter the certifi 2.	ication date ication date cation date itification ertification date ication date	02/16/1				127. 00 128. 00 129. 00 130. 00 131. 00 132. 00 133. 00
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Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	LUTHERAN HOSP X IDENTIFICATION DATA			l: 15001	7 Perio		u of Form CMS Worksheet S-	
						07/01/2013	Part I	ononod.
					То	06/30/2014	Date/Time Pr 12/1/2014 9:	
1.00		. 00			<u>'</u>	3. 00		
If this facility is part of a chai				143 th	ne name a	ind address	of the	
home office and enter the home off 41.00 Name: COMMUNITY HEALTH SYSTEMS	Contractor name and		number.	Contr	actor's l	Number: 1030	.1	
42.00 Street: 4000 MERIDIAN BLVD	PO Box:	WF3		COITE	actor 5 i	Number . 1030	'1	142. 0
43. 00 Ci ty: FRANKLI N		TN		Zip C	ode:	3706	7	143. 0
							1 00	
44.00 Are provider based physicians' cos	ts included in Workshop	+ 12					1. 00 Y	144. 0
45.00 f costs for renal services are cl			hev co	sts for	inpatie	nt	Y	145. 0
services only? Enter "Y" for yes o		71, 410 1		313 101	Theatro		•	1 10. 0
						1 00	2.00	_
46.00 Has the cost allocation methodolog	v changed from the previ	iously filed	cost r	enort?		1. 00 N	2. 00	146. 0
Enter "Y" for yes or "N" for no in					es,	IV		140.0
enter the approval date (mm/dd/yyy		,		-, ,	.			
47.00 Was there a change in the statisti						N		147. 0
48.00 Was there a change in the order of					_	N		148. 0
49.00 Was there a change to the simplifino.	ea cost finding method?	Enter "Y" To	or yes	or "N"	Tor	N		149. 0
ITO.		Part A		Part		Title V	Title XIX	
		1.00		2.00		3. 00	4. 00	
Does this facility contain a provi								
or charges? Enter "Y" for yes or " 55.00Hospital	N for no for each comp	N	t A an	<u>u Part</u> N	в. (See	42 CFR 9413 N	N N	 155. 0
56.00 Subprovider - IPF		N	İ	N		N	N N	156. 0
57.00 Subprovi der - IRF		N	İ	N		N	N	157. 0
58. 00 SUBPROVI DER								158. 0
59. 00 SNF		N		N		N	N	159. 0
60. OO HOME HEALTH AGENCY 61. OO CMHC		N		N N		N N	N N	160. 0 161. 0
81. OO CMITC				IN		IN	IV	161. 0
							1. 00	
Mul ti campus						0001.0		۱.,. ۵
65.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus nospitai that has o	one or more c	ampuse	s in ai	rrerent	CBSAS?	N	165. C
Enter 1 for yes of 10 for no.	Name	County		State	Zip Cod	e CBSA	FTE/Campus	
	0	1. 00		2. 00	3.00	4. 00	5. 00	
66.00 If line 165 is yes, for each							O. C	00 166. C
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								
							1. 00	+
Health Information Technology (HIT) incentive in the Amer	i can Recovery	and R	ei nvest	ment Act		1.00	
67.00 s this provider a meaningful user	under Section §1886(n)	? Enter "Y"	for ye	s or "N	l" for no		Y	167. C
68.00 If this provider is a CAH (line 10			line 1	67 is "	Y"), ent	er the		0168.0
reasonable cost incurred for the H 69.00 of this provider is a meaningful u			AU (I:	00 10F	ic "N")	ontor the	0.5	50169. 0
transition factor. (see instruction)		u is not a C	AH (II	ie 105	15 N),	enter the	0.5	04104. (
12. district ractor. (300 matractic	,					Beai nni na	Endi na	_

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)

Begi nni ng

1. 00

10/01/2012

Endi ng

2.00

09/30/2013

	Financial Systems L FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	LUTHERAN HOSPITAL OF IND STIONNAIRE Prov			Peri od:	eu of Form CMS- Worksheet S-2	
					From 07/01/2013 To 06/30/2014	Date/Time Pre	
					Y/N	12/1/2014 9:5 Date	5 a
	Ta				1.00	2.00	
	General Instruction: Enter Y for all YES responded/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all I	NO res	sponses. Enter	all dates in	the	
0	Provider Organization and Operation Has the provider changed ownership immediate	Ly prior to the heginnin	a of	the cost	N	T	1
	reporting period? If yes, enter the date of			nstructions)			
				Y/N 1. 00	2. 00	V/I 3. 00	-
0	Has the provider terminated participation in			N N	2.00	3.00	
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3, "V"	for				
0	Is the provider involved in business transact	tions, including managem	ent	Υ			;
	contracts, with individuals or entities (e.g.						
	or medical supply companies) that are related officers, medical staff, management personnel						
	of directors through ownership, control, or						
	relationships? (see instructions)			Y/N	Type	Date	
			-	1.00	2. 00	3. 00	
	Financial Data and Reports	parad by a Cartified D.	lia	NI		04 /20 /2012	Η.
0	Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for			N		06/30/2013	
	or "R" for Reviewed. Submit complete copy or	enter date available in					
0	column 3. (see instructions) If no, see instructions are the cost report total expenses and total		,	N			
U	those on the filed financial statements? If			IV			
					Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
0	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes,	is the	e provider is	N		1
0	the legal operator of the program? Are costs claimed for Allied Health Programs'	2 If "V" see instruction	ıc		Υ		
0	Were nursing school and/or allied health produced			during the	N		
^	cost reporting period? If yes, see instruction				V		
0	Are costs claimed for Intern-Resident program yes, see instructions.	ns craimed on the curren	t cosi	report? IT	Y		
00	Was an Intern-Resident program been initiated	d or renewed in the curr	ent co	ost reporting	N		1
00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & R in a	ın Annı	roved	N		1
	Teaching Program on Worksheet A? If yes, see						Ι.
						Y/N 1.00	-
	Bad Debts					1.00	
00	Is the provider seeking reimbursement for back					Y	1.
	If line 12 is yes, did the provider's bad del	ot collection policy cna		aring this cos	st reporting	N	
			inge ut				'
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co-payments wai ve	Ü	yes, see inst	ructi ons.	N	
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement		ed? If				1
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a		ed? If	/es, see instr Pai		Y Part B	1
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	or cost reporting period Description	ed? If	yes, see instr Par Y/N	ructions. rt A Date	Y Part B Y/N	1
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	or cost reporting period	ed? If	/es, see instr Pai	ructions.	Y Part B	1
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R	or cost reporting period Description	ed? If	yes, see instr Par Y/N	ructions. rt A Date	Y Part B Y/N	1
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio	or cost reporting period Description	ed? If	yes, see instr Par Y/N 1.00	ructions.	Y Part B Y/N 3.00	1
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	or cost reporting period Description	ed? If	yes, see instr Par Y/N 1.00	ructions.	Y Part B Y/N 3.00	1
00 00 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	or cost reporting period Description	ed? If	yes, see instr Par Y/N 1.00	ructions.	Y Part B Y/N 3.00	1 1
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00 00 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is	Description 0	ed? If	yes, see instr Par Y/N 1.00	ructions.	Y Part B Y/N 3.00	1 1
00 00 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns	Description 0	ed? If	yes, see instr Par Y/N 1.00	ructions.	Y Part B Y/N 3.00	1
000	period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments	Description 0	ed? If	yes, see instr Par Y/N 1.00	ructions.	Y Part B Y/N 3.00	1, 1, 1, 1
00 00 00 00	PS&R Data PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional	Description 0	ed? If	yes, see instr Par Y/N 1.00 Y	ructions.	Part B Y/N 3.00 Y	1 1 1
00 00 00 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments	Description 0	ed? If	yes, see instr Par Y/N 1.00 Y	ructions.	Part B Y/N 3.00 Y	1 1 1
00 00 00 00	PS&R Data PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report or totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Description 0	ed? If	yes, see instr Par Y/N 1.00 Y	ructions.	Part B Y/N 3.00 Y N	111111111111111111111111111111111111111
00 00 00 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments	Description 0	ed? If	yes, see instr Par Y/N 1.00 Y	ructions.	Part B Y/N 3.00 Y	1 1 1 1
00 00 00 00	PS&R Data PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report or totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Description 0	ed? If	yes, see instr Par Y/N 1.00 Y	ructions.	Part B Y/N 3.00 Y N	111111111111111111111111111111111111111
00 00 00 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Description 0	ed? If	yes, see instr Par Y/N 1.00 Y N	ructions.	Part B Y/N 3.00 Y N	11 11 11 11 11 11 11 11 11 11 11 11 11
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see	Description 0	ed? If	yes, see instr Par Y/N 1.00 Y	ructions.	Part B Y/N 3.00 Y N	15 16 17 18 18 19 20

Heal th	Financial Systems	LUTHERAN HOSPITAL O	F INDIANA		In lie	eu of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		Provi der C		Period: From 07/01/2013 To 06/30/2014	Worksheet S Part II	i-2 Prepared:
				Pa	rt A	Part B	
		Descriptio	n	Y/N	Date	Y/N	
		0		1. 00	2.00	3.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT C	HILDRENS HOS	SPI TALS)			
22.00	Capital Related Cost	0.16	A			1	
22. 00 23. 00	Have assets been relifed for Medicare purpose Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.			s made durin	ng the cost		22. 00 23. 00
24. 00	Were new leases and/or amendments to existing If yes, see instructions	g leases entered in	to during th	nis cost repo	orting period?		24. 00
25. 00	Have there been new capitalized leases entereinstructions.	ed into during the	cost reporti	ng period? I	f yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	uired during the co	st reportino	g period? If	yes, see		26. 00
27. 00	Has the provider's capitalization policy charcopy.	nged during the cos	t reporting	period? If y	/es, submit		27. 00
28 00	Interest Expense Were new Loans, mortgage agreements or Letter	rs of credit entere	d into duri	na the cost r	reporting		28. 00
20.00	period? If yes, see instructions.	is or or our contors	a aa	.g :::0 0001 .	opor cring		20.00
29. 00	Did the provider have a funded depreciation a treated as a funded depreciation account? If	yes, see instructi	ons		•		29. 00
30. 00	Has existing debt been replaced prior to its instructions.	scheduled maturity	with new de	ebt? If yes,	see		30. 00
31. 00	Has debt been recalled before scheduled mature instructions.	rity without issuan	ce of new de	ebt? If yes,	see		31. 00
	Purchased Services						
32. 00	Have changes or new agreements occurred in parrangements with suppliers of services? If			through conf	ractual		32. 00
33. 00	If line 32 is yes, were the requirements of 5 no, see instructions.			to competiti	ve bidding? If		33. 00
	Provi der-Based Physi ci ans					1	
34. 00	Are services furnished at the provider faciling types, see instructions.	ity under an arrang	ement with p	provi der-base	ed physi ci ans?		34. 00
35. 00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			s with the pr	rovi der-based		35. 00
	private and during the door reporting period:	,05, 500 1115114	01.0110.		Y/N	Date	
					1. 00	2. 00	
	Home Office Costs						
	Were home office costs claimed on the cost re				Υ		36. 00
37. 00	If line 36 is yes, has a home office cost stallf yes, see instructions.	atement been prepar	ed by the ho	ome office?	Υ		37. 00

36.00	Were home office costs claimed on the cost report?		Υ		36. 00
37.00	If line 36 is yes, has a home office cost statement been pr	repared by the home office?	Υ		37. 00
	If yes, see instructions.				
38. 00	If line 36 is yes , was the fiscal year end of the home of	fice different from that of	Υ	12/31/2013	38. 00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home office.			
39. 00	If line 36 is yes, did the provider render services to other	Υ		39. 00	
	see instructions.				
40.00	If line 36 is yes, did the provider render services to the	N		40. 00	
	instructions.				
		1. 00	2.	00	
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	LI SA	PARRI SH		41.00
	held by the cost report preparer in columns 1, 2, and 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	LI SA_PARRI SH@C	HS. NET	43.00	
	report preparer in columns 1 and 2, respectively.				

From 07/01/2013 To 06/30/2014 Part II Date/Time Prepared: 12/1/2014 9:55 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 11/04/2014 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer.

43.00

43.00

Enter the telephone number and email address of the cost

report preparer in columns 1 and 2, respectively.

 Heal th Financial
 Systems
 LUTHERAN

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared:

					To	06/30/2014	Date/Time Prep 12/1/2014 9:5	
							I/P Days / 0/P) alli
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Davs	CAH Hours	Title V	
	Component	Line Number	INO.	OI BCGS	Avai I abl e	CAIT HOULS	TI LIC V	
		1.00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		234	85, 410	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			234	85, 410	0. 00	0	7. 00
0.00	beds) (see instructions)	21.00			0	0.00		0.00
8.00	INTENSIVE CARE UNIT	31. 00		0	7 200	0.00	0	8. 00
8. 01 8. 02	PEDIATRIC INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 01 31. 02		20 24	7, 300 8, 760	0. 00 0. 00	0	8. 01 8. 02
8. 02 8. 03	CARDIO INTENSIVE CARE UNIT	31. 02 31. 03		24 84	30, 660	0.00	0	8. 02 8. 03
9. 00	CORONARY CARE UNIT	32.00		24	8, 760	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	32.00		24	8, 700	0.00	U	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)	10.00		386	140, 890	0.00	0	14. 00
15. 00	CAH visits				,		Ö	15. 00
16. 00	SUBPROVIDER - IPF	40. 00		o	0		Ö	16. 00
17.00	SUBPROVIDER - IRF							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)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			386				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF				0			31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room			0	0			32. 00 32. 01
32. UI	outpatient days (see instructions)							32. UI
33 00	LTCH non-covered days			ŀ				33. 00
55. 00	21011 Horr covered days		ı	ı				55.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

outpatient days (see instructions)

LTCH non-covered days

0

0

32.00

32.01

33.00

12/1/2014 9:55 am Full Time Equivalents I/P Days / O/P Visits / Trips Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 20, 460 3, 758 51, 738 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 18, 262 10, 186 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 20, 460 3, 758 51, 738 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 8.00 PEDIATRIC INTENSIVE CARE UNIT 8.01 0 88 906 8.01 8.02 NEONATAL INTENSIVE CARE UNIT 0 674 4,545 8.02 7, 379 8.03 CARDIO INTENSIVE CARE UNIT 1, 590 28,006 8.03 9.00 CORONARY CARE UNIT 425 7, 206 9.00 2.442 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 NURSERY 1.969 13.00 143 13.00 Total (see instructions) 2, 031. 33 14.00 30, 281 6,678 94, 370 8.14 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 0 0.00 0.00 16.00 17 00 SUBPROVIDER - IRF 17 00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 20.00 OTHER LONG TERM CARE 21 00 21 00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 0 0 Ω 24.10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26, 25 26, 25 2,031.33 27 00 Total (sum of lines 14-26) 8 14 27 00 28. 00 Observation Bed Days 752 28.00 29.00 Ambul ance Trips 29.00 0 Employee discount days (see instruction) 30.00 0 30.00 31.00 Employee discount days - IRF 0 31.00

32.00

32.01

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared:
 Heal th Financial
 Systems
 LUTHERAN

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 150017

				To	06/30/2014	Date/Time Prep 12/1/2014 9:5	
		Full Time		Di scha	arges	12/1/2014 7.3	Jani
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
4 00		11. 00	12. 00	13.00	14.00	15.00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	5, 667	1, 028	18, 500	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			3, 098	o		2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
8. 01 8. 02	PEDIATRIC INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT						8. 01 8. 02
8. 03	CARDIO INTENSIVE CARE UNIT						8. 03
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	5, 667	1, 028	18, 500	
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - I PF	0. 00	0	0	0	0	16. 00
17. 00	SUBPROVI DER - I RF						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	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						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 29. 00	Observation Bed Days Ambulance Trips						28. 00 29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

					T	06/30/2014	Date/Time Pre 12/1/2014 9:5	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷	
				Worksheet A-6)	3)	col. 4	col. 5)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1.00	SALARIES Total salaries (see	200. 00	104, 079, 412	0	104, 079, 412	4, 188, 065. 00	24. 85	1.00
	instructions)	2001.00	.0.,0,,,		101/07//112	.,,	233	
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3.00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
	В		_					
4. 00	Physician-Part A -		0	0	0	0. 00	0.00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	4. 01
5.00	Physician-Part B		0	0	0	0. 00		
6. 00 7. 00	Non-physician-Part B	21. 00	0	0	0	0. 00 0. 00		
7.00	Interns & residents (in an approved program)	21.00	0	0	U	0.00	0.00	7.00
7. 01	Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office personnel		0	0	0	0.00	0.00	8. 00
9.00	SNF	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		2, 481, 758	475, 001	2, 956, 759	115, 517. 72	25. 60	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		13, 595	0	13, 595	519. 75	26. 16	11. 00
12. 00	Care Contract Labor: Top Level		95, 689	0	95, 689	429. 82	222, 63	12.00
	management and other		•					
	management and administrative services							
13. 00	Contract Labor: Physician-Part		539, 437	0	539, 437	3, 601. 00	149. 80	13. 00
14.00	A - Administrative		0		0	0.00	0.00	14.00
14. 00	Home office salaries & wage-related costs		Ü	0	0	0. 00	0.00	14. 00
15. 00	Home office: Physician Part A		7, 895, 360	0	7, 895, 360	110, 010. 00	71. 77	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16. 00
	Physicians Part A - Teaching]
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		21, 545, 122	0	21, 545, 122			17. 00
	instructions)		2.70.07.122		2.70.07.122			
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		672, 743	0	672, 743			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
	В		_					
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25.00	approved program)				0			25.00
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	720, 074	0	720, 074	25, 196. 00	28. 58	26. 00
27. 00	Administrative & General	5. 00	10, 280, 456			·		
28. 00	Administrative & General under		0	0	0	0.00		1
20.00	contract (see inst.)	4 00	0		0	0.00	0.00	29. 00
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	1, 697, 225	0	1, 697, 225	0. 00 72, 469. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32.00	Housekeepi ng	9. 00	1, 748, 247	0	1, 748, 247	144, 010. 00		
33. 00	Housekeeping under contract (see instructions)		0	١	U	0. 00	0.00	33. 00
34.00	Di etary	10. 00	2, 737, 970	-1, 507, 680	1, 230, 290			
35. 00	Di etary under contract (see instructions)		0	0	0	0. 00	0. 00	35. 00
36. 00	Cafeteri a	11. 00	0	1, 544, 259	1, 544, 259	114, 187. 41	13. 52	
37. 00	Maintenance of Personnel	12.00	0	0	0	0.00		
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	4, 442, 002 1, 359, 737		1, 525, 972 1, 760, 071	39, 563. 00 105, 846. 00		38. 00 39. 00
40. 00		15. 00	5, 636, 234		5, 636, 234			40.00
		'		'				

Health Financial Systems	L	UTHERAN HOSPIT	AL OF INDIANA		In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3		
					From 07/01/2013			
				'	To 06/30/2014			
						12/1/2014 9: 5	<u>am</u>	
	Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly		
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
			(from	(col.2 ± col.	Salaries in	col . 5)		
			Worksheet A-6)	3)	col. 4			
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00		
41.00 Medical Records & Medical	16. 00	1, 895, 941	812, 151	2, 708, 09	2 135, 125. 00	20. 04	41.00	
Records Li brary								
42.00 Social Service	17. 00	0	1, 956, 174	1, 956, 17	4 62, 764. 00	31. 17	42.00	
43.00 Other General Service	18. 00	0	0		0.00	0.00	43.00	

HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 07/01/2013 To 06/30/2014		
		Worksheet A		Recl assi fi cati	,		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$		col . 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		104, 079, 412	0	104, 079, 41:	2 4, 188, 065. 00	24. 85	1.00
	instructions)							
2. 00	Excluded area salaries (see instructions)		2, 481, 758	475, 001	2, 956, 75	9 115, 517. 72	25. 60	2. 00
3.00	Subtotal salaries (line 1		101, 597, 654	-475, 001	101, 122, 65	3 4, 072, 547. 28	24. 83	3. 00
	minus line 2)							
4. 00	Subtotal other wages & related costs (see inst.)		8, 544, 081	0	8, 544, 08	1 114, 560. 57	74. 58	4. 00
5.00	Subtotal wage-related costs (see inst.)		21, 545, 122	0	21, 545, 12:	0.00	21. 31	5. 00
6.00	Total (sum of lines 3 thru 5)		131, 686, 857			6 4, 187, 107. 85	31. 34	6. 00
7. 00	Total overhead cost (see instructions)		30, 517, 886	-475, 000	30, 042, 88	6 1, 377, 671. 00	21. 81	7. 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150017	From 07/01/2013	Worksheet S-3 Part IV Date/Time Prepared:

PART IV - WAGE RELATED COSTS Part A - Core List		To 06/30/2014	Date/Time Prep 12/1/2014 9:5	pared: 5 am
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST				
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 2, 258, 144 1.00 401K Empl oyer Contribution 2, 258, 144 1.00 401K Empl oyer Contribution 2, 258, 144 1.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 4.00 4.00			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 0 0 0 0 0 0 0 0 0	1.00	401K Employer Contributions	2, 258, 144	1. 00
A. 00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration Fees 0 6.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 The Plan Administration Fees 0 7.00 The Pl	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
5.00	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
Legal / Accounting / Management Fees - Pension Plan		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
To be	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
Heal th Insurance (Purchased or Self Funded) 10,711,851 8.00 9.00 10	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 203, 327 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 89, 033 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) -1, 231 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 33, 639 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 'Workers' Compensation Insurance 913, 039 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 IRCA-Employers Portion Only 6, 026, 920 17.00 18.00 Medicare Taxes - Employers Portion Only 1, 409, 522 18.00 19.00 Unemployment Insurance 0 1, 003, 776 20.00 State or Federal Unemployment Taxes 1, 003, 776 20.00 0THER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 22.00 Day Care Cost and Allowances </td <td></td> <td>HEALTH AND INSURANCE COST</td> <td></td> <td></td>		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 203, 327 10.00	8.00	Health Insurance (Purchased or Self Funded)	10, 711, 851	8. 00
11.00 Life Insurance (If employee is owner or beneficiary) 89,033 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) -1,231 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 33,639 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 913,039 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion)	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	203, 327	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 17.00 Non cumulative portion) 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 10.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	89, 033	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only Redicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	-1, 231	12. 00
15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost in Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Non Only 16.00 16. 00 16. 00 16. 00 16. 00 17. 00 19. 00 21. 00 21. 00 22. 00 22. 00 24. 00 Part B - Other than Core Related Cost 24. 00	13.00	Disability Insurance (If employee is owner or beneficiary)	33, 639	13.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Empl oyers Portion Only Medi care Taxes - Empl oyers Portion Only 19.00 Unempl oyment I nsurance 20.00 State or Federal Unempl oyment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuit ion Reimbursement 24.00 Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion TAXES 17.00 FI CA-Employers Portion Only 6,026,920 17.00 18.00 Medicare Taxes - Employers Portion Only 1,409,522 18.00 19	15.00	'Workers' Compensation Insurance	913, 039	15. 00
TAXES 17. 00 FI CA-Employers Portion Only 17. 00 18. 00 Medicare Taxes - Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 18. 00 19.	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00 Fi CA-Employers Portion Only 6, 026, 920 17. 00 18. 00 Medicare Taxes - Employers Portion Only 1, 409, 522 18. 00 19. 00 Unemployment Insurance 0 19. 00 20. 00 OTHER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 0 23. 00 24. 00 Part B - Other than Core Related Cost				
18.00 Medicare Taxes - Employers Portion Only 1, 409, 522 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 1,003,776 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 22,648,020 24.00 Part B - Other than Core Related Cost				
19.00 Unemployment Insurance 0 19.00 State or Federal Unemployment Taxes 0 1,003,776 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuit ion Reimbursement 0 23.00 Tuit ion Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 22,648,020 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 1,003,776 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 22,648,020 Part B - Other than Core Related Cost			1, 409, 522	18. 00
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			0	19. 00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20.00		1, 003, 776	20. 00
instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost		* · · · = · ·		
22. 00	21. 00		0	21. 00
23. 00	00.00		0	00.00
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 22,648,020 24.00				
Part B - Other than Core Related Cost				
	24.00		22, 648, 020	24.00
25. UU UI HEK EMPLUYEE BENEFI I S	25 00		420 452	25 00
	∠5. UU	UITEK EMPLOYEE DENEFIIS	-430, 153	25.00

∐oal ±b	Financial Systems	LUTHERAN HOSPITAL O	E INDIANA		In Lie	u of Form CMS-2	0552 10
	AL CONTRACT LABOR AND BENEFIT COST	LUTTERAN HUSFITAL O		CCN: 150017	Peri od: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part V Date/Time Pre	pared:
	Cost Center Description				Contract Labor	12/1/2014 9:5 Benefit Cost	5 am
	<u> </u>				1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Ident	i fi cati on:					
1.00	Total facility's contract labor and benefit	cost			0	0	1. 00
2.00	Hospi tal				0	0	2. 00
3.00	Subprovi der - I PF				0	0	3. 00
4.00	Subprovider - IRF						4. 00
5.00	Subprovider - (Other)				0	0	5. 00
6.00	Swing Beds - SNF				0	0	6. 00
7. 00	Swing Beds - NF				0	0	7. 00
8. 00	Hospi tal -Based SNF						8. 00
9.00	Hospi tal -Based NF						9. 00
10. 00	Hospi tal -Based OLTC						10. 00
11. 00	Hospi tal -Based HHA						11. 00
12.00	Separately Certified ASC						12.00
13. 00	Hospi tal -Based Hospi ce						13. 00
14. 00	Hospital-Based Health Clinic RHC						14.00
15. 00	Hospital-Based Health Clinic FQHC						15. 00
16. 00	Hospi tal -Based-CMHC						16. 00
17. 00	Renal Dialysis				0	0	17. 00
18. 00	Other				0	0	18. 00

HOSPITAL UNCOMPRISATED AND INDIGENT CARE DATA	Heal th	Financial Systems LUTHERAN HOSPITAL OF	I NDI ANA		In Lie	u of Form CMS-2	2552-10			
Incorporated and Indigent care cost computation	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150017		Worksheet S-10	0			
Incompensated and indigent care cost computation 1.00						D . /T' D				
Uncompensated and Indigent care cost computation					10 06/30/2014					
Uncompensated and indigent care cost computation 0.00						127 17 2011 7. 0	o din			
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)						1. 00				
Medicaid (See Instructions for each line) 47,171,837 2.0										
Net revenue from Medicaid 47,171,837 2.00 2	1.00		ded by li	ne 202 column	8)	0. 161561	1. 00			
3.00 10 you receive DSH or supplemental payments from Medicaid?	0.00					47 474 007	0.00			
1			navmonts	from Modicaio	12	IN				
Medical d charges		1	, ,	II oli wedi care	1 :	0				
Medical d cost (line 1 times line 6) 34,543,150 7.00 8.00 0 1 1 1 1 1 1 1 1		11 13	wear car a			-				
8.00		1								
State Children's Heal th Insurance Program (SCHIP) (see instructions for each line) 9, 00 0.00 0.00 0.00 0.00 0.10 0.00	8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	es 2 and 5; if		8. 00			
9.00 Not revenue from stand-alone SCHIP 0 0 0.00										
10.00 Stand-alone SCHIP charges 0 10.00 11.00 Stand-alone SCHIP cost (line 1 times line 10) 0 11.00 12.00 0 11.00 0 0 11.00 0 11.00 0 0 12.00 0 12.00 0 0 12.00 0 0 0 12.00 0 0 0 12.00 0 0 0 0 0 0 0 0 0			ons for e	ach line)						
11. 00 Stand-al one SCHIP cost (line 1 times line 10) 11. 00 12. 00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero) 12. 00 20. 00 13. 00 14. 00 14. 00 14. 00 15. 00						-				
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 1,996,099 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 10) 10.00 10.0						_				
enter zero) Other state or local government indigent care program (see instructions for each line) 13. 00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 16, 913, 445 14. 00 10) 15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unrel mbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 736, 454 19. 00 20. 00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1, 223, 476 8, 063, 005 20. 00 21. 00 Total initial obligation of patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21. 00 22. 00 Partial payment by patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21. 00 23. 00 Cost of charity care (line 21 minus line 22) 1, 088, 847 179, 403 1, 265, 250 23. 00 24. 00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care p		1	l: no 11 m	inua lina O.	if . zono thon	-				
Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included in lines 2, 5 or 9) 1,996,099 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 10) 15.00 State or local indigent care program cost (line 1 times line 14) 2,732,553 15.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17.00 Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations 0 18.00 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 Total initial obligation of patients approved for charity care (at full 6,839,529 1,223,476 8,063,005 10.00 Cost of initial obligation of patients approved for charity care (at full 6,839,529 1,223,476 8,063,005 17.00 Cost of initial obligation of patients approved for charity care (line 1 1,105,001 197,666 1,302,667 17.00 Cost of initial obligation of patients approved for charity care (line 1 1,105,001 197,666 1,302,667 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost	12.00	· ·	ime ii iii	inus iine 9;	ii < Zero then	U	12.00			
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 16, 913, 445 14.00 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) 17.00 Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 18.00 18.01 19.00 2.00 18.00 National or state or local indigent care programs (sum of lines 19.00 18.0			uctions f	or each line)						
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 16, 913, 445 14.00 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 10.00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1,223, 476 8, 063, 005 20.00 10.00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1,223, 476 8, 063, 005 20.00 10.00 Total initial obligation of patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21.00 10.00 Total payment by patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21.00 10.00 Total payment by patients approved for charity care 19, 154 18, 263 37, 417 22.00 10.00 Total bad debt systems of the entire hospital complex (see instructions) 29, 475, 391 26.00 10.00 Total bad debts for the entire hospital complex (see instructions) 29, 353, 637 28, 00 11.00 Total bad debts for the entire hospital complex (see instructions) 29, 353, 637 28, 00 121, 754 27.00 29, 353, 637 28, 00 29, 353, 637 28, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353, 637 29, 00 29, 353,	13. 00					1, 996, 099	13. 00			
15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 736, 454 16.00 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 Covernment grants, appropriations or transfers for support of hospital operations 0 18.00 Covernment grants, appropriations or transfers for support of hospital operations 0 18.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 19.00 19.00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1, 223, 476 19.00 19.00 19.00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1, 223, 476 19.00 19.00 19.00 Cost of initial obligation of patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 19.00 19.00 19.00 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 24 is "yes," charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid complex (see instructions) 29.475, 391 26.00 19.70 Medicare bad debts for the entire hospital complex (see instructions) 29.475, 391 29.00 19.00 Cost of onn-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.353, 637 28.00 19.00 Cost of uncompensated care (line 23 column 3 plus line 29) 19.00 Cost of uncompensated care (line 23 column 3 pl										
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 136, 454 local 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care (overnment grants, appropriations or transfers for support of hospital operations (sum of lines 736, 454 local 19, 00 local 200 loc		10)								
13; if < zero then enter zero Uncompensated care (see instructions for each line) 17.00 17.00 18.00 18.00 18.00 19.00										
Uncompensated care (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines Total (col. 1 + col. 2) 1.00	16. 00		gent care	program (lir	e 15 minus line	736, 454	16. 00			
17. 00 Private grants, donations, or endowment income restricted to funding charity care (Sovernment grants, appropriations or transfers for support of hospital operations (Stand 16) 19. 00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines (Stand 16) 10										
18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 Uninsured patients Insured patients Insur	17 00		ding char	ity care		0	17 00			
Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients patients										
8, 12 and 16) Uninsured patients Total (col. 1 patients Pa					s (sum of lines	736, 454				
patients patients + col. 2) 20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20) 22.00 Partial payment by patients approved for charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 2 times line 28) 3.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4.742, 403 29, 00 6.007, 653 30.00		8, 12 and 16)								
20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20) 22.00 Partial payment by patients approved for charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1.00 Cost of uncompensated care (line 23 column 3 plus line 29)										
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times line 20) Partial payment by patients approved for charity care 19,154 18,263 37,417 22.00 23.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29,00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4,742,403 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,007,653 30.00	21. 00			1, 105, 00	197, 666	1, 302, 667	21. 00			
23.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 23.00 1.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29,353,637 29,00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4,742,403 4,742,403 6,007,653 30.00		times line 20)	•							
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24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4,742,403 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29)	23. 00	Cost of charity care (line 21 minus line 22)		1, 085, 84	179, 403	1, 265, 250	23. 00			
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4,742,403 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29)						1.00				
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25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 29,475,391 26.00 29,475,391 26.00 29,353,637 28.00 29,00 6,007,653 30.00	24.00			nu a rengtii c	n Stay IIIII t	IN	24.00			
26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 29, 475, 391 26.00 29, 375, 391 26.00 29, 375, 391 26.00 29, 375, 391 26.00 29, 375, 391 26.00 29, 375, 391 26.00 29, 475, 475 27.00 29, 30, 637 28.00 29, 475, 475 27.00 29, 475, 475 475 27.00 29, 475, 475 475 475 475 29, 475, 475 475 475 475 29, 475, 475 475 475 475 29, 475, 475 475 475 475 29, 475, 475 475 475 475 29, 475, 475	25. 00			ogram's Lenat	h of stay limit	o	25. 00			
27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 121,754 27.00 29,353,637 28.00 4,742,403 29.00 6,007,653 30.00										
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4,742,403 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,007,653 30.00	27. 00	Medicare bad debts for the entire hospital complex (see instruct	i ons)				1			
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,007,653 30.00	28. 00					29, 353, 637	28. 00			
			nse (line	1 times line	28)					
31.00 lotal unreimbursed and uncompensated care cost (line 19 plus line 30) 6,744,107 31.00			20)							
	31.00	liotal unreimbursed and uncompensated care cost (line 19 plus line	e 30)			6, 744, 107	31.00			

	Financial Systems	LUTHERAN HOSPITAL	OF INDIANA		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	F	Period: From 07/01/2013	Worksheet A	
					o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
						(col. 3 +-	
		1.00	2.00	3. 00	4. 00	<u>col . 4)</u> 5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		6, 356, 295	6, 356, 295			
2.00	00200 CAP REL COSTS-MVBLE EQUIP	700 074	15, 103, 594	15, 103, 594		20, 597, 860	
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMITTING	720, 074 10, 280, 456	1, 138, 217 100, 302, 876	1, 858, 291 110, 583, 332		15, 626, 621 40, 073, 399	4. 00 5. 01
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	10, 280, 430	100, 302, 870	110, 363, 332		48, 494, 448	
7. 00	00700 OPERATION OF PLANT	1, 697, 225	9, 501, 671	11, 198, 896		11, 191, 813	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 319, 950	1, 319, 950	-74	1, 319, 876	
9.00	00900 HOUSEKEEPI NG	1, 748, 247	1, 234, 312	2, 982, 559		2, 982, 559	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 737, 970	3, 442, 272	6, 180, 242 (2, 856, 081 3, 584, 948	
13.00	01300 NURSING ADMINISTRATION	4, 442, 002	1, 017, 420	5, 459, 422		1, 718, 963	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 359, 737	40, 772, 131	42, 131, 868		6, 096, 137	1
15. 00	01500 PHARMACY	5, 636, 234	26, 184, 685	31, 820, 919			•
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 895, 941	1, 084, 027	2, 979, 968		4, 376, 479	
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0 2, 785, 941	2, 785, 941	_,,,	2, 125, 305 0	17. 00 21. 00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		2, 765, 941	2, 700, 941	-2, 785, 941 2, 785, 941	2, 785, 941	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	178, 102	110, 358	288, 460		288, 384	
23. 01	02301 PHARMACY RESIDENCY PROGRAM	156, 737	25, 063	181, 800	0	181, 800	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	17 (00 000		0.4.0.47.005		22 542 222	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	17, 620, 303 14, 350, 394	6, 626, 782 3, 333, 330	24, 247, 085 17, 683, 724		22, 542, 820 0	1
31.00	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 141, 036	620, 542	2, 761, 578		894, 996	
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	2, 141, 030	020, 342	2, 701, 370	2, 752, 477	2, 752, 477	
31. 03	03101 CARDIO INTENSIVE CARE UNIT	0	0	C	12, 296, 057	12, 296, 057	1
32. 00	03200 CORONARY CARE UNIT	0	0	C	4, 486, 796		1
40.00	04000 SUBPROVI DER - I PF	0	0	(4.47	0	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	61, 477	61, 477	272, 240	333, 717	43.00
50. 00	05000 OPERATING ROOM	8, 451, 902	12, 865, 631	21, 317, 533	-3, 963, 051	17, 354, 482	50.00
51.00	05100 RECOVERY ROOM	2, 799, 775	730, 080	3, 529, 855	-3, 529, 855	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		.,	1, 384, 727	1
53.00	05300 ANESTHESI OLOGY	120, 836	3, 990, 324	4, 111, 160		3, 956, 580	1
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 PET SCAN	3, 613, 216 550, 213	2, 136, 340 63, 166	5, 749, 55 <i>6</i> 613, 379		5, 561, 956 196, 887	1
56. 00	05600 RADI OI SOTOPE	353, 944	1, 780, 768	2, 134, 712		1, 564, 130	1
57.00	05700 CT SCAN	642, 653	201, 899	844, 552		837, 452	
58. 00	05800 MRI	374, 374	35, 865	410, 239		0	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	4, 470, 469 3, 709, 962	10, 221, 652 1, 327, 512	14, 692, 121 5, 037, 474		14, 465, 671 4, 408, 187	1
66. 00	06600 PHYSI CAL THERAPY	2, 183, 248	616, 864	2, 800, 112			
	06700 OCCUPATI ONAL THERAPY	515, 108	46, 461	561, 569			67. 00
68. 00	06800 SPEECH PATHOLOGY	228, 996	25, 789	254, 785		0	
69. 00	06900 ELECTROCARDI OLOGY	3, 132, 380	1, 751, 483	4, 883, 863		1, 079, 353	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(1, 393, 284 17, 574, 253	1, 393, 284 17, 574, 253	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	(18, 785, 922	18, 785, 922	
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	Ö	Č	24, 190, 648	24, 190, 648	
74. 00	07400 RENAL DIALYSIS	0	1, 981, 576	1, 981, 57 <i>6</i>		1, 981, 576	1
76.00	03140 CARDIO CATH LAB	0	0	(E47 054	2, 131, 659	2, 131, 659	1
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	434, 420	82, 931	517, 351 (4, 482, 693 470, 210	
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		7 470, 210	470, 210	70.02
90.00	09000 CLI NI C	2, 039, 151	857, 964	2, 897, 115			90.00
91.00	09100 EMERGENCY	3, 347, 388	1, 890, 072	5, 237, 460	-225	5, 237, 235	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	2, 114, 068	4, 445, 631	6, 559, 699	-267, 163	6, 292, 536	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	1, 815, 524	1, 815, 524	0	1, 815, 524	96. 00
10E 0	SPECIAL PURPOSE COST CENTERS		ما		1 / 4 / 544	1 / 4/ 544	105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	0	(1, 646, 511 757, 277	
118.00		104, 046, 561	267, 888, 475	371, 935, 036			
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	313	313			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT		456, 341 0	456, 341 (456, 341 0	194. 00
	07950 CLOSED PSTCH UNIT		0	(2, 055, 843	2, 055, 843	
	07952 SENI OR CI RCLE	32, 851	41, 254	74, 105			194. 02
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	183, 135	183, 135	194. 03
200.00	TOTAL (SUM OF LINES 118-199)	104, 079, 412	268, 386, 383	372, 465, 795	0	372, 465, 795	<u> </u> 200. 00

 Health Financial
 Systems
 LUTHERAN HOR

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 150017 | Peri od: From 07/01/2013 To 06/30/2014

Worksheet A
Date/Time Prepared: 12/1/2014 9:55 am

				am
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	6, 725, 632	17, 103, 083		1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	690, 762	21, 288, 622		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-7, 868	15, 618, 753		4. 00
5. 01 00540 ADMITTING	-32, 983, 137	7, 090, 262		5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	-2, 935, 557	45, 558, 891	Ę	5. 02
7.00 00700 OPERATION OF PLANT	-70, 120	11, 121, 693	l e e e e e e e e e e e e e e e e e e e	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	90, 501	1, 410, 377		8. 00
9. 00 00900 HOUSEKEEPI NG	0	2, 982, 559		9. 00
10. 00 01000 DI ETARY	0	2, 856, 081		0.00
11. 00 01100 CAFETERI A	-2, 134, 940	1, 450, 008		1.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-15, 700	1, 703, 263		3.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	6, 096, 137		4. 00 5. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-20, 136	7, 214, 551 4, 356, 343		6. 00
17. 00 01700 SOCIAL SERVICE	20, 130	2, 125, 305		7. 00
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRV	o	2, 120, 000	l e	1. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o	2, 785, 941		2. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	288, 384		3. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	0	181, 800	23	3. 01
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-2, 805, 240	19, 737, 580	l e e e e e e e e e e e e e e e e e e e	0.00
31.00 03100 INTENSIVE CARE UNIT	0	0		1.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	894, 996	l de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	1. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	-90, 080	2, 662, 397		1. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	0	12, 296, 057		1. 03
32. 00 03200 CORONARY CARE UNIT	0	4, 486, 796	l e	2.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	0	0 330, 037		0.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	-3, 680	330, 037	4.	3. 00
50. 00 05000 OPERATING ROOM	-450, 006	16, 904, 476	50	0. 00
51. 00 05100 RECOVERY ROOM	0	0		1. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	l o	1, 384, 727		2. 00
53. 00 05300 ANESTHESI OLOGY	-3, 822, 768	133, 812		3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-7, 016	5, 554, 940		4. 00
54. 01 05401 PET SCAN	0	196, 887	54	4. 01
56. 00 05600 RADI 0I SOTOPE	0	1, 564, 130	56	6. 00
57.00 05700 CT SCAN	0	837, 452		7. 00
58. 00 05800 MRI	0	0		8. 00
60. 00 06000 LABORATORY	-202, 500	14, 263, 171		0.00
65. 00 06500 RESPIRATORY THERAPY	0	4, 408, 187		5. 00
66. 00 06600 PHYSI CAL THERAPY	0	3, 321, 235		6.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	O O		7. 00 8. 00
69. 00 06900 ELECTROCARDI OLOGY		1, 079, 353	l e	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		1, 393, 284	l de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	0.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	17, 574, 253		1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	18, 785, 922	l e e e e e e e e e e e e e e e e e e e	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	24, 190, 648	73	3.00
74.00 07400 RENAL DIALYSIS	o	1, 981, 576	74	4. 00
76.00 03140 CARDIO CATH LAB	0	2, 131, 659	76	6. 00
76. 01 03050 ENDOSCOPY	0	4, 482, 693	l e	6. 01
76. 02 03051 CARDI AC REHAB	0	470, 210	76	6. 02
OUTPATIENT SERVICE COST CENTERS	000 41	0.400.45=		0.00
90. 00 09000 CLI NI C	-203, 136	3, 403, 455	l e	0.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	-174, 600	5, 062, 635	l e e e e e e e e e e e e e e e e e e e	1.00
OTHER REIMBURSABLE COST CENTERS			9,	2. 00
95. 00 09500 AMBULANCE SERVI CES	-3, 059, 970	3, 232, 566	OI	5. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	-1, 815, 524	3, 232, 300		6. 00
SPECIAL PURPOSE COST CENTERS	1,015,524	<u> </u>	^^	0. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	1, 646, 511	109	5. 00
106. 00 10600 HEART ACQUISITION		757, 277	l e e e e e e e e e e e e e e e e e e e	6. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-43, 295, 083	326, 400, 975		8. 00
NONREI MBURSABLE COST CENTERS		, , , , , , , ,		-
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	313	190	0. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	456, 341		2. 00
194.00 07950 CLOSED PSYCH UNIT	0	O		4. 00
194. 01 07951 MARKETI NG	0	2, 055, 843	l e	4. 01
194. 02 07952 SENI OR CI RCLE	0	74, 105		4. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	0	183, 135		4. 03
200.00 TOTAL (SUM OF LINES 118-199)	-43, 295, 083	329, 170, 712	200	0. 00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 07/01/2013 | To 06/30/2014 | Date/Time Prepared: 12/1/2014 9:55 am Provider CCN: 150017

	1				12/1/2014 9: 55 at	m
		Increases	0.1	0.11		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFITS	3.00	4.00	5.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 773, 222	1	1. 00
	TOTALS			13, 773, 222		
	B - OXYGEN					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	877, 894	1	1. 00
2. 00	PATI ENT	0. 00	0	0		2. 00
3. 00		0.00	o	Ö		3. 00
0.00	TOTALS — — — —	— — 	o			
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	5, 409, 093		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0	•	3. 00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	o	0		5. 00
7. 00		0.00	0	Ö		7. 00
8.00		0.00	O	0	8	3. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0	1	0.00
11. 00 12. 00		0. 00 0. 00	0	0	1	1. 00 2. 00
13. 00		0.00	0	0		2. 00 3. 00
14. 00		0.00	o	Ö		4. 00
15. 00		0.00	0	O		5. 00
16.00		0.00	0	0		5. 00
17. 00		0.00	0	0		7. 00
18.00		0.00	0	0		3. 00
19. 00 20. 00		0. 00 0. 00	0	0		9. 00 0. 00
21. 00		0.00	0	0		1. 00
22. 00		0.00	o	Ö		2. 00
23.00		0.00	0	0	23	3. 00
24. 00		0.00	0	0		4. 00
25. 00		0.00	0	0		5. 00
26. 00			0	5, 409, 093	26	5. 00
	D - OTHER CAPITAL COSTS		<u> </u>	3, 407, 073		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	314, 624	1	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	О	3, 757, 152	2	2. 00
3.00	CAP REL COSTS-MVBLE EQUIP		0	8 <u>5, 1</u> 73	3	3. 00
	TOTALS		0	4, 156, 949		
1. 00	E - MARKETING DEPARTMENT MARKETING	194. 01	307, 237	1, 746, 856		1. 00
1.00	TOTALS		307, 237	1, 746, 856	'	1.00
	F - CNO RECLASS	L	00.720.7	177107000		
1.00	NURSING ADMINISTRATION	1300	274, 624	0	1	1.00
	TOTALS		274, 624	0		
1 00	G - MEDICAL SUPPLIES	71 00	ما	1/ /0/ 250		
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	16, 696, 359	'	1. 00
2.00	IMPL. DEV. CHARGED TO	72.00	o	18, 785, 922	2	2. 00
	PATIENTS			,		
3.00	OPERATI NG ROOM	5000	0	77 <u>7, 5</u> 69	3	3. 00
	TOTALS		0	36, 259, 850		
1. 00	H - DRUGS / IVS DRUGS CHARGED TO PATIENTS	73. 00	0	24, 190, 648		1. 00
1.00	TOTALS			24, 190, 648	'	1.00
	I - A&G COSTS		<u> </u>	21/170/010		
1.00	OTHER ADMINISTRATIVE AND	5. 02	5, 332, 548	61, 025, 108		1.00
	GENERAL					
2.00	DI ETARY	10.00	36, 579	259, 413		2. 00
3. 00 4. 00	CENTRAL SERVICES & SUPPLY MARKETING	14. 00 194. 01	400, 334 1, 249	1, 204, 654 501		3. 00 4. 00
4. 00 5. 00	OTHER NONREIMBURSABLE COST	194.01	166, 515	16, 620		i. 00 5. 00
	CENTERS					
	TOTALS		5, 937, 225	62, 506, 296		
	J - RADI OLOGY COSTS					
1.00	RADI OLOGY-DI AGNOSTI C	54. 00 54. 01	924, 587 35, 040	99, 031		1.00
2. 00 3. 00	PET SCAN	54. 01 0. 00	35, U40	161, 847 0		2. 00 3. 00
5.00	TOTALS — — — —		959, 627		3	. 00
	· · ·	ı	/ 52/	, 0, 0	ı	

						0 06/30/20	14 Date/IIme Prepar 12/1/2014 9:55 a	
		Increases					127 17 20 11 71 00 0	
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	K - DIETARY							
1.00	CAFETERI A	<u>11.</u> 00	<u>1, 544, 2</u> 59	<u>2, 040, 6</u> 89			1	1.00
	TOTALS		1, 544, 259	2, 040, 689				
	L - MISC DEPARTMENT							
1.00	OTHER ADMINISTRATIVE AND	5. 02	422, 330	35, 961			1	1.00
	GENERAL							
2.00	MEDICAL RECORDS & LIBRARY	16. 00	812, 151	615, 647				2.00
3.00	SOCI AL SERVI CE	17. 00	1, 956, 174	169, 131				3.00
4.00	OPERATING ROOM	50.00	2, 799, 774	730, 080				4.00
5.00	CARDI AC REHAB	76. 02	407, 559	62, 651				5.00
6.00	PHYSI CAL THERAPY	66. 00	744, 104	72, 250			· ·	6. 00
7.00	ELECTROENCEPHALOGRAPHY	70.00	939, 717	453, 567				7.00
8.00	CARDIO CATH LAB	76. 00	1, 188, 201	943, 458				8.00
9.00	ENDOSCOPY	<u>76.</u> 01	2, 890, 456	<u>1, 592, 2</u> 37				9.00
	TOTALS		12, 160, 466	4, 674, 982				
	M - ORGAN ACQUISITION							
1.00	KIDNEY ACQUISITION	105.00	0	1, 646, 511				1.00
2.00	HEART ACQUISITION	106. 00	0	757, 277			•	2.00
3.00	CLINIC	90.00	<u>463, 3</u> 42	<u>269, 1</u> 00			3	3.00
	TOTALS		463, 342	2, 672, 888				
	N - ICU COSTS		-1					
1. 00	PEDIATRIC INTENSIVE CARE UNIT	31. 01	761, 018	133, 978				1. 00
2.00	NEONATAL INTENSIVE CARE UNIT	31. 02	2, 141, 036	611, 441			2	2.00
3.00	CARDIO INTENSIVE CARE UNIT	31. 03	9, 915, 162	2, 380, 895				3.00
4.00	CORONARY CARE UNIT	32.00	3, 674, 214	812, 582				4.00
	TOTALS		16, 491, 430	3, 938, 896				
	O - LABOR AND DELIVERY							
1.00	NURSERY	43.00	267, 764	4, 476				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 111, 063	273, 664				2.00
	TOTALS		1, 378, 827	278, 140				
	P - INTERNS AND RESIDENTS							
1.00	I&R SERVICES-OTHER PRGM	22. 00	0	2, 785, 941			-	1.00
	COSTS APPRV							
	TOTALS		0	2, 785, 941				
500.00	Grand Total: Increases		39, 517, 037	165, 573, 222			500	0.00

Health Financial Systems RECLASSIFICATIONS

CLASSIFICATIONS Provider CCN: 150017

Peri od: Worksheet A-6 From 07/01/2013 To 06/30/2014 Date/Ti me Prepared:

In Lieu of Form CMS-2552-10

12/1/2014 9:55 am

Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - EMPLOYEE BENEFITS 5.02 OTHER ADMINISTRATIVE AND 13, 773, 222 0 1.00 GENERAL TOTALS o 13, 773, 222 B - OXYGEN 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 94, 027 0 1.00 ANESTHESI OLOGY 0 2.00 53.00 154, 580 0 2.00 3.00 RESPIRATORY THERAPY 65. 00 0 629, 287 0 3.00 TOTALS 877.894 C - RENTAL AND LEASE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 50, 620 10 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 2.00 4.00 4.892 0 2.00 3.00 ADMITTING 5.01 0 12, 319 0 3.00 116, 704 4.00 OTHER ADMINISTRATIVE AND 5.02 0 0 4.00 GENERAL 5.00 OPERATION OF PLANT 7.00 0 7,083 0 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 8.00 74 6.00 7.00 DI ETARY 10.00 0 35, 205 0 7.00 NURSING ADMINISTRATION o 0 8.00 13.00 3,690 8.00 0 CENTRAL SERVICES & SUPPLY 0 9 00 14 00 1 361 387 9 00 0 10.00 PHARMACY 15.00 0 415, 720 10.00 11.00 MEDICAL RECORDS & LIBRARY 16.00 o 31, 287 0 11.00 PARAMED ED PRGM-(SPECIFY) 0 12.00 23.00 0 12.00 76 ADULTS & PEDIATRICS 0 0 30 00 47, 298 13 00 13 00 14.00 INTENSIVE CARE UNIT 31.00 0 5, 875 0 14.00 PEDIATRIC INTENSIVE CARE 0 15.00 31.01 9, 101 15.00 UNI T 0 16,00 OPERATING ROOM 50.00 0 651, 551 16, 00 RADI OLOGY-DI AGNOSTI C 0 0 17.00 54.00 989, 534 17.00 18.00 RADI OI SOTOPE 56.00 0 570, 582 0 18.00 0 19.00 CT SCAN 57.00 7, 100 19.00 0 LABORATORY 60.00 0 226, 450 20.00 20.00 PHYSICAL THERAPY 0 21.00 66.00 0 295, 231 21.00 ELECTROCARDI OLOGY 69.00 273, 386 0 22.00 22.00 0 23.00 **ENDOSCOPY** 76.01 o 3, 574 23.00 CLINIC 90.00 0 24.00 22, 966 0 24.00 25.00 **EMERGENCY** 91.00 0 225 0 25.00 26.00 AMBULANCE SERVICES 95.00 0 267, 163 0 26.00 TOTALS 5, 409, 093 D - OTHER CAPITAL COSTS 1.00 OTHER ADMINISTRATIVE AND 5.02 0 4, 156, 949 12 1.00 GENERAL 2.00 0.00 2.00 0 0 13 3.00 0.00 0 12 3.00 TOTALS 4, 156, 949 - MARKETING DEPARTMENT ADMI TTI NG 5. 01 307, 237 1, 746, 856 1.00 1.00 0 TOTALS 307, 237 1, 746, 856 CNO RECLASS OTHER ADMINISTRATIVE AND 1.00 5.02 274, 624 0 1.00 GENERAL TOTALS 0 274, 624 G - MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY 1.00 14. 00 36, 185, 305 0 1.00 RADI OLOGY-DI AGNOSTI C 0 24, 797 2.00 54.00 0 2.00 ELECTROCARDI OLOGY 4<u>9, 7</u>48 3.00 69.00 0 3.00 **TOTALS** 0 36, 259, 850 H - DRUGS / IVS 1 00 PHARMACY 15. 00 0 24, 190, 648 0 1 00 24, 190, 648 TOTALS - A&G COSTS 1.00 ADMI TTI NG 5. 01 5, 937, 225 62, 506, 296 0 1.00 2 00 0 00 2 00 0 0 3.00 0.00 0 0 0 3.00 0 4.00 0.00 0 4.00 0.00 5 00 5 00 0 TOTALS 5, 937, 225 62, 506, 296 J - RADIOLOGY COSTS 1.00 RADI OLOGY-DI AGNOSTI C 54.00 35, 040 161, 847 0 1.00 2. 00 2 00 PET SCAN 54 01 550, 213 63, 166 0 3.00 MRI 58.00 374, 374 35, 865 0 3.00 TOTALS 959, 627 260, 878

Provider CCN: 150017

Peri od: From 07/01/2013 To 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Decreases

	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6, 00	7, 00	8.00	9. 00	10, 00		
	K - DIETARY						
1.00	DI ETARY	10.00	1, 544, 259	2, 040, 689	0		1.00
	TOTALS — — — — —		1, 544, 259	2, 040, 689			
	L - MISC DEPARTMENT						
1.00	RECOVERY ROOM	51.00	2, 799, 775	730, 080	0		1. 00
2.00	ELECTROCARDI OLOGY	69.00	2, 101, 057	1, 380, 319	O		2. 00
3.00	OCCUPATIONAL THERAPY	67.00	515, 108	46, 461	0		3. 00
4.00	SPEECH PATHOLOGY	68.00	228, 996	25, 789	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	3, 190, 654	820, 739	0		5. 00
6.00	OPERATING ROOM	50.00	2, 890, 456	1, 592, 237	0		6. 00
7.00	ENDOSCOPY	76. 01	434, 420	79, 357	0		7. 00
8.00		0.00	0	0	0		8. 00
9.00		0.00	0_	0	0		9. 00
	TOTALS		12, 160, 466	4, 674, 982			
	M - ORGAN ACQUISITION						
1.00	OPERATING ROOM	50.00	463, 342	2, 672, 888	0		1.00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0_	0	0		3. 00
	TOTALS		463, 342	2, 672, 888			
	N - ICU COSTS						
1.00	PEDIATRIC INTENSIVE CARE	31. 01	2, 141, 036	611, 441	0		1.00
	UNI T						
2.00	INTENSIVE CARE UNIT	31. 00	14, 350, 394	3, 327, 455	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0_	0	0		4. 00
	TOTALS		16, 491, 430	3, 938, 896			
	O - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	1, 378, 827	278, 140	0		1. 00
2.00		0.00	•	0	0		2. 00
	TOTALS		1, 378, 827	278, 140			_
	P - INTERNS AND RESIDENTS						1
1.00	I&R SERVICES-SALARY &	21. 00	0	2, 785, 941	0		1. 00
	FRI NGES APPRV				<u> </u>		
	TOTALS		0	2, 785, 941			
500.00	Grand Total: Decreases		39, 517, 037	165, 573, 222			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150017 Peri od: Worksheet A-7 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 9, 573, 476 0 1.00 541, 192 10, 539, 929 0 541, 192 2.00 Land Improvements 0 2.00 152, 714, 654 0 3. 00 3.00 28, 724 28, 724 Buildings and Fixtures 0 0 4.00 Building Improvements 17, 075, 613 2, 794, 210 2, 794, 210 0 4.00 5.00 Fixed Equipment 45, 986, 381 110, 697 110, 697 0 5.00 124, 459, 167 0 6.00 Movable Equipment 9, 530, 358 9, 530, 358 0 6.00 0 7.00 21, 351 21, 351 HIT designated Assets 1, 482, 299 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 361, 831, 519 13, 026, 532 13, 026, 532 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 361, 831, 519 13, 026, 532 O 13, 026, 532 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 9, 573, 476 0 1.00 2.00 Land Improvements 11, 081, 121 0 2.00 152, 743, 378 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 19, 869, 823 4.00 5.00 Fi xed Equipment 46, 097, 078 0 5.00 Movable Equipment 133, 989, 525 0 6.00 6.00 7.00 HIT designated Assets 1,503,650 0 7.00

374, 858, 051

374, 858, 051

0

0

8.00

9.00

10.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

Heal th	Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150017	Peri od: From 07/01/2013 To 06/30/2014	Worksheet A-7 Part II Date/Time Pre 12/1/2014 9:5	pared: 5 am
			SU	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	6, 356, 295	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	15, 103, 594	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	21, 459, 889	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 356, 295		·	·	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15, 103, 594				2.00
	T 1 1 (C11 1 C)	1	04 450 000	I .			

0 0 0

6, 356, 295 15, 103, 594 21, 459, 889

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 07/01/2013 To 06/30/2014		
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description		Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 - col. 2)	instructions)		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	193, 267, 797	0	193, 267, 797	0. 515576	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	181, 590, 253	0	181, 590, 253			2.00
3.00	Total (sum of lines 1-2)	374, 858, 050		374, 858, 050			3. 00
		ALLOCATION OF OTHER CAPITAL			SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT		1 0	,	4 215 072	F0 (20	1 00
1.00	CAP REL COSTS-BLDG & FIXI	0	1	(1,010,770		1.00
2. 00 3. 00	Total (sum of lines 1-2)	0	ļ ~		14, 707, 198 19, 023, 171	5, 409, 093 5, 358, 473	2. 00 3. 00
3.00	Total (Sull of Titles 1-2)	0	·	IU JMMARY OF CAPI		5, 358, 473	3.00
			30	JIVIIVIART OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI					47.400	4 00
1.00	CAP REL COSTS-BLDG & FIXT	8, 765, 954				,,	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 087, 158			,		2.00
3.00	Total (sum of lines 1-2)	9, 853, 112	399, 797	3, 757, 152	2 0	38, 391, 705	3. 00

| Period: | Worksheet A-8 | From 07/01/2013 | To 06/30/2014 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 150017

Expense Classification on North-Seet A 1.00 1					To	06/30/2014	Date/Time Prep 12/1/2014 9:55	
Cost Center Description Resis/Cade (2) Amount Cent Center I nee P Next A.2 Set							12/1/2014 9.33	o alli
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00								
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00								
Triving trained Triving trained Copy Copy		Cost Center Description						
Investment Income = CAP RTL OCCAP RTL COSTS-MOWILL FIDURP 2.00 0 2.00	1. 00		1.00					1. 00
Investment income - other	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
Chapter 2) Chapter 3) Chapter 4) Col Irade, quantity, and time of scanners (chapter 8) Col Chapter 5) Col Chapter 6) Col Chapter 7) Col Chapter 8) Col Chapter 9) Col	3 00			0		0.00	0	3 00
0 0 0 0 0 0 0 0 0 0		(chapter 2)						
Color Colo		di scounts (chapter 8)		U			0	
Sentral of provider space by Sentral	5. 00			0		0. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Stations excluded) (chapter 21) 0 0.00 0.	6.00	Rental of provider space by	В	-1, 204, 307	CAP REL COSTS-BLDG & FIXT	1. 00	9	6. 00
21)	7.00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
Chapter 21 0		, , ,						
Parking of (chapter 21) A -8-2 -13,575,430 0 0.00 0	8. 00			0		0.00	О	8. 00
adjustment		Parking Lot (chapter 21)				0.00	_	
Chapter 23)	10. 00	1 3	A-8-2	-13, 575, 430			0	10. 00
12.00 Related organization 13.00 Laundry and I linen service 0 13.00 Laundry and I linen service 0 0 0 0 0 15.00 1	11. 00		В	-7, 016	RADI OLOGY-DI AGNOSTI C	54. 00	0	11. 00
13.00 Laundry and I linen service 0 0.00 0.13.00 15.00 1	12. 00	Related organization	A-8-1	7, 783, 577			0	12. 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 17.00 0 17.00 0 18.00 0	13. 00			0		0.00	0	13. 00
and others				-2, 134, 940	CAFETERI A			
Supplies to other than Datients 17.00 Sale of drugs to other than Datients 17.00 Sale of drugs to other than Datients 18.00 Sale of medical records and Datients Da		and others		0				
17. 00 Sale of drugs to other than patients 0 0 0 0 0 0 0 0 17. 00 18. 00 Sale of medical records and abstracts 0 0 0 0 0 0 0 0 18. 00 19. 00 Nursing school (tuition, fees, books, etc.) 0 0 0 0 0 0 0 0 20. 00 Vending machines B -31,850 OTHER ADMINISTRATIVE AND 5. 02 0 20. 00 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 22. 00 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 0 22. 01 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 0 22. 02 0 0 0 0 0 0 0 0 0	16.00			U		0.00	0	16.00
patients	17. 00			0		0. 00	0	17. 00
abstracts	18 00	patients		0		0.00	0	18 00
books_ etc.) vending machines B		abstracts		0				
CENERAL Content Cont	19.00			U		0.00	0	19.00
Interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of I imitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of I imitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OSTS-MUBLE EQUIP A - 8-78, 287 CAP REL COSTS-MUBLE EQUIP 2.00 9 27.00 27.00 28.00 Non-physicians' assistant 0 0.00 0.29.00 0.00 0.90 0.00 0.90 0.00 0.90 0.00 0.00 0.90 0.00 0.	20. 00	Vending machines	В	-31, 850		5. 02	0	20. 00
Charges (chapter 21)	21. 00			0		0.00	o	21. 00
overpayments and borrowings to repay Medicare overpayments 23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26. 00 (costSS-BLDG & FIXT 27. 00 (costS-BLDG & FIXT 28. 00 No-physician Anosherist 19. 00 9 27. 00 (costSS-BLDG & FIXT 29. 00 9 27. 00 (costSS-BLDG & FIXT 29. 00 9 27. 00 (costSS-BLDG & FIXT 29. 00 (costSSS-BLDG & FIXT 29. 00 (costSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS		charges (chapter 21)						
23.00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) A-8-3 OPHYSICAL THERAPY 66.00 24.00	22. 00	overpayments and borrowings to		Ü		0.00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00 (Chapter 21) 27.00 Depreciation - CAP REL A 243, 605 CAP REL COSTS-MVBLE EQUIP 2.00 9 27.00 (COSTS-BLDG & FIXT 5.00) 28.00 Non-physician Anesthetist 0 0*** Cost Center Deleted *** 19.00 28.00 (Physicians' assistant 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00		A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	20.00	therapy costs in excess of		J		33. 33		20.00
1 imitation (chapter 14) Utilization review -	24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00 27.00 Depreciation - CAP REL A 243, 605 CAP REL COSTS-MVBLE EQUIP 2.00 9 27.00 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29.00 2								
Chapter 21) Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00	25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest A 243, 605 CAP REL COSTS-MVBLE EQUIP 2. 00 9 27. 00 28. 00 0 **** Cost Center Deleted *** 19. 00 0 29. 00 0 0 29. 00 0 30. 00 4-8-3 0 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 99 31. 00 ADULTS & PEDIATRICS 30. 00 31. 00 31. 00 32. 00 32. 00	07.00	(chapter 21)		070 007	OAD DEL COCTO DI DO A FLYT	1 00		0/ 00
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28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 0 **** Cost Center Deleted **** 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	27. 00		A	243, 605	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 OCCUPATIONAL THERAPY 67.00 30.00		Non-physician Anesthetist		0	*** Cost Center Deleted ***		0	
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY		-	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 SPEECH PATHOLOGY 68. 00 31. 00 0 0 0 0 0 32. 00								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest								
	32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
	33. 00		A	-31, 502, 516	ADMI TTI NG	5. 01	0	33. 00

Heal th	Financial Systems	L	UTHERAN HOSPIT	AL OF INDIANA	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				eriod: rom 07/01/2013	Worksheet A-8	
					o 06/30/2014		pared:
						12/1/2014 9:5	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	TRALLIU NO DEVENUES	1.00	2.00	3.00	4. 00	5. 00	00.01
33. 01	TRAI NI NG REVENUES	В		NURSI NG ADMI NI STRATI ON	13. 00	0	00.01
33. 02	OTHER MISC REVENUES	В		OTHER ADMINISTRATIVE AND	5. 02	0	33. 02
33. 03	PATIENT PHONES WAGE COST	A		GENERAL OTHER ADMINISTRATIVE AND	5. 02	0	33. 03
33. 03	PATTENT PHONES WAGE COST	A		GENERAL	5.02	0	33.03
33. 04	PATIENT PHONES BENEFITS COST	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	n	33. 04
33. 05	PATIENT PHONES EXPENSE	A	· ·	ADMITTING	5. 01	o O	33. 05
33. 06	PATIENT PHONES DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 06
00.00	COST		3, 55 .	NEE	2.00	ĺ	00.00
33. 07	PATIENT TV - CABLE EXPENSE	A	-70, 120	OPERATION OF PLANT	7. 00	0	33. 07
33. 08	PATIENT TV DEPRECIATION	A	-10, 736	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 08
33. 09	MARKETI NG	A	-73, 979	OTHER ADMINISTRATIVE AND	5. 02	0	33. 09
				GENERAL			
33. 10	LEGAL FEES	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 10
				GENERAL		_	
33. 11	PHYSICIAN RECRUITING	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 11
33. 12	LOBBYING IN ASSOCIATION DUES	A		GENERAL OTHER ADMINISTRATIVE AND	5. 02	0	33. 12
33. 12	LUBBTING IN ASSOCIATION DUES	A		GENERAL	5.02	0	33. 12
33. 13	CHARI TABLE CONTRIBUTIONS	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 13
				GENERAL		_	
33. 14	PENALTI ES	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 14
				GENERAL			
33. 15	EQUITY IN AFFILIATES	Α	110, 131	OTHER ADMINISTRATIVE AND	5. 02	0	33. 15

GENERAL

GENERAL

GENERAL

-43, 295, 083

-679, 467 OTHER ADMINISTRATIVE AND

-29, 251 OTHER ADMINISTRATIVE AND

GENERAL 2, 369, 841 OTHER ADMINI STRATI VE AND

5. 02

5.02

5.02

33. 16

33. 17

33. 18

50.00

TOTAL (sum of lines 1 thru 49)

INTERCOMPANY LEASE RECEIPTS

(Transfer to Worksheet A,

NON-COMEPETE AGREEMENT

EXPENSES

VALET SERVICE

33. 16

33. 17

33. 18

column 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: 150017 Peri od: Worksheet A-8-1 From 07/01/2013
To 06/30/2014 Date/Time Prepared: OFFICE COSTS

				To 06/30/2014	Date/Time Pre	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
1 00	HOME OFFICE COSTS:	CAD DEL COCTO DI DO A FLYT	DI DECT CADITAL INTEDECT	0 (20 242		1 00
1.00	l control of the cont	li de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	DIRECT CAPITAL INTEREST	8, 630, 242	0	1.00
2.00			PASI CAPITAL - BLDG	42, 272	0	2.00
3. 00 4. 00			PASI CAPITAL - EQUIP PASI OPERATING	21, 147	0	3.00
4. 00 4. 01		-	POOLED CAPITAL - BLDG	763, 134	0	4. 00 4. 01
			POOLED CAPITAL - BLDG	135, 712	0	4. 01
4. 02				1, 087, 158	U	
4. 03		OTHER ADMINISTRATIVE AND GEN		8, 262, 148	0 410 222	4. 03
4. 04	1			1, 047, 460		
4. 05	1		CIG ASSETS	737, 600		4. 05
4.06			HLS - CAPITAL	149, 474	0	4. 06
4. 07			HLS - OPERATING	1, 257, 941	1, 316, 914	4. 07
4. 08		OTHER ADMINISTRATIVE AND GEN		0	3, 257, 739	4. 08
4. 09		OTHER ADMINISTRATIVE AND GEN		0	5, 432	4. 09
4. 10		OTHER ADMINISTRATIVE AND GEN		0	105, 644	4. 10
4. 11	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	1, 199, 847	4. 11
4. 12	1	OTHER ADMINISTRATIVE AND GEN		0	251, 942	4. 12
4. 13	1	OTHER ADMINISTRATIVE AND GEN		0	313, 108	4. 13
4. 14	1	OTHER ADMINISTRATIVE AND GEN		0	20, 202	4. 14
4. 15	1	OTHER ADMINISTRATIVE AND GEN		0	180, 064	4. 15
4. 16	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	37, 867	4. 16
4. 17	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	88, 620	4. 17
4. 18	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	49, 791	4. 18
4. 19			PASI COLLECTION FEES	0	1, 949, 012	4. 19
4. 21			EBOS FEES	0	10, 670	
4. 22			PASI LIEN UNIT COLLECTION FE	0	273, 155	4. 22
4. 23		OTHER ADMINISTRATIVE AND GEN	INTEREST EXPENSE	0 404 555	1, 487, 500	
5. 00	TOTALS (sum of lines 1-4).			22, 134, 288	14, 350, 711	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.			1		

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 COMMUNITY HEALT 100.00	6. 00
7.00	В	0. 00 PASI 100. 00	7. 00
8.00	E	0. 00 HOSPI TAL LAUNDR 100. 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

2.00 42, 272 9 3.00 21, 147 9 4.00 763, 134 0 4.01 135, 712 11 4.02 1, 087, 158 11 4.03 8, 262, 148 0 4.04 -1, 370, 763 0 4.05 -647, 381 9 4.06 149, 474 9 4.07 -58, 973 0 4.08 -3, 257, 739 0 4.09 -5, 432 0 4.10 -105, 644 0 4.11 -1, 199, 847 0 4.12 -251, 942 0 4.13 -313, 108 0 4.14 -20, 202 0 4.15 -180, 064 0 4.16 -37, 867 0	OTTTOL	00313				To 06/30/2014	Date/Time Pre 12/1/2014 9:5	epared: 55 am
COJ		Net	Wkst. A-7 Ref.					
Col. 5)* Col. 50 7.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED		Adjustments						
A. COSTS NOURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00		(col. 4 minus						
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00		col. 5)*						
HOME OFFICE COSTS:		6. 00	7. 00					
1. 00 8, 630, 242 11 2. 00 42, 272 9 3. 00 21, 147 9 4. 00 763, 134 0 4. 01 135, 712 11 4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0				MENTS REQUIRED AS A RESULT OF TRAN	SACTIONS WITH RELATED C	RGANIZATIONS OR (CLAIMED	
2.00 42, 272 9 3.00 21, 147 9 4.00 763, 134 0 4.01 135, 712 11 4.02 1, 087, 158 11 4.03 8, 262, 148 0 4.04 -1, 370, 763 0 4.05 -647, 381 9 4.06 149, 474 9 4.07 -58, 973 0 4.08 -3, 257, 739 0 4.09 -5, 432 0 4.10 -105, 644 0 4.11 -1, 199, 847 0 4.12 -251, 942 0 4.13 -313, 108 0 4.14 -20, 202 0 4.15 -180, 064 0 4.16 -37, 867 0								
3.00 4.00 763,134 0 4.01 135,712 11 4.02 1,087,158 11 4.03 8,262,148 0 4.04 -1,370,763 0 4.05 -647,381 9 4.06 149,474 9 4.07 -58,973 0 4.08 -3,257,739 0 4.09 -5,432 0 4.10 -105,644 0 4.11 -1,199,847 0 4.12 -251,942 0 4.13 -313,108 0 4.14 14.14 -20,202 0 4.15 -180,064 0 4.16 -37,867	1.00							1. 00
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4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 12
4. 15								4. 13
4.16 -37,867 0 4.1								4. 14
								4. 15
4 17 _88 620 0 4 1	4. 16							4. 16
	4. 17	-88, 620						4. 17
	4. 18	-49, 791	0					4. 18
								4. 19
								4. 21
		-273, 155	0					4. 22
								4. 23
5.00 7,783,577 5.0	5.00	7, 783, 577						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.

 	cordinate i dilaret 27 the dimedite difference of cordinate of the cordinate in cordinate in the partit	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

Termbur Schieff under trute AVIII.							
6.00	HOSP COMPANY		6. 00				
7.00	COLLECTI ONS		7. 00				
8.00	LAUNDRY		8. 00				
9.00			9. 00				
10.00			10.00				
100.00			100.00				

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10 Peri od: Worksheet A-8-2 From 07/01/2013 Date/Time Prepared: 12/1/2014 P. 55 am Provider CCN: 150017

					1	o 06/30/2014	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	JJ alli
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		OTHER ADMINISTRATIVE AND	934, 300	922, 503	11, 797	171, 400	79	1. 00
2. 00		GENERAL MEDICAL RECORDS & LIBRARY	44, 692	0	44, 692	171, 400	298	2. 00
3.00		ADULTS & PEDIATRICS	2, 805, 240		·	0		3. 00
4. 00		NEONATAL INTENSIVE CARE UNIT	90, 080	90, 080		0		4. 00
5.00	1	NURSERY	3, 680			0	0	5. 00
6.00	50.00	OPERATING ROOM	450, 006	450, 006	0	0	0	6. 00
7.00	53. 00	ANESTHESI OLOGY	3, 822, 768	3, 822, 768	0	0	0	7. 00
8.00	60.00	LABORATORY	202, 500	202, 500	0	0	0	8. 00
9.00	90. 00	CLI NI C	203, 136	203, 136	0	0	0	9.00
10.00	91. 00	EMERGENCY	174, 600	174, 600	0	0	0	10.00
11. 00		AMBULANCE SERVICES	3, 059, 970	3, 059, 970	0	0	0	11.00
12.00	96. 00	DURABLE MEDICAL EQUIP-RENTED	1, 815, 524	1, 815, 524	0	0	0	12.00
200.00			13, 606, 496				377	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	9.00	Educati on	12 13. 00	14.00	
1 00	1.00	2.00 OTHER ADMINISTRATIVE AND	8.00		12.00		14.00	1. 00
1. 00		GENERAL	6, 510	320	0	0	J	1.00
2.00		MEDICAL RECORDS & LIBRARY	24, 556	1, 228	0	0	0	2. 00
3.00	30. 00 ADULTS & PEDIATRICS		0	1		0	0	3. 00
4.00	31. 02 NEONATAL INTENSIVE CARE UNIT		0	0	0	0	0	4. 00
5.00	43. 00 NURSERY		0	0	0	0	0	5.00
6.00	50.00 OPERATING ROOM		0	0	0	0	0	6.00
7.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	7. 00
8.00		LABORATORY	0	0	0	0	0	8.00
9. 00		CLI NI C	0	0	0	0	0	9. 00
10. 00		EMERGENCY	0	0	0	0	0	10. 00
11. 00		AMBULANCE SERVICES	0	0	0	0		11. 00
12. 00	96. 00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	_	12. 00
200.00			31, 066			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16, 00	17. 00	18. 00		
1.00		OTHER ADMINISTRATIVE AND	0			927, 790		1. 00
		GENERAL	_	,,,,,,	, ===	,		
2.00	16. 00	MEDICAL RECORDS & LIBRARY	0	24, 556	20, 136	20, 136		2.00
3.00	30. 00 ADULTS & PEDIATRICS		0	0	0	2, 805, 240		3.00
4.00	31.02 NEONATAL INTENSIVE CARE UNIT		0	0	0	90, 080		4. 00
5.00	43. 00 NURSERY		0	0	0	3, 680		5. 00
6.00	50. 00 OPERATI NG ROOM		0	0	0	450, 006		6. 00
7.00		ANESTHESI OLOGY	0	0	0	3, 822, 768		7. 00
8.00		LABORATORY	0	0	0	202, 500		8. 00
9.00		CLINIC	0	0	0	203, 136		9. 00
10.00		EMERGENCY	0	0	0	174, 600		10.00
11. 00		AMBULANCE SERVICES	0	0	0	3, 059, 970		11. 00
12.00	96. 00	DURABLE MEDICAL EQUIP-RENTED	0	· -	0	1, 815, 524		12.00
200. 00	1		0	31, 066	25, 423	13, 575, 430	I	200. 00

	Financial Systems	LUTHERAN HOSPIT		001 450047 5		u of Form CMS-	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150017 F	eriod: rom 07/01/2013	Worksheet B Part I	
					o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
			CAPI TAL REI	LATED COSTS		12/1/2014 7.3	Jam
			DI DO A FLAT	I 18/81 5 5011 8		45.41.771.110	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	ADMITTING	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)	1.00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	17, 103, 083	17, 103, 083	8			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	21, 288, 622		21, 288, 622	1		2. 00
4. 00 5. 01	OO400 EMPLOYEE BENEFITS DEPARTMENT OO540 ADMITTING	15, 618, 753 7, 090, 262	447, 218 368, 630			8, 112, 355	4. 00 5. 01
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	45, 558, 891	741, 439			0, 112, 333	5. 02
7. 00	00700 OPERATION OF PLANT	11, 121, 693	3, 697, 478			0	1
8.00	00800 LAUNDRY & LINEN SERVICE	1, 410, 377	21, 444			0	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 982, 559 2, 856, 081	71, 997 692, 892			0	7.00
11. 00	01100 CAFETERI A	1, 450, 008	072, 072			0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 703, 263	163, 838		237, 518	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 096, 137	299, 212			0	14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	7, 214, 551 4, 356, 343	171, 289 182, 942			0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	2, 125, 305	123, 243			0	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0) c	o	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	2, 785, 941	0 000	0	0	0	22. 00
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PHARMACY RESIDENCY PROGRAM	288, 384 181, 800	69, 060 0	403	l	0	
20.01	INPATIENT ROUTINE SERVICE COST CENTERS	101,000		1	21,070		20.01
30. 00	03000 ADULTS & PEDI ATRI CS	19, 737, 580	2, 532, 461			399, 833	
31.00	03100 I NTENSI VE CARE UNI T	004.004	104 (17	0	1	0 700	
31. 01 31. 02	02080 PEDIATRIC INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	894, 996 2, 662, 397	104, 617 264, 300			9, 790 57, 912	•
31. 03	03101 CARDIO INTENSIVE CARE UNIT	12, 296, 057	944, 392			263, 438	•
32. 00	03200 CORONARY CARE UNIT	4, 486, 796	367, 747	83, 510	571, 891	102, 095	•
40.00	04000 SUBPROVI DER - I PF	0	12.020	0	-	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	330, 037	13, 038	1, 521	41, 677	6, 891	43. 00
50.00	05000 OPERATI NG ROOM	16, 904, 476	2, 468, 392	4, 512, 882	1, 229, 305	1, 475, 377	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	1, 384, 727 133, 812	1, 910		172, 937 18, 808	28, 595 172, 273	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 554, 940	378, 421	1		370, 372	
54. 01	05401 PET SCAN	196, 887	41, 192	1		23, 447	54. 01
56.00	05600 RADI OI SOTOPE	1, 564, 130		1		118, 229	
57. 00 58. 00	05700	837, 452	47, 449 0	49, 366	100, 029	301, 516 0	1
	06000 LABORATORY	14, 263, 171	406, 933	731, 447	695, 828	669, 659	
	06500 RESPI RATORY THERAPY	4, 408, 187	137, 189	236, 823	577, 456	216, 945	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 321, 235	290, 377	220, 749	455, 642	72, 472	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	1, 079, 353	323, 521	326, 061	160, 525	249, 224	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 393, 284	35, 915	501, 459	146, 267	35, 393	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 574, 253 18, 785, 922	0		0	400, 802 828, 977	
73. 00	07300 DRUGS CHARGED TO PATIENTS	24, 190, 648	0		0	1, 323, 555	
74. 00	07400 RENAL DIALYSIS	1, 981, 576	189, 604	3, 954	. 0	37, 193	•
76. 00	03140 CARDIO CATH LAB	2, 131, 659	154, 549			315, 032	
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	4, 482, 693	166, 107 0			200, 363	1
76. 02	OUTPATIENT SERVICE COST CENTERS	470, 210	0	32, 762	63, 437	14, 082	76. 02
90.00	09000 CLI NI C	3, 403, 455	487, 909	12, 668	389, 513	12, 975	90.00
91. 00	09100 EMERGENCY	5, 062, 635	481, 724	356, 459	521, 021	359, 133	1
92. 00	O9200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	3, 232, 566	11, 032	293, 088	329, 055	27, 933	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	1
105 5	SPECIAL PURPOSE COST CENTERS	4 (1) = 2 -1	F0 0:=				105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	1, 646, 511 757, 277	50, 267 0				105. 00 106. 00
118.00		326, 400, 975	_				
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	313	57, 407				190.00
194.00 194.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT	456, 341 0	0	3, 024			192. 00 194. 00
	07951 MARKETI NG	2, 055, 843	o	1	-		194. 01
	•	· · · · · · · · · · · · · · · · · · ·		<u> </u>	·		-

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 07/01/2013 To 06/30/2014	Part Date/Time Pre	narod.	
				10 00/30/2014	12/1/2014 9:5		
		CAPI TAL REI	ATED COSTS				
		DI DO 4 FINT			45111 771 110		
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG		
	for Cost Allocation			BENEFITS DEPARTMENT			
	(from Wkst A			DEPARTMENT			
	col. 7)						
	0	1. 00	2.00	4. 00	5. 01		
194. 02 07952 SENI OR CI RCLE	74, 105	0		0 5, 113	0	194. 02	
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	183, 135	0	88, 08	25, 918	0	194. 03	
200.00 Cross Foot Adjustments						200. 00	
201.00 Negative Cost Centers		0		0 0		201. 00	
202.00 TOTAL (sum lines 118-201)	329, 170, 712	17, 103, 083	21, 288, 62	2 16, 087, 843	8, 112, 355	202. 00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150017 Peri

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2013 | Part | | To 06/30/2014 | Date/Time Prepared: |

			1	0 06/30/2014	Date/lime Pre 12/1/2014 9:5	
Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE		
	5A. 01	5. 02	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS		,	,			
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	52, 492, 986	52, 492, 986				5. 01 5. 02
7. 00 00700 OPERATION OF PLANT	15, 442, 094					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 431, 821	271, 654				8.00
9. 00 00900 HOUSEKEEPI NG	3, 353, 192				4, 101, 018	9. 00
10. 00 01000 DI ETARY	3, 806, 659				241, 735	10.00
11. 00 01100 CAFETERI A	1, 690, 372			0	0	11. 00
13. 00 01300 NURSING ADMINISTRATION	2, 111, 757	400, 655	254, 046	0	57, 160	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	7, 038, 843				104, 388	1
15. 00 01500 PHARMACY	8, 370, 112				59, 759	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	5, 008, 059		1		63, 824	16.00
17. 00 01700 SOCIAL SERVICE	2, 553, 026	484, 375	191, 099	0	42, 997	17. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	2 705 041	528, 565	0	0	0	21.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	2, 785, 941 385, 569		•	4, 594	24, 093	23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	206, 196		107,004	4, 374	24, 073	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	200, 170	07, 121		J		20.01
30. 00 03000 ADULTS & PEDI ATRI CS	28, 202, 908	5, 350, 854	3, 926, 802	623, 113	883, 520	30.00
31. 00 03100 INTENSIVE CARE UNIT	0		0		0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 151, 359	218, 443	162, 217	11, 816	36, 498	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	3, 438, 965	652, 461	409, 820	13, 525	92, 208	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	15, 268, 405	2, 896, 813	1, 464, 364	213, 665	329, 478	31. 03
32. 00 03200 CORONARY CARE UNIT	5, 612, 039	1, 064, 750	570, 224	71, 259	128, 299	32. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40. 00
43. 00 04300 NURSERY	393, 164	74, 593	20, 217	0	4, 549	43. 00
ANCILLARY SERVICE COST CENTERS	24 500 422	E 044 004	2 027 450	242 270	0/1 1/7	
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	26, 590, 432 0				861, 167 0	50. 00 51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	1, 586, 259	1	1	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	326, 803			0	666	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 553, 313				132, 023	54.00
54. 01 05401 PET SCAN	824, 551				14, 371	1
56. 00 05600 RADI OI SOTOPE	1, 843, 684				33, 474	1
57. 00 05700 CT SCAN	1, 335, 812					57.00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	16, 767, 038	3, 181, 143	630, 986	2, 326	141, 970	60.00
65. 00 06500 RESPI RATORY THERAPY	5, 576, 600			· ·	47, 862	65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 360, 475	827, 295	450, 254	11	101, 306	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 138, 684			· ·		
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 112, 318				12, 530	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 975, 055 19, 614, 899			0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	25, 514, 203			0	0	73.00
74. 00 07400 RENAL DIALYSIS	2, 212, 327			0	66, 149	74.00
76. 00 03140 CARDI O CATH LAB	4, 210, 236		239, 642		53, 919	76.00
76. 01 03050 ENDOSCOPY	5, 817, 813					ı
76. 02 03051 CARDI AC REHAB	580, 491			0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	4, 306, 520	817, 059	756, 546	26, 643	170, 221	90.00
91. 00 09100 EMERGENCY	6, 780, 972	1, 286, 527	746, 956	202, 835	168, 063	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
OTHER REIMBURSABLE COST CENTERS	0.000.474	700 704	17.407		0.040	05.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	3, 893, 674 0				3, 849	95. 00
SPECIAL PURPOSE COST CENTERS	0	0	0	U	0	96. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	1, 713, 914	325, 174	77, 943	0	17 537	105. 00
106. 00 10600 HEART ACQUISITION	786, 151			0		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	326, 165, 691	51, 922, 856		1, 736, 726		
NONREI MBURSABLE COST CENTERS	0207.007071	0177227000	10/202/01/	1,700,720	1,000,770	1 101 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	62, 324	11, 824	89, 014	0	20, 028	190. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	459, 365			O		192. 00
194.00 07950 CLOSED PSYCH UNIT	0	0	0	0	0	194. 00
194. 01 07951 MARKETI NG	2, 106, 979	399, 749	0	0		194. 01
194. 02 07952 SENI OR CI RCLE	79, 218			0		194. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	297, 135		0	0	0	194. 03
200.00 Cross Foot Adjustments	0	•				200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 07/01/2013 Fo 06/30/2014		
Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5A. 01	5. 02	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118-201)	329, 170, 712	52, 492, 986	18, 371, 86°	1, 736, 726	4, 101, 018	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2013 | Part |
| To 06/30/2014 | Date/Time Prepared: | 12/1/2014 9:55 am | Provider CCN: 150017

				06/30/2014	12/1/2014 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11 00	10.00	SUPPLY	45.00	
CENEDAL CEDVICE COCT CENTEDS	10. 00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS=BEDG & TTXT			•			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			•			4.00
5. 01 00540 ADMI TTI NG			•			5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
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	5, 845, 006					10.00
11. 00 01100 CAFETERI A	0	2, 011, 080				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	o	23, 795	1			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	Ö	63, 666		9, 006, 304		14. 00
15. 00 01500 PHARMACY	o	91, 927	1	220, 601	10, 596, 025	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	ol	81, 268	1	7, 509	0	16.00
17. 00 01700 SOCIAL SERVICE	o	37, 757	1	1, 315	0	17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	o	0.,	o o	0	0	21. 00
22. 00 02200 Lar Services-Other Prom Costs Apprv	o	0	o o	5	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	o	3, 428	o	342	0	23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	o	3, 453	1	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	-,			-1		
30. 00 03000 ADULTS & PEDIATRICS	2, 431, 753	408, 188	804, 659	335, 523	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0	0	0	0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	52, 129	14, 349	37, 704	11, 773	0	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	335, 831	43, 073		54, 636	0	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	1, 155, 855	217, 507	491, 237	204, 425	0	31. 03
32.00 03200 CORONARY CARE UNIT	227, 484	74, 375		81, 599	0	32.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	114, 670	5, 417	13, 266	9, 018	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	186, 406	391, 293	1, 064, 934	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	22, 506	55, 047	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	5, 780	0	337	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	104, 049	223, 085	73, 732	0	54.00
54. 01 05401 PET SCAN	0	863	1, 736	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	7, 056	17, 536	4, 835	0	56. 00
57. 00 05700 CT SCAN	0	16, 101	31, 840	11, 790	0	57. 00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0	114, 008	0	607, 235	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	87, 523	0	64, 638	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	54, 058	0	18, 230	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	26, 835	1	4, 573	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	21, 643	1	63, 490	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2, 638, 225	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 968, 405	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	10, 596, 025	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	7, 486	0	74. 00
76. 00 03140 CARDI O CATH LAB	0	23, 620		118, 645	0	76. 00
76. 01 03050 ENDOSCOPY	0	71, 547		175, 159	0	76. 01
76. 02 03051 CARDI AC REHAB	0	11, 973	0	2, 511	0	76. 02
OUTPATIENT SERVICE COST CENTERS	اه	15 440	100.004	70.004		
90. 00 09000 CLI NI C	0	45, 113		70, 921	0	90.00
91. 00 09100 EMERGENCY	0	81, 193	165, 843	166, 695	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	ام	44 275		1/ 01	0	05 00
95. 00 09500 AMBULANCE SERVICES	0	44, 375		16, 815	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS	ما	F 070	l ol	ما	0	105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	5, 279	1	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	4 217 722	3, 015	1	0 005 400		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	4, 317, 722	2, 001, 146	2, 847, 413	9, 005, 402	10, 596, 025	1118.00
NONREI MBURSABLE COST CENTERS	^I	^		T _x ,	^	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 212 505	0		46		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 312, 585	0	0	0		192.00
194. 00 07950 CLOSED PSYCH UNIT	O O	((10		0		194.00
194. 01 07951 MARKETI NG	O O	6, 618		768		194. 01
194. 02 07952 SENI OR CI RCLE	214 400	726		88		194. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	214, 699	2, 590	0	O	0	194. 03
200.00 Cross Foot Adjustments		^			^	200.00
201.00 Negative Cost Centers	0	0	0	· υ	0	201. 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150017 I	Peri od:	Worksheet B	
				From 07/01/2013		
				To 06/30/2014		
					12/1/2014 9:5	<u>5 am </u>
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OI	N SERVICES &		
				SUPPLY		
	10.00	11. 00	13.00	14.00	15. 00	
202.00 TOTAL (sum lines 118-201)	5, 845, 006	2, 011, 080	2, 847, 41	9, 006, 304	10, 596, 025	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150017

Peri od: Worksheet B From 07/01/2013 Part I To 06/30/2014 Date/Time Prepared:

12/1/2014 9:55 am INTERNS & RESIDENTS PARAMED ED MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Cost Center Description RECORDS & Y & FRINGES PRGM COSTS PRGM LI BRARY **APPRV APPRV** 23.00 16.00 17.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMITTING 5.01 5.01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 6, 394, 487 16.00 01700 SOCIAL SERVICE 17.00 3, 310, 569 17.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21 00 0 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 3, 314, 511 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 598, 262 23.00 23.00 C 02301 PHARMACY RESIDENCY PROGRAM 23.01 23.01 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 315, 133 163, 141 0 380, 104 435, 119 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 31.01 02080 PEDIATRIC INTENSIVE CARE UNIT 7.716 3, 995 0 15, 204 2.250 31.01 02060 NEONATAL INTENSIVE CARE UNIT 23, 630 0 288, 879 31 02 45,644 10, 126 31 02 31. 03 03101 CARDIO INTENSIVE CARE UNIT 207, 631 107, 489 0 42, 530 31.03 03200 CORONARY CARE UNIT 0 0 21, 377 32.00 80, 467 41,657 32.00 04000 SUBPROVI DER - I PF 0 40.00 0 40.00 0 04300 NURSERY 0 2,812 43.00 5.432 0 0 43.00 ANCILLARY SERVICE COST CENTERS 15, 977 05000 OPERATING ROOM 50 00 1, 163, 481 602, 525 897, 047 50 00 51.00 05100 RECOVERY ROOM 0 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 22.538 11,668 0 Λ 52 00 05300 ANESTHESI OLOGY 135, 779 70, 291 0 53.00 53.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 291, 913 151, 121 54.00 0 05401 PET SCAN 18.480 54.01 9, 567 54.01 0 05600 RADI OI SOTOPE 0 56.00 93, 183 48, 240 0 56.00 57.00 05700 CT SCAN 237, 643 123, 026 0 0 57.00 05800 MRI 0 58.00 0 58.00 06000 LABORATORY 527, 799 0 0 60.00 273, 237 Λ 60.00 30, 408 65.00 06500 RESPIRATORY THERAPY 170, 987 88, 518 0 65.00 66.00 06600 PHYSI CAL THERAPY 57, 120 29, 570 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 0 C 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 196, 428 101, 689 0 69.00 0 07000 ELECTROENCEPHALOGRAPHY 27, 895 0 70.00 70.00 14, 441 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 315.897 0 71 00 163, 537 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 653, 367 338, 242 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 1,043,174 540, 041 0 73.00 07400 RENAL DIALYSIS 29.314 0 74.00 15, 176 74.00 0 0 03140 CARDIO CATH LAB 76.00 248, 296 128, 540 0 121, 633 4,501 76.00 76.01 03050 ENDOSCOPY 157, 918 81, 753 0 0 76.01 03051 CARDI AC REHAB 11,099 5, 746 0 76.02 76.02 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 10, 226 5, 294 0 1, 429, 194 29, 253 90.00 26, 328 09100 EMERGENCY 283, 055 0 91.00 91.00 146, 535 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 22,016 11, 397 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 96.00 SPECIAL PURPOSE COST CENTERS 0 105. 00 105.00 10500 KIDNEY ACQUISITION 4 833 2.502 0 0 106.00 10600 HEART ACQUISITION 10,023 5, 189 0 0 10, 801 106. 00 SUBTOTALS (SUM OF LINES 1-117) 598, 262 118. 00 118.00 6, 394, 487 3, 310, 569 0 3, 162, 469 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 152, 042 0 194.00 07950 CLOSED PSYCH UNIT 0 0 0 194.00 0 194. 01 07951 MARKETI NG 0 0 194, 01 0 0 194. 02 07952 SENI OR CIRCLE 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 03

Heal th Finar	ncial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der	CCN: 150017	Peri od:	Worksheet B	
					From 07/01/2013	Part I	
				[To 06/30/2014		
						12/1/2014 9:5	<u>5 am</u>
				I NTERNS 8	RESIDENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALA	R SERVI CES-OTHER	PARAMED ED	
	·	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
		LI BRARY		APPRV	APPRV		
		16.00	17.00	21.00	22.00	23. 00	
200.00	Cross Foot Adjustments				0 0	0	200. 00
201. 00	Negative Cost Centers		0		0 0	0	201. 00
202.00	TOTAL (sum lines 118-201)	6, 394, 487	3, 310, 569		0 3, 314, 511	598, 262	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems LUTHERAN HOSPITAL OF INDIANA COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150017 Peri od: Worksheet B From 07/01/2013 Part I 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Intern & Cost Center Description **PHARMACY** Subtotal Total RESI DENCY Residents Cost **PROGRAM** & Post Stepdown Adjustments 23.01 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMITTING 5.01 5. 01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 02301 PHARMACY RESIDENCY PROGRAM 248, 770 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 44, 260, 817 -380, 104 43, 880, 713 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 0 0 1, 725, 453 -15, 204 1, 710, 249 31.01 02060 NEONATAL INTENSIVE CARE UNIT 5, 514, 873 -288, 879 5, 225, 994 31 02 31 02 31. 03 03101 CARDIO INTENSIVE CARE UNIT 22, 599, 399 0 22, 599, 399 31.03 03200 CORONARY CARE UNIT 0 8, 155, 565 0 8, 155, 565 32.00 32.00 0 04000 SUBPROVI DER - I PF 0 40.00 40.00 04300 NURSERY 0 643, 138 643, 138 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 40, 987, 895 -897, 047 40, 090, 848 50 00 51.00 05100 RECOVERY ROOM 00000000000000000 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 1, 998, 973 0 1, 998, 973 52 00 52 00 53.00 05300 ANESTHESI OLOGY 604, 621 604, 621 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 11, 826, 071 0 11, 826, 071 54.00 05401 PET SCAN 1, 089, 879 0 1, 089, 879 54.01 54.01 0 05600 RADI OI SOTOPE 56.00 2, 546, 579 2, 546, 579 56.00 57.00 05700 CT SCAN 2, 126, 328 0 2, 126, 328 57.00 58.00 05800 MRI 0 58.00 22, 245, 742 06000 LABORATORY n 22, 245, 742 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 7, 343, 930 -30, 408 7, 313, 522 65.00 66.00 06600 PHYSI CAL THERAPY 5, 898, 319 5, 898, 319 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 495, 048 3, 495, 048 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 708, 768 0 2, 708, 768 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 24, 503, 049 0 24, 503, 049 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 27, 296, 369 0 27, 296, 369 72.00 07300 DRUGS CHARGED TO PATIENTS 42, 782, 921 0 42, 782, 921 73.00 248, 770 73.00 07400 RENAL DIALYSIS 3.044.186 3. 044. 186 74.00 0 74.00 0 03140 CARDIO CATH LAB 76.00 0 6, 043, 353 -121, 633 5, 921, 720 76.00 76.01 03050 ENDOSCOPY 0 7, 927, 673 7, 927, 673 76.01 03051 CARDI AC REHAB 76.02 0 721, 954 721, 954 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 7, 790, 974 -1, 429, 194 6, 361, 780 90.00 10, 055, 002 09100 EMERGENCY 0 10, 055, 002 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 4, 747, 964 0 4, 747, 964 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105 00 2, 147, 182 2, 147, 182 0 0 106.00 10600 HEART ACQUISITION 0 964, 332 0 964, 332 106.00 SUBTOTALS (SUM OF LINES 1-117) 248, 770 -3, 162, 469 320, 633, 888 118.00 323, 796, 357 118.00 NONREI MBURSABLE COST CENTERS

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014	Part I	narad.
					Date/Time Pre 12/1/2014 9:5	pareu: <u>5 am</u>
Cost Center Description	PHARMACY	Subtotal	Intern &	Total		
	RESI DENCY		Residents Cos	t		
	PROGRAM		& Post			
			Stepdown			
			Adjustments			
	23. 01	24. 00	25.00	26.00		
200.00 Cross Foot Adjustments	0	0		0 0		200. 00
201.00 Negative Cost Centers	0	0		0 0		201. 00
202.00 TOTAL (sum lines 118-201)	248, 770	329, 170, 712	-3, 314, 51	1 325, 856, 201		202. 00

| Peri od: | Worksheet B | From 07/01/2013 | Part | I | To 06/30/2014 | Date/Time Prepared: Provider CCN: 150017

Cost Center Description					То	06/30/2014	Date/Time Pre 12/1/2014 9:5	
Accidence Received Reliable Control				CAPI TAL REI	LATED COSTS		1	<u> </u>
BRIENTS PRINTENT		Coot Contar Decemintion	Di mantin	DIDC 0 FLVT	M/DLE FOULD	Cubtatal	EMDL OVEE	
CEREBAL SERVICE DOST CENTERS D. 2.00 2.00 2.00 4.00 0.00		cost center bescription		BLDG & FIXI	MARTE EGOLA	Subtotai		
DEBERAL SERVICE COST CENTERS			Capi tal					
Company Comp				1.00	0.00	0.4	4.00	
1.00 001000 CAP MEL COSIS*-BLEG & FINT		GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
4.00 0.000 D.000	1.00							1.00
5.01 DOS-40] ANNI TILIKS 13 361, 630 25, 261 393, 991 18, 315 5 0 7 7 7 7 7 7 7 7 7								ı
5.02 0.0560 OTHER ADMINISTRATIVE AND GENERAL 0 741, 439 5, 339, 654 6, 061, 073 24, 869 5, 00 0.0560 24, 869 5, 00 0.0560 24, 869 5, 00 0.0560 27, 444 26, 70 0.0500			0	l				1
0.0000 DOTOD DEPENTION OF PELANT 0 3,697.778 358,750 4,066.228 7,702 7,00			0	l				l
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000		00700 OPERATION OF PLANT	0	l			· ·	•
10.00 01000 DETARY		1 1	0	l				1
11.00 01100 CAFETERIA 0			0					•
13.00 01300 NURSH NO ADMINI STRATION 0 10.3 838 7.1 83 170.795 6.925 13.00		1 1	0	1				•
15.00 01500 PARBIACY 0 171, 280 106, 992 228, 281 25, 577 15.00 170, 00 17			0	1	_	-		
16. 00 01-600 MEDI CAL RECORDS & LIBRARY 0 182, 942 47,259 233, 201 12, 289 16. 00 21. 00 21. 00 20. 00 20. 01 23, 243 8, 877 17. 00 21. 00 20. 00			0	l				1
17.00 01700 SOCIAL SERVICE 0 123, 243 0 123, 244 8, 877 17.00 22.00 0200 18R SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 0 0 22.00 23.00 023			0	l				ł
21.00 02100 IAS SERVICES-SALARY S, FRINGES APPRV 0 0 0 0 0 0 0 22 0.00 220.00 02200 IAS SERVICES-STHER PROBLE OSTS APPRV 0 0 0 0 0 0 0 0 0 23.00 0300 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 0 0		I I	0	l				•
23.00			0	1	1			•
03201 PHARMACY RESIDENCY PROGRAM 0 0 0 0 0 0 711 23.01			0	0	0	0	0	
INPATIL ENT ROUTINE SERVICE COST CENTERS 0 2,532,461 3,005,085 5,537,546 73,751 30.00 30.00 03000 MULTIS & PEDIA PRICE STORY 10,000 0 0 0 0 0 0 0 31.00			0	l	1			
0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0	23.01		0	0	0	O _I	/11	23.01
13.1 0	30. 00		0	2, 532, 461	3, 005, 085	5, 537, 546	73, 751	30. 00
31.02			0	1		- 1		ł
31 03 03101 (ARDIO I NTERISI VE CARE UNIT 0 944, 392 221, 223 1, 165, 615 44, 965 31, 03 20 03200 (ORDANRY CARE UNIT 0 367, 747 83, 510 451, 257 16, 674 32 00 40, 00 04000 SUBPROVI DER - I PF 0 0 367, 747 83, 510 451, 257 14, 599 1, 215 40, 00 40, 00 151, 00 151			0					1
32.00 03200 COROMARY CARE UNIT 0 367, 747 83, 510 451, 257 16, 674 32.00		I I	0	1				
40. 00 040000 SUBPROVI DER - I PF			0	l				1
ANCILLARY SERVICE COST CENTERS 50.00			0	1				ł
50.00	43.00		0	13, 038	1, 521	14, 559	1, 215	43. 00
S1 00 OS 100 RECOVERY ROOM & LABOR ROOM O	50 00		1 0	2 468 392	4 512 882	6 981 274	35 841	50 00
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 5,042 52.00			0				•	•
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 378, 421 1, 548, 725 1, 927, 146 20, 434 54. 00 54.01 05401 PET SCAN 0 41. 12 557, 571 598, 763 159 54. 01 56.00 05600 RADI OI SOTOPE 0 95, 948 10, 286 106, 234 1, 606 56. 00 57.00 05700 CT SCAN 0 47, 449 49, 366 96, 815 2, 916 57. 00 60.00 05600 MRI 0 0 0 0 0 0 60.00 05600 RSDI RATORY HERAPY 0 406, 933 731, 447 1, 138, 380 20, 287 60. 00 60.00 05600 RESPI RATORY HERAPY 0 290, 377 220, 749 511, 126 13, 284 66. 00 60.00 06600 PSPECH ATHOLOGY 0 0 0 0 0 0 0 68.00 05600 SEPECH PATHOLOGY 0 323, 521 326, 061 649, 582 4, 680 69. 00 69.00 05900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69. 00 71.00 07000 07000 07000 0 0 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	5, 042	52. 00
54.01 DEAD DET SCAN 0 41, 192 557, 571 598, 763 1,59 54. 01			0	l				•
56.00 0500		1 1	0	l				•
57.00 05700 CT SCAN 0 47,449 49,366 96,815 2,916 57.00 58.00 05800 MRI 0 0 0 0 0 0 58.00 05800 MRI 0 0 0 0 0 0 0 0 58.00 06000 LABORATORY 0 406,933 731,447 1,138,380 20,287 60.00 65.00 065000 RESPIRATORY THERAPY 0 137,189 236,823 374,012 16,836 65.00 66.			0	l				•
60.00 06000 LABORATORY 0 406, 933 731, 447 1, 138, 380 20, 287 60.00	57. 00	I I	0	l		96, 815		1
65.00 06500 RESPIRATORY THERAPY 0 137, 189 236, 823 374, 012 16, 836 65. 00 66.00 06600 PHYSI CAL THERAPY 0 290, 377 220, 749 511, 126 13, 284 66. 00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69.00 06900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69. 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 35, 915 501, 459 537, 374 4, 264 70. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 189, 604 3, 954 193, 558 0 74. 00 76.00 03140 CARDI O CATH LAB 0 154, 549 1, 424, 053 1, 578, 602 5, 392 76. 00 76.01 03050 ENDOSCOPY 0 166, 107 518, 751 684, 858 13, 117 76. 01 76.02 03051 CARDI AC REHAB 0 0 0 32, 762 32, 762 1, 850 76.02 03051 CARDI AC REHAB 0 0 487, 909 12, 668 500, 577 11, 356 90. 00 79.00 09000 CLINIC 0 487, 790 12, 668 500, 577 11, 356 90. 00 79.00 09000 CLINIC 0 0 0 0 0 0 79.00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09500 AMBULANCE SERVICES 0 11, 032 293, 088 304, 120 9, 594 79.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 17, 045, 676 21, 189, 792 38, 235, 468 466, 785 118, 00 79.00 190.00 190.00 PHYSI CI ANS 'PRIVATE OFFICES 0 0 3, 024 3, 024 0 192, 00 79.00 194.00 09750 CLOSED PSYCH UNIT 0 0 0 0 0 0 79.40 0194, 00 09750 CLOSED PSYCH UNIT 0 0 0 0 0 0 79.40 0194, 00 0194, 00 0194, 00 79.40 0194, 00 0194, 00 0194, 00 79.40 0194, 00 0194, 00 0194, 00		I I	0	1		- 1		•
66.00 06600 PHYSI CAL THERAPY 0 290, 377 220, 749 511, 126 13, 284 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69.00 70.00 07000 ELECTROCARDI OLOGY 0 359, 15 501, 459 537, 374 4, 264 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 75.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 76.00 03140 CARDI O CATH LAB 0 154, 549 1, 424, 053 1, 578, 602 5, 392 76.00 76.01 03050 ENDSCOPY 0 166, 107 518, 751 684, 858 13, 117 76.01 76.02 03051 CARDI A C REHAB 0 0 0 32, 762 32, 762 1, 850 76.02 76.00 09000 CLINI C 0 487, 909 12, 668 500, 577 11, 356 90.00 790.00 09000 DUBRAGENCY 0 481, 724 356, 459 838, 183 15, 190 91.00 790.00 09000 DUBRAGENCY 0 481, 724 356, 459 838, 183 15, 190 91.00 790.00 09000 DUBRAGENCY 0 481, 724 356, 459 838, 183 15, 190 91.00 790.00 09000 DUBRABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 700.00 09000 DUBRABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 0 0 700.00 09000 PHYSI CLAUS I TI ON 0 0 0 0 0 0 0 0			0	l				•
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0			0	l				•
69. 00 06900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 35, 915 501, 459 537, 374 4, 264 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 73. 00		06700 OCCUPATIONAL THERAPY	0	1			0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0	0	0	0		
71. 00			0					1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 189, 604 3, 954 193, 558 0 74. 00 76. 00 03140 CARTH LAB 0 154, 549 1, 424, 053 1, 578, 602 5, 392 76. 00 76. 01 03050 ENDOSCOPY 0 166, 107 518, 751 684, 858 13, 117 76. 01 76. 02 03051 CARDI AC REHAB 0 0 0 32, 762 32, 762 1, 850 76. 00 09000 CLI NI C 0 487, 909 12, 668 500, 577 11, 356 90. 00 79. 00 09000 OBSERVATI ON BEDS (NON-DISTINCT PART 0 481, 724 356, 459 838, 183 15, 190 79. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 79. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79. 00 09500 AMBULANCE SERVI CES 0 11, 032 293, 088 304, 120 9, 594 79. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79. 00 10500 KI DNEY ACQUI SI TI ON 0 50, 267 11, 004 61, 271 0 105. 00 79. 00 10600 HEART ACQUI SI TI ON 0 0 0 16, 157 16, 157 0 106. 00 79. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 77, 46, 604 62, 011 0 190. 00 792. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 024 3, 024 0 192. 00 794. 00 19750 CLOSED PSYCH UNIT 0 0 0 0 0 0 794. 00 107951 MARKETI NG 0 0 3, 120 3, 120 1, 400 194. 01 794. 01 07951 MARKETI NG 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 0 795. 00 07950 CLOSED		I I	Ö	0 0		0		
74. 00 07400 RENAL DIALYSIS 0 189,604 3,954 193,558 0 74. 00 76. 00 03140 CARDI 0 CATH LAB 0 154,549 1,424,053 1,578,602 5,392 76. 00 76. 01 03050 ENDOSCOPY 0 166,107 518,751 684,858 13,117 76. 01 76. 02 03051 CARDI AC REHAB 0 0 0 32,762 32,762 1,850 76. 02 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 487,909 12,668 500,577 11,356 90. 00 91. 00 09200 DIRER REI MBURSABLE COST CENTERS 95. 00 09200 DIRER REI MBURSABLE COST CENTERS 96. 00 09500 AMBULANCE SERVICES 0 11,032 293,088 304,120 9,594 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	0	
76. 00 03140 CARDI O CATH LAB 0 154,549 1,424,053 1,578,602 5,392 76. 00 76. 01 03050 ENDOSCOPY 0 166,107 518,751 684,858 13,117 76. 01 03050 ENDOSCOPY 0 0 166,107 518,751 684,858 13,117 76. 01 03050 CARDI AC REHAB 0 0 0 32,762 32,762 1,850 76. 02 00 09000 CLI NI C 0 0 487,909 12,668 500,577 11,356 90. 00 09100 EMERGENCY 0 481,724 356,459 838,183 15,190 91. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART OF THER REI MBURSABLE COST CENTERS 0 0 11,032 293,088 304,120 9,594 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 96. 00 9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 50,267 11,004 61,271 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 17,045,676 21,189,792 38,235,468 466,785 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 17,045,676 21,189,792 38,235,468 466,785 118. 00 NONREI MBURSABLE COST CENTERS 0 0 3,024 3,024 0 192. 00 194. 00 107951 MARKETI NG 0 0 0 0 0 0 0 0 194. 00 194. 00 107951 MARKETI NG 0 0 0 0 0 0 0 0 0 0 194. 00 194. 00 107951 MARKETI NG 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	100 (04	0	102 550		
76. 01 03050 ENDOSCOPY 0 166, 107 518, 751 684, 858 13, 117 76. 01 76. 02 03051 CARDI AC REHAB 0 0 0 32, 762 32, 762 1, 850 76. 02 01 76			0					1
OUTPATI ENT SERVI CE COST CENTERS OUTPATI ENT SERVI CE COST CE		I I	Ö	1				ł
90. 00	76. 02		0	0	32, 762	32, 762	1, 850	76. 02
91. 00	00 00		1 0	497 000	12 440	E00 E77	11 254	00 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0		I I		l				1
95. 00					333, 131		,	1
96. 00								
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 50, 267 11, 004 61, 271 0 105.00 106.00			-	,				1
105. 00	96.00		0		<u> </u>	U	0	96.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 17, 045, 676 21, 189, 792 38, 235, 468 466, 785 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 57, 407 4, 604 62, 011 0 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 024 3, 024 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 194. 00 194. 01 194. 01 197. 01 19	105.00		0	50, 267	11, 004	61, 271	0	105. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 57, 407 4, 604 62, 011 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 024 3, 024 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 0 0 3, 120 3, 120 1, 400 194. 01	106.00	10600 HEART ACQUISITION	_	0	16, 157	16, 157	0	106. 00
190. 00	118.00		0	17, 045, 676	21, 189, 792	38, 235, 468	466, 785	J118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 024 3, 024 0 192. 00 194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194. 00 194. 01 194. 01 07951 MARKETI NG 0 0 3, 120 3, 120 1, 400 194. 01	190. 00		0	57. 407	4.604	62. 011	0	190, 00
194. 01 07951 MARKETI NG 0 0 3, 120 3, 120 1, 400 194. 01			0	0			0	192. 00
194. 01 07951 MARKETING 0 0 3, 120 1, 400 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 0 0 149 194. 02	194.00	07950 CLOSED PSYCH UNIT	0	0	0	0	0	194. 00
174. 02 07702 SLINI ON CINCLE U U U U 149 194. 02			0	0			1, 400	194. 01
	174. UZ	- O 7 7 3 2 SENT ON OF NOLE	1 0	<u> </u>	1 0	U	149	1174. UZ

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014		pared:
					12/1/2014 9:5	5 am
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	88, 08	88, 082		194. 03
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	17, 103, 083	21, 288, 62	38, 391, 705	469, 090	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150017

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared: |

				'	0 06/30/2014	Date/lime Pre 12/1/2014 9:5	
	Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE		
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	412 207					4.00
5. 01 5. 02	OO540 ADMITTING OO560 OTHER ADMINISTRATIVE AND GENERAL	412, 206					5. 01 5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	31, 599		61, 015		8. 00
9. 00	00900 HOUSEKEEPI NG	Ö	74, 002			207, 220	1
10.00	01000 DI ETARY	0	84, 009			12, 215	1
11. 00	01100 CAFETERI A	0	37, 305		0	0	1
13.00	01300 NURSING ADMINISTRATION	0	46, 604	60, 908	0	2, 888	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0			0	5, 275	1
15. 00	01500 PHARMACY	0			0	3, 020	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0			0	3, 225	
17. 00	01700 SOCIAL SERVICE	0	56, 343	45, 817	0	2, 173	1
21. 00 22. 00	O2100 L&R SERVICES-SALARY & FRINGES APPRV O2200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	61, 483		0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		8, 509		161	0 1, 217	1
23. 00	02301 PHARMACY RESIDENCY PROGRAM			23, 074	0	1, 217	1
20.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1,001				20.01
30.00	03000 ADULTS & PEDIATRICS	20, 344	622, 372	941, 467	21, 893	44, 645	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	498			415	1, 844	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	2, 947	75, 895		475	4, 659	1
31. 03	03101 CARDIO INTENSIVE CARE UNIT	13, 404	336, 958		7, 507	16, 648	1
32.00	03200 CORONARY CARE UNIT	5, 195	123, 852	136, 713		6, 483	
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	
43. 00	04300 NURSERY	351	8, 677	4, 847	0	230	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	74, 511	586, 824	917, 647	12, 025	43, 514	50.00
51. 00	05100 RECOVERY ROOM	74, 311		917, 047	12,023	43, 314	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 455	_		0	Ő	1
53.00	05300 ANESTHESI OLOGY	8, 765		710	0	34	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 845	188, 763	140, 681	3, 066	6, 671	54.00
54.01	05401 PET SCAN	1, 193	18, 197	15, 314	0	726	54. 01
56.00	05600 RADI OI SOTOPE	6, 016	1		0	1, 691	56. 00
57. 00	05700 CT SCAN	15, 341	29, 480	17, 640		836	1
58. 00	05800 MRI	0	0	0	0	0	
60.00	06000 LABORATORY	34, 073			82	7, 174	1
65. 00 66. 00	06500 RESPIRATORY THERAPY	11, 038	l ·		233	2, 418	1
67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	3, 687	96, 231 0	107, 950	0	5, 119 0	1
68. 00	06800 SPEECH PATHOLOGY	0			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	12, 681	47, 199	120, 272	230	5, 703	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 801	46, 617		0	633	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 393			0		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	42, 179		0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	67, 343			0	0	
74. 00	07400 RENAL DI ALYSI S	1, 892				3, 342	1
76. 00	03140 CARDIO CATH LAB	16, 029					
76. 01	03050 ENDOSCOPY	10, 195		61, 752			1
76.02	03051 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	717	12, 811	0	0	0	76. 02
90. 00	09000 CLINIC	660	95, 041	181, 385	936	8, 601	90.00
	09100 EMERGENCY	18, 273					1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 2/3	147, 047	179,000	7, 120	0, 472	92.00
, 00	OTHER REIMBURSABLE COST CENTERS		1				1 .2. 55
95.00	09500 AMBULANCE SERVICES	1, 421	85, 929	4, 101	0	194	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	312			0		105. 00
	10600 HEART ACQUISITION	647	l ·		0		106. 00
118. 00	,	412, 206	6, 039, 645	4, 383, 381	61, 015	206, 208	J118. 00
100.00	NONREI MBURSABLE COST CENTERS	_	1 275	24 244	^	1 010	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 375 10, 138		0		190. 00 192. 00
	07950 CLOSED PSYCH UNIT		10, 138		0		194.00
	07951 MARKETI NG		46, 499	0			194. 00
	07952 SENI OR CI RCLE	0	1, 748		l 0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	l o	6, 557		l		194. 03
200.00]				200. 00
201.00		0	0	0	0	0	201. 00

Health Financial Systems	LUTHERAN HOSPI	TAL OF INDIANA		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014		narod:
				10 00/30/2014	12/1/2014 9:5	
Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE		
		AND GENERAL				
	5. 01	5. 02	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118-201)	412, 206	6, 105, 962	4, 404, 72	22 61, 015	207, 220	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				06/30/2014	12/1/2014 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11. 00	13.00	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
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. 01 00540 ADMITTING						5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
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	1, 118, 479					10. 00
11. 00 01100 CAFETERI A	0	44, 313				11. 00
13.00 O1300 NURSING ADMINISTRATION	0	524	288, 825			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	1, 403	0	949, 991		14. 00
15. 00 01500 PHARMACY	0	2, 026	0	23, 269	580, 571	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1, 791	0	792	0	16. 00
17. 00 01700 SOCI AL SERVI CE	0	832	0	139	0	17. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	76	1	36	0	23. 00
23. 01 O2301 PHARMACY RESIDENCY PROGRAM	0	76	0	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	465, 333	8, 994	81, 637	35, 391	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	_	0	0	31.00
31. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T	9, 975	316		1, 242	0	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	64, 263	949		5, 763	0	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	221, 180	4, 793		21, 563	0	31. 03
32. 00 03200 CORONARY CARE UNIT	43, 530	1, 639		8, 607	0	32. 00
40. 00 04000 SUBPROVI DER - PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	21, 943	119	1, 346	951	0	43. 00
ANCI LLARY SERVI CE COST CENTERS		4.407	00.407	440.000		F0 00
50. 00 05000 OPERATI NG ROOM	0	4, 107		112, 328	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	_	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	496		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	127		36	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 293		7, 777	0	54.00
54. 01 05401 PET SCAN	0	19	1	510	0	54. 01
56. 00 05600 RADI OI SOTOPE	0	155		510	0	56.00
57. 00 05700 CT SCAN	U	355	3, 229	1, 244	-	57. 00
58. 00 05800 MRI	0	2 512	0	(4.051	0	58.00
60. 00 06000 LABORATORY	0	2, 512	1	64, 051	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 929	0	6, 818	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 191		1, 923	0	66.00
	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	U E01	1	402	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	591 477		482 6, 697	0	69. 00 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4//	1	278, 278	0	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		313, 115	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		313, 113	580, 571	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		790	0	74.00
76. 00 03140 CARDI O CATH LAB	0	520	5, 971	12, 515	0	76.00
76. 01 03050 ENDOSCOPY	0	1, 577		18, 476	0	76. 01
76. 02 03051 CARDI AC REHAB	0	264		265	0	76. 01
OUTPATIENT SERVICE COST CENTERS	<u> </u>	204	<u> </u>	200		70.02
90. 00 09000 CLINIC	0	994	12, 575	7, 481	0	90.00
91. 00 09100 EMERGENCY	0	1, 789		17, 583	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o _l	1, 707	10, 021	17, 303	O	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVI CES	0	978	o	1, 774	0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	1	1, 7, 7	0	96.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		70.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	116	o	nl	Ω	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	66	1	0		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	826, 224	44, 094		949, 896	580, 571	
NONREI MBURSABLE COST CENTERS	020, 224	44, 074	200, 023	747, 070	300, 371	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	<u> </u>	0	E	n	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	251, 171	0	1	0		192.00
194.00 07950 CLOSED PSYCH UNIT	231, 171	0		0		194. 00
194. 01 07951 MARKETI NG	0	146		81		194. 01
194. 02 07952 SENI OR CI RCLE	0	140	1			194. 01
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	41, 084	57		9		194. 02
200.00 Cross Foot Adjustments	41,004	37		٩	U	200.00
201.00 Negative Cost Centers	0	0	0	٥	Λ	200.00
	<u> </u>		<u> </u>	9	0	

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014	Part II Date/Time Pre	narod:
					12/1/2014 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI (N SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
202.00 TOTAL (sum lines 118-201)	1, 118, 479	44, 313	288, 82	949, 991	580, 571	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150017

Peri od: Worksheet B From 07/01/2013 Part II To 06/30/2014 Date/Time Prepared:

12/1/2014 9:55 am INTERNS & RESIDENTS PARAMED ED MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Cost Center Description RECORDS & Y & FRINGES PRGM COSTS PRGM LI BRARY **APPRV APPRV** 23.00 16.00 17.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMITTING 5.01 5. 01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 426, 831 16.00 01700 SOCIAL SERVICE 17.00 237, 424 17.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21 00 0 0 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 61, 483 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 C 105, 944 23.00 23.00 02301 PHARMACY RESIDENCY PROGRAM 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 21,028 11, 737 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 515 287 31.01 02060 NEONATAL INTENSIVE CARE UNIT 3.046 31 02 1,700 31 02 31. 03 03101 CARDIO INTENSIVE CARE UNIT 13,855 7, 733 31.03 03200 CORONARY CARE UNIT 32.00 5, 369 2, 997 32.00 04000 SUBPROVI DER - I PF 40.00 0 C 40.00 04300 NURSERY 362 202 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 77, 774 42, 601 50 00 51.00 05100 RECOVERY ROOM 51.00 05200 DELIVERY ROOM & LABOR ROOM 1,504 52 00 839 52 00 05300 ANESTHESI OLOGY 9,060 5,057 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 479 10, 872 54.00 05401 PET SCAN 1, 233 54.01 54.01 688 05600 RADI OI SOTOPE 3, 471 56.00 6, 218 56.00 57.00 05700 CT SCAN 15,858 8,851 57.00 58.00 05800 MRI 58.00 06000 LABORATORY 35, 219 19, 657 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 11, 410 6,368 65.00 66.00 06600 PHYSI CAL THERAPY 3,812 2, 127 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 C 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 13, 107 7, 316 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,861 1, 039 70.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 21.079 11, 765 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 598 24, 334 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 69, 610 38, 852 73.00 07400 RENAL DIALYSIS 1.956 74.00 1, 092 74.00 03140 CARDIO CATH LAB 76.00 16, 568 9, 248 76.00 76.01 03050 ENDOSCOPY 10,538 5, 882 76.01 03051 CARDI AC REHAB 741 413 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 682 381 90.00 09100 EMERGENCY 18,888 10, 542 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 469 820 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 105 00 323 180 106.00 10600 HEART ACQUISITION 669 373 106.00 426, 831 SUBTOTALS (SUM OF LINES 1-117) 118.00 237, 424 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 0 194.00 07950 CLOSED PSYCH UNIT 0 194.00 194. 01 07951 MARKETI NG 194. 01 0 194. 02 07952 SENI OR CIRCLE 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 194.03

Health Financial Systems	LUTHERAN HOSPI	TAL OF INDIANA		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eri od:	Worksheet B	
				rom 07/01/2013 o 06/30/2014	Date/Time Pre	pared:
					12/1/2014 9:5	5 am
			INTERNS &	RESI DENTS		
Cost Center Description	MEDICAL RECORDS &	SOCI AL SERVI CE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	
	LI BRARY		APPRV	APPRV	PRGIVI	
	16.00	17. 00	21.00	22. 00	23. 00	
200.00 Cross Foot Adjustments			C	61, 483	105, 944	200. 00
201.00 Negative Cost Centers	C	0	C	0		201. 00
202.00 TOTAL (sum lines 118-201)	426, 831	237, 424	[C	61, 483	105, 944	202. 00

	Financial Systems	LUTHERAN HUSPITA		001 450047 5		U OF FORM CMS-2552	2-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 07/01/2013 To 06/30/2014		ed:
	Cost Center Description	PHARMACY RESI DENCY PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23. 01	24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMI TTI NG						5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL					· · · · · · · · · · · · · · · · · · ·	5. 02
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE					· · · · · · · · · · · · · · · · · · ·	7. 00 3. 00
9. 00	00900 HOUSEKEEPING					· · · · · · · · · · · · · · · · · · ·	9. 00
10.00	01000 DI ETARY					l .	0. 00
11.00	01100 CAFETERI A					l .	1.00
13. 00 14. 00	O1300 NURSI NG ADMINI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY					l I	3. 00 4. 00
15. 00	01500 PHARMACY						5. 00
	01600 MEDICAL RECORDS & LIBRARY					l I	5. 00
17. 00	01700 SOCIAL SERVICE					l I	7. 00
21. 00 22. 00	O2100 L&R SERVICES-SALARY & FRINGES APPRV O2200 L&R SERVICES-OTHER PRGM COSTS APPRV					l I	1.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)						3. 00
23. 01	02301 PHARMACY RESIDENCY PROGRAM	5, 338				l .	3. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS		7, 886, 138 0	1			0.00
31.00	03100 INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT		214, 791			l .	1. 00 1. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT		663, 832			l I	1. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT		2, 255, 162				1. 03
32. 00	03200 CORONARY CARE UNIT		823, 282	1		l .	2. 00
40. 00 43. 00	04000 SUBPROVI DER - PF 04300 NURSERY		0 54, 802) C		l .	0. 00 3. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		01,002	-1	01,002	10	<i>7.</i> 00
50.00	05000 OPERATI NG ROOM		8, 928, 133			l .	0. 00
51.00	05100 RECOVERY ROOM		40.034	1		l I	1.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		49, 926 33, 459				2. 00 3. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		2, 368, 653			l .	4. 00
54. 01	05401 PET SCAN		636, 468			l I	4. 01
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN		204, 038	1			5. 00 7. 00
58. 00	05800 MRI		193, 498 0				3. 00
60.00	06000 LABORATORY		1, 842, 748				0. 00
65. 00	06500 RESPI RATORY THERAPY		605, 133		,	l I	5. 00
	06600 PHYSI CAL THERAPY		746, 450				5. 00
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		0				7. 00 3. 00
69. 00	06900 ELECTROCARDI OLOGY		861, 843				9. 00
	07000 ELECTROENCEPHALOGRAPHY		614, 115	1	614, 115		0. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		728, 206 856, 107	1			1.00
73. 00			1, 319, 449		,		3. 00
74.00	07400 RENAL DIALYSIS		321, 941				4. 00
76.00	03140 CARDIO CATH LAB		1, 799, 228	1		l I	5. 00
76. 01	03050 ENDOSCOPY 03051 CARDI AC REHAB		954, 383 49, 823	1		l .	6. 01 6. 02
70.02	OUTPATIENT SERVICE COST CENTERS		47, 023	,	47,023	70). UZ
90.00	09000 CLI NI C		820, 669				0. 00
91.00			1, 281, 621				1.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			C)	92	2. 00
95. 00	09500 AMBULANCE SERVICES		410, 400) C	410, 400	95	5. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		0			l .	5. 00
405.00	SPECIAL PURPOSE COST CENTERS		110 500		110 500	105	
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION		119, 599 35, 262				5. 00 5. 00
118.00		0				l I	3. 00
	NONREI MBURSABLE COST CENTERS	-	21/211/121		31,311,131		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		85, 744			l I	0.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT		264, 333			l I	2. 00 4. 00
	07950 CLOSED PSYCH UNIT		51, 246				4. 00 4. 01
194. 02	07952 SENI OR CI RCLE		1, 922	: c	1, 922	194	1. 02
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS		136, 536	o C	136, 536	194	1. 03

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B
				From 07/01/2013	Part II
				To 06/30/2014	Date/Time Prepared:
					12/1/2014 9:55 am
Cost Center Description	PHARMACY	Subtotal	Intern &	Total	
	RESI DENCY		Residents Cos	t	
	PROGRAM		& Post		
			Stepdown		
			Adjustments		
	23. 01	24.00	25. 00	26.00	
200.00 Cross Foot Adjustments	5, 338	172, 765		0 172, 765	200. 00
201.00 Negative Cost Centers	0	0)	0 0	201. 00
202.00 TOTAL (sum lines 118-201)	5, 338	38, 391, 705		0 38, 391, 705	202. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	LUTHERAN HOSPI		CCN: 150017 P	<u> </u>	wof Form CMS-2 Worksheet B-1	
COST ALLOCATION - STATISTICAL BASIS		Frovider	F	rom 07/01/2013		
			T	o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	CAPITAL RE	LATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMITTING	Reconciliation	
	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	(GROSS CHAR		
			DEPARTMENT (GROSS	GES)		
			SALARI ES)			
GENERAL SERVICE COST CENTERS	1.00	2. 00	4. 00	5. 01	5A. 02	
1.00 O0100 CAP REL COSTS-BLDG & FIXT	716, 220	ol				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		9, 982, 305				2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	18, 728					4.00
5. 01 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	15, 437 31, 049			1, 984, 598, 649 0	-52, 492, 986	5. 01 5. 02
7. 00 00700 OPERATION OF PLANT	154, 838				02, 172, 700	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	898		0	0	0	8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	3, 015 29, 016				0	9. 00 10. 00
11. 00 01100 CAFETERI A	29,010		1, 544, 259		o o	11. 00
13.00 01300 NURSING ADMINISTRATION	6, 86			0	0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	12, 530 7, 173			0	0 0	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	7, 173				0	16.00
17.00 01700 SOCIAL SERVICE	5, 161		1, 956, 174		0	17. 00
21.00 02100 L&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	(-	0	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)	2, 892	-1	178, 102	0	0	22. 00 23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM		1			0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10/ 051	1 400 004	1/ 2/1 /7/	07 00/ 570	0	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	106, 051	1, 409, 094	16, 241, 476 0	97, 806, 578 0	0	30. 00 31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	4, 38	1 11, 021	761, 018	2, 394, 923	ő	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	11, 068				0	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	39, 548 15, 400					31. 03 32. 00
40. 00 04000 SUBPROVI DER - 1 PF	15, 400		3,074,214		0	40.00
43. 00 04300 NURSERY	546	713	267, 764	1, 685, 765	0	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	103, 368	2, 116, 105	7, 897, 878	361, 071, 239	0	50.00
51. 00 05100 RECOVERY ROOM	103, 300	. 1	0	0 0 0 0 0 0	o o	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		-	1, 111, 063		0	52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	80 15, 847		120, 836 4, 502, 763		0	53. 00 54. 00
54. 01 05400 RADI OLOGI - DI AGNOSTI C	1, 725				0	54. 00
56. 00 05600 RADI OI SOTOPE	4, 018	4, 823	353, 944	28, 920, 949	i e	56. 00
57. 00 05700 CT SCAN 58. 00 05800 MRI	1, 987	7 23, 148	642, 653	73, 756, 438	0 1 0	57. 00 58. 00
60. 00 06000 LABORATORY	17, 041	342, 978	4, 470, 469	163, 810, 992		60.00
65. 00 06500 RESPI RATORY THERAPY	5, 745	111, 047	3, 709, 962	53, 068, 637	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	12, 160		2, 927, 352	17, 728, 066	0 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		1	0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	13, 548	-	1, 031, 323	_	Ö	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 504	235, 136	939, 717		l	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS			0	98, 043, 620 202, 783, 096	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		o o	ő	323, 765, 854	ő	73. 00
74. 00 07400 RENAL DI ALYSI S	7, 940			9, 098, 177	0	74.00
76. 00 03140 CARDI 0 CATH LAB 76. 01 03050 ENDOSCOPY	6, 472 6, 956				0	76. 00 76. 01
76. 02 03051 CARDI AC REHAB	0, 750				0	76. 02
OUTPATIENT SERVICE COST CENTERS			·			
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	20, 432 20, 173					90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	20, 173	107, 143	3, 347, 366	87, 830, 370		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	462					95.00
96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS		0	0	0	0	96. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	2, 105	5, 160	0	1, 500, 085	0	105. 00
106. 00 10600 HEART ACQUISITION	712.01			3, 110, 700		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	713, 816	9, 935, 963	102, 851, 486	1, 984, 598, 649	-52, 492, 986	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 404	2, 159	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES			0	0		192. 00
194. 00 07950 CLOSED PSYCH UNIT 194. 01 07951 MARKETI NG		l .	0 308, 486	0		194. 00 194. 01
	1	-1 1, 403	1 550, 400		<u> </u>	1

Heal th Finan	cial Systems	LUTHERAN HOSPIT	AL OF INDIA	ANA		In Lie	eu of Form CMS-2	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi	der C	CCN: 150017	Peri od:	Worksheet B-1	
						From 07/01/2013 To 06/30/2014		
		CAPI TAL REI	_ATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQU (DOLLAR VAI		EMPLOYEE BENEFITS	ADMITTING (GROSS CHAR	Reconciliation	
					DEPARTMENT (GROSS SALARI ES)	GES)		
		1.00	2.00		4. 00	5. 01	5A. 02	
194. 02 07952	SENIOR CIRCLE	0		0	32, 85	51 0	0	194. 02
194. 03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	41,	302	166, 51	5 0	0	194. 03
200. 00	Cross Foot Adjustments							200. 00
201. 00	Negative Cost Centers							201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	17, 103, 083	21, 288,	622	16, 087, 84	8, 112, 355		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 879650	2. 132	2636	0. 15565	0. 004088		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)				469, 09	412, 206		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part II)				0. 00453	0. 000208		205. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150017 Peri od: Worksheet B-1 From 07/01/2013 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Cost Center Description OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY ADMI NI STRATI VE LINEN SERVICE (SQUARE FEET) (MEALS SERVED) PLANT AND GENERAL (SQUARE FEET) (POUNDS OF (ACCUM. COST) LAUNDRY) 10.00 7.00 9.00 5.02 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 ADMITTING 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 276, 677, 726 00700 OPERATION OF PLANT 15, 442, 094 496, 168 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 1, 431, 821 898 2, 145, 118 9.00 00900 HOUSEKEEPI NG 3, 353, 192 3, 015 492, 255 01000 DI ETARY 3, 806, 659 29, 016 0 29, 016 714, 581 10.00 1, 690, 372 11.00 01100 CAFETERI A 0 Λ 01300 NURSING ADMINISTRATION 13.00 2, 111, 757 6,861 6,861 0 14.00 01400 CENTRAL SERVICES & SUPPLY 7, 038, 843 12, 530 12, 530 7, 173 01500 PHARMACY 8, 370, 112 0 7, 173 15.00 0 01600 MEDICAL RECORDS & LIBRARY 5, 008, 059 0 16,00 7, 661 7,661 0 17.00 01700 SOCIAL SERVICE 2, 553, 026 5, 161 0 5, 161 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 C 0 0 0 2, 785, 941 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22 00 0 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 385, 569 2,892 5, 674 2, 892 0 02301 PHARMACY RESIDENCY PROGRAM 206, 196 23.01 0 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 28, 202, 908 297, 294 106, 051 769, 639 106, 051 03100 INTENSIVE CARE UNIT 31.00 0 31.01 02080 PEDIATRIC INTENSIVE CARE UNIT 1, 151, 359 4, 381 14, 595 4, 381 6, 373 11, 068 31 02 02060 NEONATAL INTENSIVE CARE UNIT 3.438.965 16, 705 11.068 41, 057 03101 CARDIO INTENSIVE CARE UNIT 31.03 15, 268, 405 39, 548 263, 909 39, 548 141, 309 03200 CORONARY CARE UNIT 5, 612, 039 15, 400 88, 015 15, 400 27, 811 32.00 04000 SUBPROVIDER - IPF 40.00 0 0 04300 NURSERY 43.00 393, 164 546 0 546 14, 019 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 26, 590, 432 103, 368 422, 765 103, 368 0 51.00 05100 RECOVERY ROOM 0 C 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 586, 259 Ω O 0 0 53.00 05300 ANESTHESI OLOGY 326, 803 80 0 80 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 8, 553, 313 15, 847 107, 796 15,847 54.01 05401 PET SCAN 824.551 1, 725 1, 725 0 0 05600 RADI OI SOTOPE 56.00 1.843.684 4.018 0 4.018 0 1, 987 57.00 05700 CT SCAN 1, 335, 812 1, 987 32, 793 0 05800 MRI 58.00 0 06000 LABORATORY 16, 767, 038 17,041 17.041 60.00 2.873 0 06500 RESPIRATORY THERAPY 65.00 5, 576, 600 5, 745 8.207 5, 745 0 66.00 06600 PHYSI CAL THERAPY 4, 360, 475 12, 160 14 12, 160 0 67.00 06700 OCCUPATIONAL THERAPY 0 06800 SPEECH PATHOLOGY 68.00 0 0 0 06900 ELECTROCARDI OLOGY 69.00 2, 138, 684 13, 548 8,098 13, 548 0 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 112, 318 1,504 1,504 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 17, 975, 055 C 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 19, 614, 899 C 0 0 0 07300 DRUGS CHARGED TO PATIENTS 25, 514, 203 0 73.00 07400 RENAL DIALYSIS 74.00 2, 212, 327 7,940 0 7, 940 0 6, 472 76.00 03140 CARDIO CATH LAB 6, 472 45, 283 4, 210, 236 0 76. 01 03050 ENDOSCOPY 5, 817, 813 6, 956 75, 312 6, 956 0 580, 491 76.02 03051 CARDI AC REHAB 0 OUTPATIENT SERVICE COST CENTERS 4, 306, 520 90.00 09000 CLI NI C 20, 432 32, 908 20.432 Λ 91.00 09100 EMERGENCY 6, 780, 972 20, 173 250, 532 20, 173 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 3, 893, 674 462 0 462 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 1, 713, 914 2, 105 O 2, 105

MCRI F32 - 6. 1. 156. 4

Heal th	Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10			
COST AL	LOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2013	Worksheet B-1		
					Γο 06/30/2014			
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
		ADMI NI STRATI VE	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)		
		AND GENERAL	(SQUARE FEET)	(POUNDS OF				
		(ACCUM. COST)		LAUNDRY)				
		5. 02	7. 00	8. 00	9. 00	10.00		
201.00	Negative Cost Centers						201. 00	
202.00	Cost to be allocated (per Wkst. B,	52, 492, 986	18, 371, 861	1, 736, 72	4, 101, 018	5, 845, 006	202. 00	
	Part I)							
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 189726	37. 027501	0. 80961	8. 331084	8. 179627	203. 00	
204.00	Cost to be allocated (per Wkst. B,	6, 105, 962	4, 404, 722	61, 01	5 207, 220	1, 118, 479	204. 00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 022069	8. 877481	0. 02844	0. 420961	1. 565224	205.00	
	11)							

COST CALLOCATION STATISTICAL DASIS Provider ORL 150017 Provider CALLOCATION COST CALLOCATION COST CALLOCATION CALLOCATIO			LUTHERAN HOSPIT				eu of Form CMS-:	
Cost Center Description	COST A	ALLOCATION - STATISTICAL BASIS		Provi der			Worksheet B-1	
Cost Center Description							Date/Time Pre	pared:
CETTE S. MONINGSTANT IN SERVICES RECULS STORMS SERVICES STORMS SERVICES STORMS SERVICES		Cost Center Description	CAFETERIA	NURSLNG	CENTRAL	PHΔRMΔCV		5 am
COUNTRY SERVICE COST CENTERS 1.00 15.00 14.00 15.00 16.00 10.0		cost defiter bescription						
BERSIAL SERVICE COST CENTERS						REQUIS.)		
				7	7		,	
CREAM_SERVICE_COST_CAPILES			11 00			15.00		
2.00 CORDO CAP REL CUSTS -WINELE EQUIP 2.00 CORDO CAP REL CUSTS -WINELE EQUIP 4.00 CORDO CAP REL CUSTS -WINELE EQUI		GENERAL SERVICE COST CENTERS	111.00	10.00	11.00	101.00	10.00	
4.00 ODADO INTERNET IS DEPARTMENT A								1
5.01 0.0540 ADMITTING								1
5.02 0.0500 O.0500 O.050								1
7.00 00700 GERATION OF PLANT 100 001000 CALEFERIA N 100 001000 CALEFERIA N 100 001000 CALEFERIA N 100 001000 CALEFERIA N 11.00 011000 CALEFERIA SERVICES & SUPPLY 11.00 011000 CALEFERIA N 11.00 011								1
9.00 00000 MUSICKEET INS								1
10.00 101000 DIETARY								1
11.00 01100 CAFETERIA 10.0, 752 1.00 01100 CAFETERIA 10.0, 1752 1.00 01100 CENTRAL SERVICES & SUPPLY 5.089 57,472,552 5.6997,555 1.30,104								1
13.00 01300 IURISI NO ZOMINI STRATION 1,002 57,472,505 56,997,955 1.0 1.0 01300 IURISI NO ZOMINI STRATION 1,002 1.0 0.0 0.0 1.396,104 1.0 0.			160, 752					1
15.00 101000 PHARMACY 17.348		01300 NURSI NG ADMI NI STRATI ON	1, 902	57, 472, 552				1
16.00 16-00 MEDICAL RECORDS & LIBRARY 6,496 0 47,523 0 1,984,598,404 16,00 17,00 1700 01			1	1				1
17.00 01700 SOCIAL SERVICE 3.018				1			l	
21.00 02.00 AR SERVICES-SALARY & FINNES APPRIVED 0 0 0 0 22.00		I I		1		0	l '	1
22.00 02200 ABN SERVICES-OTHER PROM COSTS APPRV 0 0 2.90 0 0 22.00 23.01 02300 PARAMED ED PREAM-CSPECIES 7.74 0 0 0 0 0 23.01 02300 PARAMED ED PREAM-CSPECIES 7.74 0 0 0 0 0 0 23.01 02300 PARAMED ED PREAM-CSPECIES 7.75 0 0 0 0 0 0 0 0 0			1	1		Ö	·	1
1,230	22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	C	o	29	0	0	1
IMPARTIENT ROUTINE SERVICE COST CENTERS		1 1	1	1	· ·			1
30.00 30.00 ADULTIS & PEDIATRICS 32, 628 16, 241, 477 2, 123, 399 0 97, 806, 578 30, 00 31, 00 310, 10 100, 100 10 10 10 10	23. 01		276) <u> </u>	0	O	0	23.01
31.00 0.03100 INTERSIYE CARE UNIT	30. 00		32, 628	16, 241, 477	2, 123, 399	0	97, 806, 578	30.00
31.02 02000 NEONATAL INTENSIVE CARE UNIT 17,3 86 9,915; 102 1,293,731 0 14,166,360 31.02 3				1				1
31.03 (3010) CARDIO I NITENSIVE CARE UNIT		i i		1		_	1	1
32.00 0 30200 CORDINARY CARE UNIT 5, 945 3, 674, 214 516, 409 0 24, 974, 258 32.00 0 0 3000 NURSERY F 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_		
40.00 04000 04000 04000 0 0 0								
MOLILLARY SERVICE COST CENTERS			1			_	1	1
50.00	43.00		433	267, 764	57, 070	0	1, 685, 765	43. 00
51.00 05100 RECOVERY ROOM LABOR ROOM 1.799 1.111, 063 0 0 0 0 6.994, 934 52.00 52.00 05200 DELIVERY ROOM LABOR ROOM 1.799 1.111, 063 0 0 0 0 0 0 0 0 0	FO 00		14 000	7 007 070	/ 720 F74	0	2/1 071 220	1 50 00
52.00 05200 DELLYREY ROOM & LABOR ROOM 1.799 1.111. 063 0 0 6.994, 934 52. 00 53.00 53.00 63.00 ARSTHESI LOGY 46.2 0 2.132 0 42. 141. 130 53. 00 53.00 ARSTHESI LOGY 69.9 335. 040 0 0 5.735. 464 54. 01 0 0 0 0 5.735. 464 54. 01 0 0 0 0 0 0 5.735. 464 54. 01 0 0 0 0 0 0 0 0 0			14, 900					1
54.00 05400 RADI DLOCY-DI AGNOSTIC 8.317 4.502, 763 466, 625 0 90, 599, 823 54.00 156.00 05600 RADI DISTORE 564 353, 944 30, 597 0 28, 920, 949 56.00 157.00 05700 CT SCAN 1, 287 642, 653 74, 616 0 73, 756, 438 57.00 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 RESPI RATIORY THERAPY 9, 113 0 3, 842, 969 0 163, 810, 992 60.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 72, 00 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 18, 85, 76, 858 0 77, 06, 26, 30 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 18, 85, 76, 858 0 77, 06, 26, 30 159.00 07000 RESPI RATIORY THERAPY 74, 00			1, 799	1			l	1
54.01 05401 PET SCAN 69 35, 040 0 0 5, 735, 464 54.00 56.00 56.00 ABJO IDSTOPPE 564 35.3, 944 30, 597 0 22, 920, 949 56.00 57.00 05700 CT SCAN 1, 287 642, 653 74, 616 0 73, 756, 438 57.00 58.00 05800 IMIN 0 0 0 0 0 0 0 0 0		I I	1	1		0		1
56.00 OSGO RADIO I SOTOPE 564 333, 944 30, 597 0 28, 920, 949 56, 00 58, 00 07, 00 5700 CT SCAN 1, 287 642, 653 74, 616 0 73, 756, 438 57, 00 58, 00 0800 MRI 0 0 0 0 0 0 0 0 0								1
57.00 OSTOO CT SCAN 1,887 642,653 74,616 0 73,756,438 57.00		I I				_		1
58. 00 05800 MR 0 0 0 0 0 0 0 58. 00 0. 00 06000 LABORATORY 9,113 0 3,842,969 0 163,810,992 60. 00 065.00 06500 RESPIRATORY THERAPY 6,996 0 409,068 0 53,068,637 65. 00 066.00 06600 PRYSI CAL THERAPY 4,321 0 115,371 0 17,728,066 66. 00 067.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 08. 00 06900 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 071.00 071000 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 16,696,359 0 98,043,620 71.00 072.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 18,785,922 0 202,783,096 72.00 073.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 18,785,922 0 24,190,648 323,765,854 73.00 074.00 07400 RENAL DIALYSIS 0 0 0 0 47,379 0 076.00 03140 CABDIO CATH LAB 1,888 1,188,201 750,858 0 77,062,563 76.00 076.01 03050 EMDOSCOPY 5,719 2,890,456 1,108,515 0 49,012,568 76.00 076.02 03051 CARDIAC REHAB 957 0 15,894 0 3,444,797 076.02 03051 CARDIAC REHAB 957 0 106,413 0 6,83,008 0770.00 09000 CLINIC COST CENTERS 0790.00 09000 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 0						-		1
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66.00 06600 PHSI CAL THERAPY 0 0 115, 371 0 17, 728, 066 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68.00 06900 069000 SPEECH PATHOLOGY 2,145 0 28,942 0 60,964,769 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 16,696,359 0 98,043,620 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 16,696,359 0 98,043,620 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 18,785,922 0 020,783,096 72.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 24,190,648 323,765,854 73.00 74.00 07400 REVAL DI LALYSI S 0 0 0 47,379 0 9,098,177 74.00 76.00 07400 REVAL DI LALYSI S 0 0 0 47,379 0 9,098,177 74.00 76.00 07400 CARDI LA BREWLE CAST CENTERS 0 0 0 47,379 0 9,098,177 74.00 76.00 07500 ENDOSCOPY 5,719 2,890,456 1,108,515 0 49,012,568 76.00 76.01 07500 07500 ENDOSCOPY 5,719 2,890,456 1,108,515 0 49,012,568 76.00 76.02 07500 07500 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 07500 07500 76.00 0750				1		_		1
67. 00 06700 05CUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0		I I				-		1
68. 00 66800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 2, 145 0 28, 942 0 60, 964, 769 80, 00 70. 00 07000 ELECTROCENCEPHALOGRAPHY 1, 730 0 401, 802 0 8, 657, 668 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 16, 696, 359 0 98, 043, 620 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 18, 785, 922 0 2022, 783, 096 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 47, 379 0 9, 098, 177 74. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 47, 379 0 9, 098, 177 74. 00 76. 00 03401 CARDIO CATH LAB 1, 88 1, 188, 201 750, 858 0 77, 062, 563 76. 00 76. 01 03050 ENDOSCOPY 5, 719 2, 890, 456 1, 108, 515 0 49, 012, 568 76. 01 76. 02 03051 CARDIA CREHAB 957 0 15, 894 0 3, 444, 797 79. 00 09000 CLINI C 3, 606 2, 502, 494 448, 830 0 3, 173, 904 90. 00 79. 00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 79. 00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 70. 00 09000 KIDNEY ACQUI SITI ON 242 0 0 0 0 0 3, 110, 700 106, 00 70. 00 09000 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 3, 110, 700 106, 00 70. 00 0000 0000 0000 0000 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 0000 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 0000 0000 0000 0000 0000 70. 00 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000		I I				-	,,	1
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72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 18, 785, 922 0 202, 783, 096 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 47, 379 0 9, 098, 177 74. 00 74.			1, 730	1		0		1
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76. 02 03051 CARDIAC REHAB 957 0 15,894 0 3,444,797 76. 02 0179ATI ENT SERVICE COST CENTERS 90. 00 0900 CLI NI C 3,606 2,502,494 448,830 0 3,173,904 90. 00 91. 00 09100 EMERGENCY 6,490 3,347,388 1,054,953 0 87,850,570 91. 00 0920 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 106,413 0 6,833,008 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_		1
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90. 00	70.02		757) 0	15, 674	<u> </u>	3, 444, 777	70.02
92. 00	90.00		3, 606	2, 502, 494	448, 830	0	3, 173, 904	90.00
OTHER REI MBURSABLE COST CENTERS 3, 547 0 106, 413 0 6, 833, 008 95. 00		i i	6, 490	3, 347, 388	1, 054, 953	0	87, 850, 570	1
95. 00	92. 00							92.00
96. 00	95. 00		3,547	0	106, 413	0	6, 833, 008	95. 00
105. 00		I I		1	· ·			1
106. 00			_					
118.00 SUBTOTALS (SUM OF LINES 1-117) 159,958 57,472,552 56,991,845 24,190,648 1,984,598,649 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 194.00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 0 194.00 194.01 07951 MARKETI NG 529 0 4,862 0 0 194.01 194.02 07952 SENI OR CI RCLE 58 0 555 0 0 194.02				1		0		
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 194.00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194.00 194.01 07951 MARKETI NG 529 0 4,862 0 0 194.01 194.02 07952 SENI OR CI RCLE 58 0 555 0 0 194.02 194.02 07952 195.02 195.02 195.02 195.02 195.03 195.02 195.02 195.02 195.02 196.04 196.02 195.02 195.02 196.05 196.05 196.05 196.06 196.05 196.05 196.07 196.07 196.08 196.08				1	Ŭ	0 24 190 648		
190. 00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 0 190. 00 192. 00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02	110.00		137, 730	31, 412, 332	30, 771, 043	24, 170, 040	1, 704, 370, 047	1110.00
194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	293	0	0	190. 00
194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02			0	이	0	0		
194. 02 07952 SENIOR CIRCLE 58 0 555 0 0 194. 02			C		0	0	l	1
				1		0	l	1
				1		-		

Health Fina	ancial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10			
COST ALLOC	ATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1		
					From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		(FTE' S)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
				SUPPLY	REQUIS.)	LI BRARY		
			(DIRECT NRSING	(COSTED		(GROSS CHAR		
			HRS)	REQUIS.)		GES)		
		11.00	13.00	14.00	15. 00	16. 00		
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 011, 080	2, 847, 413	9, 006, 30	10, 596, 025	6, 394, 487	202. 00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 510451	0. 049544	0. 15801	2 0. 438022	0. 003222	203. 00	
204.00	Cost to be allocated (per Wkst. B,	44, 313	288, 825	949, 99	580, 571	426, 831	204. 00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 275661	0. 005025	0. 01666	0. 024000	0. 000215	205. 00	
	[11]							

	Financial Systems ALLOCATION - STATISTICAL BASIS	LUTHERAN HOSPITA		CCN: 150017 Pe	In Lie	u of Form CMS-: Worksheet B-1	
C031 F	ALLOCATION - STATISTICAL BASIS		i i ovi dei		om 07/01/2013	Date/Time Pre	pared:
			INTERNS &	RESI DENTS		12/1/2014 9:5	5 am
	Cost Center Description	SOCI AL SERVI CE (GROSS CHAR GES)			PARAMED ED PRGM (ASSI GNED TI ME)	PHARMACY RESI DENCY PROGRAM (ASSI GNED TI ME) 23. 01	
	GENERAL SERVICE COST CENTERS	17.00	21100	221 00	20.00	20.0.	
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMITTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00
9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 984, 598, 649					9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
21. 00 22. 00 23. 00 23. 01	02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY) 02301 PHARMACY RESI DENCY PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0	10, 900	10, 900	66, 466 O	10, 000	21. 00 22. 00 23. 00 23. 01
30.00	03000 ADULTS & PEDIATRICS	97, 806, 578	1, 250	1, 250	48, 341	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	
31. 01 31. 02	02080 PEDIATRIC INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	2, 394, 923 14, 166, 369	50 950	50 950	250 1, 125	0	
31. 03	03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705	0	0	4, 725	0	1
32. 00	03200 CORONARY CARE UNIT	24, 974, 258	0	0	2, 375	0	
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	0 1, 685, 765	0	0	0	0	
43.00	ANCI LLARY SERVI CE COST CENTERS	1,065,765	O	U _I	<u> </u>		43.00
50.00	05000 OPERATING ROOM	361, 071, 239	2, 950	2, 950	1, 775	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	6, 994, 934 42, 141, 130	0	0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	90, 599, 823	0	0	0	0	1
54. 01	05401 PET SCAN	5, 735, 464	0	0	0	0	1
56.00	05600 RADI OI SOTOPE	28, 920, 949	0	0	0	0	
57.00	05700 CT SCAN 05800 MRI	73, 756, 438	0	0	0	0	57. 00 58. 00
	06000 LABORATORY	163, 810, 992	0	0	ol Ol	0	
	06500 RESPI RATORY THERAPY	53, 068, 637	100	100	Ö	0	1
66.00	06600 PHYSI CAL THERAPY	17, 728, 066	0	0	0	0	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	O O	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	60, 964, 769	o	0	Ö	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	8, 657, 668	o	0	0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	98, 043, 620 202, 783, 096	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	323, 765, 854	0	0	o	10, 000	1
74. 00	07400 RENAL DIALYSIS	9, 098, 177	0	0	0	0	
76.00	03140 CARDI O CATH LAB	77, 062, 563	400	400	500	0	
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	49, 012, 568 3, 444, 797	0	0	0	0	
70.02	OUTPATIENT SERVICE COST CENTERS	0, 111, 777	<u> </u>	o _l	91		70.02
90.00	09000 CLI NI C	3, 173, 904	4, 700	4, 700	3, 250	0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	87, 850, 570	0	0	2, 925	0	91. 00 92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	6, 833, 008	0	0	0	0	95. 00
96. 00		0	0	0	0	0	
	10500 KIDNEY ACQUISITION	1, 500, 085	0	0	0		105. 00
	10600 HEART ACQUISITION	3, 110, 700	0	0	1, 200		106.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1, 984, 598, 649	10, 400	10, 400	66, 466	10, 000	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	O	0	O	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	500	500	0		192.00
	007950 CLOSED PSYCH UNIT 107951 MARKETING	0	0	0	0		194. 00 194. 01
- 74.0	1/07 YO I INPURIENT THO	<u> </u>	ΟĮ		υ _l	0	11/4.01

Health Finar	ncial Systems	LUTHERAN HOSPIT	AL OF INDIANA	In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS	Provi der CCN: 150017			Peri od:	Worksheet B-1	
					From 07/01/2013 To 06/30/2014		
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE PRGM COSTS	R PARAMED ED PRGM	PHARMACY RESI DENCY	
		(GROSS CHAR	APPRV	APPRV	(ASSI GNED	PROGRAM	
		GES)	(ASSI GNED	(ASSI GNED	TIME)	(ASSI GNED	
			TIME)	TIME)		TIME)	
		17. 00	21. 00	22. 00	23. 00	23. 01	
194. 02 07952	SENIOR CIRCLE	0	0		0	0	194. 02
194. 03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	3, 310, 569	0	3, 314, 51	1 598, 262	248, 770	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 001668	0. 000000	304. 08357	9. 001023	24. 877000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	237, 424	0	61, 48	3 105, 944	5, 338	204. 00
	1	1	1				1

0. 000000

5. 640642

1. 593958

0. 533800 205. 00

Unit cost multiplier (Wkst. B, Part

				To 06/30		7/2013 Tall 1 1 1 1 1 1 1 1 1 1	
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	43, 880, 713		43, 880, 713	0	43, 880, 713	30.00
31.00	03100 INTENSIVE CARE UNIT	0		(o	0	31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249		1, 710, 249	ol	1, 710, 249	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	5, 225, 994		5, 225, 994		5, 225, 994	1
31. 03	03101 CARDIO INTENSIVE CARE UNIT	22, 599, 399		22, 599, 399	ol	22, 599, 399	
32. 00	03200 CORONARY CARE UNIT	8, 155, 565		8, 155, 565	ol ol	8, 155, 565	32.00
40.00	04000 SUBPROVI DER - I PF	0			ol	0	40.00
43.00	04300 NURSERY	643, 138		643, 138	0	643, 138	43.00
	ANCILLARY SERVICE COST CENTERS				-1		
50.00		40, 090, 848		40, 090, 848	3 0	40, 090, 848	50.00
51. 00		0		(0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 998, 973		1, 998, 973		1, 998, 973	1
53.00	05300 ANESTHESI OLOGY	604, 621		604, 62		604, 621	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	11, 826, 071		11, 826, 07		11, 826, 071	
54. 01	05401 PET SCAN	1, 089, 879		1, 089, 879		1, 089, 879	
56. 00	05600 RADI OI SOTOPE	2, 546, 579		2, 546, 579		2, 546, 579	1
57. 00	05700 CT SCAN	2, 126, 328		2, 126, 328		2, 126, 328	1
58. 00	05800 MRI	2, 120, 020		2, 120, 020		2, 120, 020	58.00
60. 00	06000 LABORATORY	22, 245, 742		22, 245, 742	o o	22, 245, 742	
65. 00	06500 RESPI RATORY THERAPY	7, 313, 522		7, 313, 522		7, 313, 522	1
66. 00	06600 PHYSI CAL THERAPY	5, 898, 319		5, 898, 319		5, 898, 319	
67. 00	06700 OCCUPATI ONAL THERAPY	3, 070, 317	0	3, 070, 31		0, 070, 317	67. 00
68. 00	06800 SPEECH PATHOLOGY		0			0	68. 00
69. 00		3, 495, 048	0	3, 495, 048		3, 495, 048	1
70. 00	07000 ELECTROCARDI OLOGI	2, 708, 768		2, 708, 768		2, 708, 768	1
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 503, 049		24, 503, 049		24, 503, 049	
71.00		27, 296, 369		27, 296, 369		27, 296, 369	
73. 00	07300 DRUGS CHARGED TO PATIENTS	42, 782, 921		42, 782, 92		42, 782, 921	
74.00		3, 044, 186		3, 044, 186		3, 044, 186	1
76. 00	03140 CARDI O CATH LAB	5, 921, 720		5, 921, 720		5, 921, 720	1
	03050 ENDOSCOPY				1		1
76. 01		7, 927, 673		7, 927, 673		7, 927, 673	1
76. 02	03051 CARDI AC REHAB	721, 954		721, 954	l 0	721, 954	76. 02
00.00	OUTPATIENT SERVICE COST CENTERS	/ 2/1 700	I	/ 2/1 70/		/ 2/1 700	00.00
	09000 CLINIC	6, 361, 780		6, 361, 780		6, 361, 780	1
91.00		10, 055, 002		10, 055, 002		10, 055, 002	1
92. 00		628, 657		628, 657		628, 657	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	4 747 074		4 747 04	ار	4 747 0/4	05.00
	09500 AMBULANCE SERVI CES	4, 747, 964		4, 747, 964		4, 747, 964	1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		() 0	0	96. 00
405.0	SPECIAL PURPOSE COST CENTERS	0.447.400		0.447.40	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0.447.400	105.00
	10500 KIDNEY ACQUISITION	2, 147, 182		2, 147, 182		2, 147, 182	
106. 0	10600 HEART ACQUISITION	964, 332		964, 332		964, 332	
	I SUDINTAL (SEE INSTRUCTIONS)	1 3/1 /6/ 5/5	1 ()	1 471 767 549	\i ()	3/1 /6/ 5/5	12111 (11)

321, 262, 545

320, 633, 888

628, 657

628, 657

0

321, 262, 545 200. 00 628, 657 201. 00 320, 633, 888 202. 00

321, 262, 545

320, 633, 888

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Provider CCN: 150017

					12/1/2014 9:5	5 am	
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	84, 850, 577		84, 850, 57	'7		30. 00
31.00	03100 INTENSIVE CARE UNIT	0			0		31.00
	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 394, 923		2, 394, 92	23		31. 01
	02060 NEONATAL INTENSIVE CARE UNIT	14, 166, 369		14, 166, 36			31. 02
	03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705		64, 441, 70			31. 03
	03200 CORONARY CARE UNIT	24, 974, 258		24, 974, 25			32. 00
	04000 SUBPROVI DER - I PF	0		2.,,,,,,	0		40. 00
	04300 NURSERY	1, 685, 765		1, 685, 76	-		43. 00
	NCILLARY SERVICE COST CENTERS	1,000,700		1,000,70	,0		10.00
	05000 OPERATING ROOM	202, 290, 538	158, 780, 701	361, 071, 23	0. 111033	0. 000000	50.00
	05100 RECOVERY ROOM	202, 270, 330	130, 700, 701		0. 000000	0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	6, 939, 038	55, 896			0. 000000	
	05300 ANESTHESI OLOGY	25, 229, 613	16, 911, 517			0. 000000	
	05300 RADI OLOGY-DI AGNOSTI C	35, 671, 817	54, 928, 006			0. 000000	
	D5401 PET SCAN	182, 489	5, 552, 975			0.000000	
	D5600 RADI OI SOTOPE	5, 306, 125	23, 614, 824			0.000000	
	D5700 CT SCAN	30, 286, 909	43, 469, 529			0.000000	
	05800 MRI	0			0.000000	0. 000000	
	06000 LABORATORY	96, 118, 328	67, 692, 664			0. 000000	
	06500 RESPI RATORY THERAPY	50, 488, 396	2, 580, 241			0. 000000	
	06600 PHYSI CAL THERAPY	10, 912, 535	6, 815, 531	17, 728, 06		0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0. 000000	
	06800 SPEECH PATHOLOGY	0	0		0. 000000	0. 000000	
	06900 ELECTROCARDI OLOGY	26, 017, 305	34, 947, 464			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 109, 368	7, 548, 300	8, 657, 66	0. 312875	0. 000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	65, 412, 497	32, 631, 123	98, 043, 62	0. 249920	0.000000	71. 00
72. 00 C	07200 IMPL. DEV. CHARGED TO PATIENTS	130, 175, 126	72, 607, 970	202, 783, 09	0. 134609	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	225, 667, 210	98, 098, 644	323, 765, 85	0. 132142	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	8, 913, 747	184, 430	9, 098, 17	7 0. 334593	0.000000	74.00
76. 00 C	03140 CARDIO CATH LAB	38, 408, 622	38, 653, 941	77, 062, 56	0. 076843	0.000000	76. 00
	03050 ENDOSCOPY	8, 353, 798	40, 658, 770	49, 012, 56	0. 161748	0.000000	76. 01
	03051 CARDI AC REHAB	2, 709, 062	735, 735			0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	343, 767	2, 830, 137	3, 173, 90	2. 004402	0. 000000	90.00
	09100 EMERGENCY	27, 583, 754	60, 266, 816			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 421, 100	10, 534, 901			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	27 12 17 100	10,001,701	12/ /00/ 00	0.0.0022	0.00000	72.00
	09500 AMBULANCE SERVICES	5, 444	6, 827, 564	6, 833, 00	0. 694857	0. 000000	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0, 444	0, 027, 304	1	0.000000	0. 000000	
	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	I	0.00000	0.00000	1 70.00
	10500 KIDNEY ACQUISITION	1, 500, 085	0	1, 500, 08) E		105. 00
	10600 HEART ACQUISITION	3, 110, 700	0				106. 00
200. 00	Subtotal (see instructions)	1, 197, 670, 970	O				200. 00
		1, 197, 670, 970	100, 921, 019	1, 984, 598, 64	7		
201.00	Less Observation Beds	1 107 470 070	704 007 470	1 004 500 /	10		201. 00
202. 00	Total (see instructions)	1, 197, 670, 970	100, 921, 619	1, 984, 598, 64	7		202. 00

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA		In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Pı	Provider CCN:	150017	From 07/01/2013	Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am
		Title XVI	H	Hosni tal	PPS

					12/1/2014 9:5	5 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
<u>[</u>	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT					31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT					31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT					31. 03
32.00	03200 CORONARY CARE UNIT					32. 00
	04000 SUBPROVIDER - IPF					40.00
	04300 NURSERY					43. 00
	ANCI LLARY SERVI CE COST CENTERS					10.00
-	05000 OPERATING ROOM	0. 111033				50. 00
1	05100 RECOVERY ROOM	0. 000000				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 285774				52.00
	05300 ANESTHESI OLOGY	0. 283774				53. 00
		1				
1	05400 RADI OLOGY-DI AGNOSTI C	0. 130531				54.00
1	05401 PET SCAN	0. 190025				54. 01
	05600 RADI OI SOTOPE	0. 088053				56. 00
	05700 CT SCAN	0. 028829				57. 00
1	05800 MRI	0. 000000				58. 00
1	06000 LABORATORY	0. 135801				60. 00
1	06500 RESPI RATORY THERAPY	0. 137813				65. 00
1	06600 PHYSI CAL THERAPY	0. 332711				66. 00
1	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
1	06800 SPEECH PATHOLOGY	0. 000000				68. 00
	06900 ELECTROCARDI OLOGY	0. 057329				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 312875				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 249920				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 134609				72. 00
73.00	07300 DRUGS CHARGED TO PATLENTS	0. 132142				73. 00
74.00	07400 RENAL DIALYSIS	0. 334593				74.00
76. 00	03140 CARDIO CATH LAB	0. 076843				76. 00
76. 01	03050 ENDOSCOPY	0. 161748				76. 01
76. 02	03051 CARDI AC REHAB	0. 209578				76. 02
	OUTPATIENT SERVICE COST CENTERS	<u> </u>				
	09000 CLI NI C	2. 004402				90. 00
91. 00	09100 EMERGENCY	0. 114456				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 048522				92. 00
	OTHER REIMBURSABLE COST CENTERS	,,				
	09500 AMBULANCE SERVICES	0. 694857				95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
	SPECIAL PURPOSE COST CENTERS	0.000000				70.00
	10500 KIDNEY ACQUISITION					105. 00
	10600 HEART ACQUISITION					106. 00
200.00	Subtotal (see instructions)					200. 00
1	1					200.00
201.00	Less Observation Beds					201.00
202. 00	Total (see instructions)					ZUZ. UU

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	1	Period: From 07/01/2013 Fo 06/30/2014		
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	43, 880, 713		43, 880, 713	3 0	43, 880, 713	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0	0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249		1, 710, 249	9 0	1, 710, 249	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	5, 225, 994		5, 225, 994	4 O	5, 225, 994	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	22, 599, 399		22, 599, 399	9 0	22, 599, 399	31. 03
32. 00 03200 CORONARY CARE UNIT	8, 155, 565		8, 155, 56!	5 0	8, 155, 565	32.00
40. 00 04000 SUBPROVI DER - I PF	0			0	0	40.00
43. 00 04300 NURSERY	643, 138		643, 138	3 0	643, 138	43.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am Provider CCN: 150017 Peri od: From 07/01/2013 To 06/30/2014 014 .. Cost Title XIX Hospi tal Charges

		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		•	+ col. 7)	Ratio	Inpati ent	
			_		Rati o	
	6.00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	84, 850, 577		84, 850, 577			30. 00
31. 00 03100 INTENSIVE CARE UNIT	0		0			31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	2, 394, 923		2, 394, 923			31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	14, 166, 369		14, 166, 369			31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705		64, 441, 705			31. 02
	1					
32. 00 03200 CORONARY CARE UNIT	24, 974, 258		24, 974, 258			32.00
40. 00 04000 SUBPROVI DER - PF	0		0			40.00
43. 00 04300 NURSERY	1, 685, 765		1, 685, 765			43. 00
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	202, 290, 538	158, 780, 701	361, 071, 239		0. 000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0. 000000	0. 000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 939, 038	55, 896			0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	25, 229, 613	16, 911, 517	42, 141, 130	0. 014348	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	35, 671, 817	54, 928, 006	90, 599, 823	0. 130531	0.000000	54.00
54. 01 05401 PET SCAN	182, 489	5, 552, 975	5, 735, 464	0. 190025	0.000000	54. 01
56. 00 05600 RADI 0I SOTOPE	5, 306, 125	23, 614, 824	28, 920, 949	0. 088053	0.000000	56.00
57. 00 05700 CT SCAN	30, 286, 909	43, 469, 529	73, 756, 438	0. 028829	0.000000	57.00
58. 00 05800 MRI	O	0	C	0.000000	0.000000	58. 00
60. 00 06000 LABORATORY	96, 118, 328	67, 692, 664	163, 810, 992	0. 135801	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	50, 488, 396	2, 580, 241			0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	10, 912, 535	6, 815, 531			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	1		0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	26, 017, 305	34, 947, 464	1		0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 109, 368	7, 548, 300			0. 000000	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	65, 412, 497	32, 631, 123			0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	130, 175, 126	72, 607, 970			0. 000000	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS					0. 000000	73. 00
	225, 667, 210	98, 098, 644				
74. 00 07400 RENAL DI ALYSI S	8, 913, 747	184, 430			0.000000	74.00
76. 00 03140 CARDI 0 CATH LAB	38, 408, 622	38, 653, 941			0.000000	76. 00
76. 01 03050 ENDOSCOPY	8, 353, 798	40, 658, 770			0.000000	76. 01
76. 02 03051 CARDI AC REHAB	2, 709, 062	735, 735	3, 444, 797	0. 209578	0. 000000	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	343, 767	2, 830, 137			0. 000000	90. 00
91. 00 09100 EMERGENCY	27, 583, 754	60, 266, 816		I	0. 000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 421, 100	10, 534, 901	12, 956, 001	0. 048522	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS			,			
95. 00 09500 AMBULANCE SERVICES	5, 444	6, 827, 564	6, 833, 008		0.000000	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0.000000	0.000000	96. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	1, 500, 085	0	1, 500, 085			105.00
106.00 10600 HEART ACQUISITION	3, 110, 700	0	3, 110, 700			106. 00
200.00 Subtotal (see instructions)	1, 197, 670, 970	786, 927, 679	1, 984, 598, 649			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	1, 197, 670, 970	786, 927, 679	1, 984, 598, 649			202. 00
	•		•	•		

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15001	From 07/01/2013	Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am
			_

				12/1/2014 9:55 ar	am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					0. 00
31.00 03100 INTENSIVE CARE UNIT					1. 00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT				31	1. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT				31	1. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT				31	1. 03
32. 00 03200 CORONARY CARE UNIT				32	2. 00
40. 00 04000 SUBPROVI DER - 1 PF				40	0. 00
43. 00 04300 NURSERY				43	3.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 000000			50	0. 00
51.00 05100 RECOVERY ROOM	0. 000000			51	1. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52	2. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53	3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	4. 00
54. 01 05401 PET SCAN	0. 000000				4. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000				6. 00
57. 00 05700 CT SCAN	0. 000000			•	7. 00
58. 00 05800 MRI	0. 000000				8. 00
60. 00 06000 LABORATORY	0. 000000				0. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			•	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			1	7. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			1	8. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				0. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				1. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				3. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000				4. 00
76. 00 03140 CARDI O CATH LAB	0. 000000				6. 00
76. 01 03050 ENDOSCOPY	0. 000000				6. 01
76. 02 03051 CARDI AC REHAB	0. 000000				6. 02
OUTPATIENT SERVICE COST CENTERS	0. 000000			/0	0. 02
90. 00 09000 CLINIC	0. 000000			90	0. 00
91. 00 09100 EMERGENCY	0. 000000				1. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				2. 00
OTHER REIMBURSABLE COST CENTERS	0. 000000			72	2.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			05	5. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			l	6. 00
SPECIAL PURPOSE COST CENTERS	0.00000			70	0. 00
105. 00 10500 KIDNEY ACQUISITION				105	5. 00
106. 00 10600 HEART ACQUISITION					6. 00
200.00 Subtotal (see instructions)					0. 00
201. 00 Less Observation Beds				•	1. 00
202.00 Total (see instructions)					2. 00
202.00 10101 (366 111311 0011 0113)	ı I			1202	2.00

Heelth Financial Systems	LUTUEDAN HOCDIT	TAL OF INDIANA		lm lie	of Form CMC	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	LUTHERAN HOSPIT COSTS		CCN: 150017	Period: From 07/01/2013 To 06/30/2014		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost (col. 1 - col 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	•			
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 31.01 PEDIATRIC INTENSIVE CARE UNIT 31.02 NEONATAL INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 40.00 SUBPROVIDER - IPF 43.00 NURSERY 200.00 Total (lines 30-199) Cost Center Description	7,886,138 0 214,791 663,832 2,255,162 823,282 0 54,802 11,898,007 Inpatient Program days	Inpatient Program Capital Cost	214, 79 663, 83 2, 255, 16 823, 28	0 0 0 01 906 12 4, 545 12 28, 006 12 7, 206 0 0	0. 00 237. 08 146. 06 80. 52 114. 25 0. 00 27. 83	31. 00 31. 01 31. 02 31. 03 32. 00 40. 00
		(col. 5 x col. 6)				
	6.00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 31. 01 PEDIATRIC INTENSIVE CARE UNIT 31. 02 NEONATAL INTENSIVE CARE UNIT 31. 03 CARDIO INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 40. 00 SUBPROVIDER - IPF 43. 00 NURSERY	20, 460 0 0 7, 379 2, 442 0	0 0 0 594, 157 278, 999 0 0				30. 00 31. 00 31. 01 31. 02 31. 03 32. 00 40. 00 43. 00
200.00 Total (lines 30-199)	30, 281	3, 947, 066	1			200. 00

		LUTHERAN HOSPIT				u of Form CMS-2	2552-10
APPOR1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Pre 12/1/2014 9:5	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges		I npati ent	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOLILARY OF BUILDE COOT OF STATE DO	1.00	2.00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.000.100	2/1 071 220	0.00470	7 (4 520 2/2	1 505 040	F0 00
		8, 928, 133					50. 00 51. 00
		0	ļ			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	49, 926				213	52.00
53.00	05300 ANESTHESI OLOGY	33, 459					53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 368, 653		•			
54. 01	05401 PET SCAN	636, 468				•	
56. 00	05600 RADI OI SOTOPE	204, 038				•	
57. 00	05700 CT SCAN	193, 498	73, 756, 438				57. 00
58. 00	05800 MRI	0	0	0.00000		0	58. 00
	06000 LABORATORY	1, 842, 748					60.00
65. 00	06500 RESPI RATORY THERAPY	605, 133					
	06600 PHYSI CAL THERAPY	746, 450	17, 728, 066				
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0.00000		0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0.00000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	861, 843		•			
	07000 ELECTROENCEPHALOGRAPHY	614, 115					
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	728, 206		•		•	
	07200 I MPL. DEV. CHARGED TO PATIENTS	856, 107					
	07300 DRUGS CHARGED TO PATIENTS	1, 319, 449					
74.00	07400 RENAL DIALYSIS	321, 941		•			
76. 00		1, 799, 228					76. 00
76. 01	03050 ENDOSCOPY	954, 383					
76. 02	03051 CARDI AC REHAB	49, 823	3, 444, 797	0. 01446	3 1, 008, 723	14, 589	76. 02
	OUTPATIENT SERVICE COST CENTERS						
$\Omega \Omega$	00000 CLINIC	920 660	2 172 004	0 25056	0 102 560	EU U10	

820, 669

0 25, 328, 872 1, 780, 641, 259

1, 281, 621 112, 981

3, 173, 904 87, 850, 570 12, 956, 001

0. 258568

0. 014589

0.008720

0.000000

50, 048

110, 666 12, 507

0 4, 178, 492 200. 00

193, 560

7, 585, 545 1, 434, 240

0 320, 746, 192

90.00

91.00

92. 00

95.00

96.00

90.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED 200. 00 | Total (lines 50-199)

91. 00 09100 EMERGENCY

Heal th Financial	Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2552-10

Health Financial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS		<u> </u>	Period: From 07/01/2013 Fo 06/30/2014	Worksheet D Part III Date/Time Pre 12/1/2014 9:5	pared: 5 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	435, 119	'	0	435, 119	30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	0	(0	31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	2, 250			2, 250	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	0	10, 126			10, 126	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	0	42, 530	1		42, 530	31. 03
32. 00 03200 CORONARY CARE UNIT	0	21, 377			21, 377	32. 00
40. 00 04000 SUBPROVI DER - PF	0	0	(0	0	40. 00
43. 00 04300 NURSERY	0	0	(0	43.00
200. 00 Total (lines 30-199)	0	511, 402)	511, 402	200.00
Cost Center Description		Per Diem (col.	Inpatient	I npati ent		
	Days	5 ÷ col . 6)	Program Days	Program		
				Pass-Through Cost (col. 7 x		
				cost (cor. / x		
	6, 00	7.00	8. 00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS	52, 490	8. 29	20, 460	169, 613		30.00
31. 00 03100 I NTENSI VE CARE UNI T	02, 170	l .		0 .07,0.0		31.00
31. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T	906			0		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	4, 545			0		31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	28, 006	1		11, 216		31. 03
32, 00 03200 CORONARY CARE UNIT	7, 206					32. 00
40. 00 04000 SUBPROVI DER - PF	0	l .		0		40.00
43. 00 04300 NURSERY	1, 969			ol o		43. 00
200.00 Total (lines 30-199)	95, 122		30, 28°	1 188, 082		200. 00
·						

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS P		Peri od: From 07/01/2013	Worksheet D Part IV
TINOUGH COSTS				Date/Time Prepared: 12/1/2014 9:55 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	Non Physician Nursing		h All Other	Total Cost

				1	0 06/30/2014	12/1/2014 9:5	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	9	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			45.033		45.033	
	O5000 OPERATING ROOM	0	0	15, 977	0	15, 977	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	05401 PET SCAN	0	0	0	0	0	54. 01
	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
	05700 CT SCAN	0	0	0	0	0	57. 00
	D5800 MRI D6000 LABORATORY	0	0	0	0	0	58. 00
	D6500 RESPI RATORY THERAPY	0	0	0	0	0	60. 00 65. 00
	06600 PHYSI CAL THERAPY	0	0	0	0	0	
1	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	66. 00 67. 00
	06800 SPEECH PATHOLOGY		0	0	0	0	68. 00
	06900 SPEECH PATHOLOGY	0	0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS		0	248, 770	0	248, 770	1
	07400 RENAL DIALYSIS		0	240,770	0	240,770	74.00
	03140 CARDIO CATH LAB		0	4, 501	0	4, 501	76.00
	03050 ENDOSCOPY		0	1, 551	0	0	76. 01
	03051 CARDI AC REHAB	o	0	0	0	0	76. 02
H-	DUTPATIENT SERVICE COST CENTERS	-1	-	-			
	09000 CLI NI C	0	0	29, 253	0	29, 253	90.00
91.00	09100 EMERGENCY	o	0	1		26, 328	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	6, 234	0	6, 234	92.00
(OTHER REIMBURSABLE COST CENTERS			<u> </u>			
	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
200.00	Total (lines 50-199)	0	0	331, 063	0	331, 063	200. 00

		LUTHERAN HOSPIT					u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THE COSTS	VICE OTHER PASS	S	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Pre 12/1/2014 9:5	
				Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and	(from	Wkst. C,	Ratio of Cost to Charges (col. 5 ÷ col 7)	Ratio of Cost	Inpatient Program Charges	
		4)		6)	')	7)		
		6.00		7. 00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00			0.00	7. 55	.0.00	
50.00	05000 OPERATI NG ROOM	15, 977	36	1, 071, 239	0.00004	4 0.000044	64, 538, 362	50.00
51.00	05100 RECOVERY ROOM	0		0	0.00000	0. 000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	ĺ	6, 994, 934	0.00000	0. 000000	29, 897	52. 00
53.00	05300 ANESTHESI OLOGY	0	4	2, 141, 130	0.00000	0. 000000	7, 717, 208	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9	0, 599, 823	0.00000	0. 000000	12, 580, 666	54.00
54.01	05401 PET SCAN	0		5, 735, 464	0.00000	0. 000000	41, 709	54. 01
56.00	05600 RADI OI SOTOPE	0	2	8, 920, 949	0.00000	0. 000000	1, 962, 080	56. 00
57.00	05700 CT SCAN	0	7	3, 756, 438	0.00000	0. 000000	10, 048, 452	57. 00
58.00	05800 MRI	0		0	0.00000	0. 000000	0	58. 00
60.00	06000 LABORATORY	0	16	3, 810, 992	0.00000	0. 000000	33, 256, 676	60.00
65.00	06500 RESPI RATORY THERAPY	0	5	3, 068, 637			16, 534, 340	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1	7, 728, 066	0.00000	0. 000000	4, 342, 602	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		0	0.00000		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		O	0.00000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	6	0, 964, 769	0.00000			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		8, 657, 668			326, 151	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9	8, 043, 620			20, 560, 285	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	20	2, 783, 096	0.00000	0. 000000	39, 776, 376	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	248, 770	32	3, 765, 854			69, 454, 688	
74.00	07400 RENAL DI ALYSI S	0		9, 098, 177			4, 996, 200	
76. 00	03140 CARDI O CATH LAB	4, 501	7	7, 062, 563			11, 363, 079	76. 00
76. 01	03050 ENDOSCOPY	0		9, 012, 568			3, 122, 716	
76. 02	03051 CARDI AC REHAB	0		3, 444, 797	0.00000	0. 000000	1, 008, 723	76. 02
	OUTPATIENT SERVICE COST CENTERS							
	100000 CLINIC	20 252		2 172 004	0 00021	7 0 000217		

29, 253

26, 328 6, 234 3, 173, 904

87, 850, 570 12, 956, 001

0 0 331, 063 1, 780, 641, 259 0.009217

0.000300

0. 000481

0.000000

0.009217

0.000300

0. 000481

0.000000

193, 560

7, 585, 545 1, 434, 240 90.00

91.00

92. 00

95.00

0 96.00 320, 746, 192 200.00

90.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED 200. 00 | Total (lines 50-199)

91. 00 09100 EMERGENCY

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150017	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared:

					12/1/2014 9:	55 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 840	36, 725, 838	1, 616			50. 00
51.00 05100 RECOVERY ROOM	0	0	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	3, 257, 491	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	13, 160, 609	0			54.00
54. 01 05401 PET SCAN	0	1, 210, 328	0			54. 01
56. 00 05600 RADI 0I SOTOPE	0	6, 432, 293	0			56. 00
57. 00 05700 CT SCAN	0	9, 882, 044	0			57. 00
58. 00 05800 MRI	0	0	0			58. 00
60. 00 06000 LABORATORY	0	5, 712, 533	0			60. 00
65. 00 06500 RESPIRATORY THERAPY	0	520, 592	2 0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	122, 264	. 0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	O	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	9, 232, 650	0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	O	1, 369, 025	0			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	7, 328, 947	· 0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	21, 780, 123	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	53, 341	21, 858, 100	16, 787			73. 00
74.00 07400 RENAL DIALYSIS	o	167, 526	0			74. 00
76.00 03140 CARDIO CATH LAB	659	11, 570, 738	671			76. 00
76. 01 03050 ENDOSCOPY	O	9, 570, 731	0			76. 01
76. 02 03051 CARDI AC REHAB	O	197, 851	0			76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 784	434, 544	4, 005			90.00
91. 00 09100 EMERGENCY	2, 276	10, 982, 563				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	690	1, 997, 510	961			92.00
OTHER REIMBURSABLE COST CENTERS			•	ı.		
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	0	0			96. 00
200.00 Total (lines 50-199)	61, 590	173, 514, 300	27, 335			200. 00

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150017	Peri od: From 07/01/2013	Worksheet D

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111033 36, 725, 838 4, 077, 780 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 285774 0 52 00 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.014348 3, 257, 491 46, 738 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 130531 13, 160, 609 0 1, 717, 867 54.00 1, 210, 328 54.01 05401 PET SCAN 0.190025 0 0 229, 993 54.01 05600 RADI OI SOTOPE 0.088053 0 56.00 6, 432, 293 566, 383 56.00 57.00 05700 CT SCAN 0.028829 9, 882, 044 0 284, 889 57.00 05800 MRI 58.00 0.000000 0 0 58.00 0 06000 LABORATORY 5, 712, 533 775, 768 0 135801 12, 746 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 0.137813 520, 592 0 71, 744 65.00 06600 PHYSI CAL THERAPY 0. 332711 122, 264 0 40, 679 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.057329 9, 232, 650 0 0 529, 299 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 312875 1, 369, 025 0 428, 334 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 249920 7, 328, 947 0 0 1, 831, 650 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72 00 0.134609 21, 780, 123 2, 931, 801 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 132142 21, 858, 100 137, 299 2, 888, 373 73.00 07400 RENAL DIALYSIS 0 74.00 0.334593 167, 526 0 56,053 74.00 03140 CARDIO CATH LAB 0 76.00 0.076843 11, 570, 738 889, 130 76.00 0 0 03050 ENDOSCOPY 76.01 0. 161748 9, 570, 731 0 1, 548, 047 76.01 03051 CARDI AC REHAB 0. 209578 197, 851 0 41, 465 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2.004402 434, 544 871,001 90.00 0 0 91.00 09100 EMERGENCY 0. 114456 10, 982, 563 0 1, 257, 020 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.048522 1, 997, 510 96, 923 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 694857 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 200.00 Subtotal (see instructions) 173, 514, 300 12, 746 137, 299 21, 180, 937 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 173, 514, 300 12, 746 137, 299 21, 180, 937 202. 00

Health Financial Systems	LUTHERAN HOSPI TAL	OF INDIANA	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150017	Peri od: From 07/01/2013	Worksheet D Part V

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54. 01 05401 PET SCAN 54.01 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 0 0 58.00 58.00 06000 LABORATORY 60 00 60 00 1.731 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 0 0 0 0 0 0 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 143 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 03140 CARDIO CATH LAB 76.00 0 76.00 03050 ENDOSCOPY 76.01 76.01 0 76.02 03051 CARDI AC REHAB 0 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 09100 EMERGENCY 0 91.00 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 200.00 200. 00 Subtotal (see instructions) 1,731 18, 143 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 202.00 1,731 18, 143 202.00

Health Financial Systems	OF INDIANA In Lieu of Form CMS-2			
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150017	Peri od:	Worksheet D

From 07/01/2013 Part V To 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111033 5, 366, 800 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 285774 52 00 0 3, 387 52 00 0 05300 ANESTHESI OLOGY 53.00 0.014348 0 599, 778 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 130531 2, 111, 953 0 54.00 54.01 05401 PET SCAN 0.190025 0 472, 869 54.01 0 05600 RADI OI SOTOPE 0.088053 56.00 473, 199 0 56.00 57.00 05700 CT SCAN 0.028829 1, 793, 997 0 57.00 05800 MRI 58.00 0.000000 0 58.00 06000 LABORATORY 0 135801 3, 021, 471 60 00 60 00 0 65.00 06500 RESPIRATORY THERAPY 0.137813 158, 505 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 332711 637, 962 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.057329 808, 863 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 312875 306, 531 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 249920 1, 108, 562 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 829, 860 72.00 72 00 0.134609 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 132142 7, 191, 255 0 73.00 07400 RENAL DIALYSIS 9, 386 74.00 74.00 0.334593 0 03140 CARDIO CATH LAB 0 76.00 0.076843 924, 252 0 76.00 03050 ENDOSCOPY Ω 76.01 0. 161748 1, 003, 789 Ω 76.01 03051 CARDI AC REHAB 0. 209578 17, 566 0 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 2.004402 90.00 09000 CLINIC 148, 203 0 0 0 91.00 09100 EMERGENCY 0. 114456 0 3, 452, 946 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.048522 531, 816 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0. 694857 95.00 09500 AMBULANCE SERVICES 95.00 0 514, 952 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 C 0 0 96.00 0 0 200.00 200.00 Subtotal (see instructions) 0 33, 487, 902 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201)

0

33, 487, 902

0 202. 00

0

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150017	Peri od: From 07/01/2013	Worksheet D Part V

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 595, 892 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 968 0 52.00 05300 ANESTHESI OLOGY 0 53.00 8,606 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 275, 675 54.00 0 54. 01 05401 PET SCAN 89.857 54.01 05600 RADI OI SOTOPE 0 56.00 41, 667 56.00 57.00 05700 CT SCAN 51, 719 0 57.00 05800 MRI 0 58.00 58.00 0 06000 LABORATORY 410. 319 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 21,844 65.00 66.00 06600 PHYSI CAL THERAPY 212, 257 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 Ol 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 46, 371 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 95, 906 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 277, 052 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 380, 925 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 950, 267 0 73.00 74.00 07400 RENAL DIALYSIS 3, 140 0 74.00 03140 CARDIO CATH LAB 0 76.00 71.022 76.00 03050 ENDOSCOPY 0 76.01 162, 361 76.01 76.02 03051 CARDI AC REHAB 3,681 0 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 297, 058 90.00 0 09100 EMERGENCY 91.00 395, 210 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 25, 805 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 357, 818 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 200.00 0 200. 00 Subtotal (see instructions) 4, 775, 420 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 202.00 4, 775, 420 0 202.00

Health Financial Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150017	Peri od: From 07/01/2013	Worksheet D-1		
			To 06/30/2014	Date/Time Prep 12/1/2014 9:5	pared: 5 am	
		Title XVIII	Hospi tal	PPS		
Cost Center Description						
				1. 00		
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private room days	Inpatient days (including private room days and swing-bed days, excluding newborn) 52,490 1.					
2.00 Inpatient days (including private room days	, excluding swing-bed	and newborn days)		52, 490	2. 00	

	Cost Center Description	113	
	cost center bescription	1. 00	
	PART I - ALL PROVIDER COMPONENTS	11.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	52, 490	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	52, 490	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		l
4.00	Semi-private room days (excluding swing-bed and observation bed days)	51, 738	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7 00
7. 00	reporting period	۷	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	20, 460	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		l
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	υĮ	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)		13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	ő	
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		l
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	1
21. 00	Total general inpatient routine service cost (see instructions)	43, 880, 713	21. 00
22. 00	Swing-Ded cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
04.00	x line 18)		04.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	٠Į	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	In line 20)	ĭ	25.00
26. 00	Total swing-bed cost (see instructions)	o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	43, 880, 713	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		l
	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28. 00
	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	43, 880, 713	
200	27 minus line 36)	, 500, , 10	1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		I
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		I
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	835. 98	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	17, 104, 151	•
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	17, 104, 151	41.00

33.00	Average per dreii private room cost dirrerential (irrie 54 x irrie 51)	0.00	33.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	43, 880, 713	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	835. 98	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	17, 104, 151	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	17, 104, 151	41.00

IVII U I	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150017	Peri od:	Worksheet D-1	2552
					From 07/01/2013 To 06/30/2014	Date/Time Pre	
			Ti tl	e XVIII	Hospi tal	12/1/2014 9: 5 PPS	5 an
	Cost Center Description	Total Inpatient Cost	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42
. 00	Intensive Care Type Inpatient Hospital Units			0.0	,0 0		72
. 00	INTENSIVE CARE UNIT	0	0	0.0	00 0	0	43
. 01	PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249				0	
. 02	NEONATAL INTENSIVE CARE UNIT	5, 225, 994				0	43
. 03	4	22, 599, 399					
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	8, 155, 565	7, 206	1, 131. 7	2, 442	2, 763, 782	44
. 00	SURGICAL INTENSIVE CARE UNIT						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00	10					1. 00	10
00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			ine)		42, 563, 212 68, 385, 629	
00	PASS THROUGH COST ADJUSTMENTS	+1 till ough +0) (See mistractive	113)		00, 303, 027	7/
00	Pass through costs applicable to Program in	patient routine	services (from	Wkst. D, sum	of Parts I and	4, 135, 148	50
. 00	Pass through costs applicable to Program in and IV)	patient ancillar	ry services (fr	om Wkst. D, s	sum of Parts II	4, 240, 082	51
. 00	Total Program excludable cost (sum of lines	50 and 51)				8, 375, 230	52
. 00	Total Program inpatient operating cost excl		lated, non-phy	sician anesth	etist, and	60, 010, 399	
	medical education costs (line 49 minus line	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION						١.,
. 00	Program discharges Target amount per discharge					0 0. 00	
. 00	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient opera	ting cost and ta	rget amount (I	ine 56 minus	line 53)	ő	1
00	Bonus payment (see instructions)	3	,		,	0	58
. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, ι	pdated and co	empounded by the	0.00	59
00	market basket	anat manamt um	datad by the m	المعاممة المعامم		0.00	1,0
. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. 00 0	
. 00	which operating costs (line 53) are less that						"
	amount (line 56), otherwise enter zero (see		•	,	3		
. 00	Relief payment (see instructions)						62
. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ictions)			0	63
. 00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	cost reporti	ng period (See	0	64
	instructions)(title XVIII only)				5 (
. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65
00	instructions)(title XVIII only)			E) (11 11 10 11 1			١,,
. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line	64 plus line 6	5)(title XVII	I only). For	0	66
. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 c	f the cost re	portina period	0	67
	(line 12 x line 19)				5 1		
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repo	rting period	0	68
00	(line 13 x line 20)	routing costs (lino 47 : lino	40)		_	40
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER I					0	69
. 00	Skilled nursing facility/other nursing faci		·				70
. 00	Adjusted general inpatient routine service						71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost applicated program general impatient routing company						73
. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient		,		Part II column		74
. 00	26, line 45)	TOURTHE SELVICE	, costs (110III W	or Koricet D, P	art ii, corumii		'
. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76
. 00	Program capital -related costs (line 9 x line						77
00	, ,		unavil dare ::	5)			78
00	Aggregate charges to beneficiaries for excellator and program routine service costs for com			*	us line 70)		80
00	Inpatient routine service costs for com		Timi tati Ui	(1110 /0 11111	11110 77)		81
	Inpatient routine service cost limitation ()				82
. 00	Reasonable inpatient routine service costs	•	ıs)				83
. 00	Program inpatient ancillary services (see i						84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		ıı ougrı 85)				86
00	Total observation bed days (see instructions					752	87
. 00							
	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			835. 98	88

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2013 To 06/30/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	7, 886, 138	43, 880, 713	0. 17971	8 628, 657	112, 981	90.00
91.00 Nursing School cost	0	43, 880, 713	0. 00000	0 628, 657	0	91.00
92.00 Allied health cost	435, 119	43, 880, 713	0. 00991	628, 657	6, 234	92.00
93.00 All other Medical Education	0	43, 880, 713	0. 00000	0 628, 657	0	93. 00

Health Financial Systems LUTHERAN HOSPITAL C	F INDIANA		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Pre	pared:
	Ti +1	e XVIII	Hospi tal	12/1/2014 9: 5 PPS	5 am
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x col.	
			onal goo	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			28, 759, 562		30. 00
31. 00 03100 NTENSIVE CARE UNIT			0		31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT			0		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT			0		31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT			23, 135, 978		31. 03
32. 00 03200 CORONARY CARE UNIT			8, 716, 117		32. 00
40. 00 04000 SUBPROVI DER - I PF			0		40. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 11103			
51.00 O5100 RECOVERY ROOM		0.00000		0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 28577		8, 544	52.00
53. 00 05300 ANESTHESI OLOGY		0. 01434			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13053			54.00
54. 01 05401 PET SCAN		0. 19002			
56. 00 05600 RADI 0I SOTOPE		0. 08805			56. 00
57. 00 05700 CT SCAN		0. 02882			57. 00
58. 00 05800 MRI		0.00000		0	58. 00
60. 00 06000 LABORATORY		0. 13580	1 ' '		60.00
65. 00 06500 RESPIRATORY THERAPY		0. 13781			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33271			
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67. 00 68. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 00000 0. 05732		0 565, 988	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 03732		102, 044	•
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0. 31287			70.00
72. 00 07100 MPL. DEV. CHARGED TO PATIENTS		0. 24992	1 ' '		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 13214			
74. 00 07400 RENAL DI ALYSI S		0. 33459			
76. 00 03140 CARDI O CATH LAB		0. 07684			
76. 01 03050 ENDOSCOPY		0. 16174			1
7. 02 03061 CARDI AC REHAR		0.1017			

1, 008, 723

7, 585, 545

1, 434, 240

320, 746, 192

320, 746, 192

193, 560

211, 406

387, 972

868, 211

69, 592

Ω

42, 563, 212 200. 00

76.02

90.00

91.00

92.00

95.00

96. 00

201. 00

202. 00

0. 209578

2. 004402

0. 114456

0.048522

0.000000

03051 CARDI AC REHAB

09000 CLI NI C

09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net Charges (line 200 minus line 201)

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

76.02

90.00

91.00

92.00

95.00

200.00

201.00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Pre	
			10 00/30/2014	12/1/2014 9:5	5 am
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	5 044 570		
30. 00 03000 ADULTS & PEDI ATRI CS			5, 214, 570		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT			285, 726		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT			2, 029, 172		31. 02
31. 03 03101 CARDLO INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT			5, 140, 621		31. 03
32. 00 03200 CORONARY CARE UNI T 40. 00 04000 SUBPROVI DER - PF			1, 522, 103		40.00
43. 00 04300 NURSERY			119, 636		43.00
ANCI LLARY SERVI CE COST CENTERS			119,030		43.00
50. 00 05000 OPERATING ROOM		0. 11103	10, 662, 009	1, 183, 835	50.00
51. 00 05100 RECOVERY ROOM		0.00000		1, 103, 033	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 28577		107, 075	
53. 00 05300 ANESTHESI OLOGY		0. 01434		19, 625	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13053		328, 676	
54. 01 05401 PET SCAN		0. 19002		1, 592	
56. 00 05600 RADI 0I SOTOPE		0. 08805		22, 034	
57.00 05700 CT SCAN		0. 02882		57, 859	57.00
58. 00 05800 MRI		0.00000	00	0	58.00
60. 00 06000 LABORATORY		0. 13580	6, 948, 981	943, 679	60.00
65. 00 06500 RESPIRATORY THERAPY		0. 13781	13 4, 432, 822	610, 900	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33271	561, 905	186, 952	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67.00
68.00 06800 SPEECH PATHOLOGY		0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 05732		82, 156	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 31287		33, 499	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 24992		967, 122	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 13460		651, 091	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 13214		2, 361, 273	
74. 00 07400 RENAL DI ALYSI S		0. 33459		151, 596	
76. 00 03140 CARDIO CATH LAB		0. 07684		114, 360	
76. 01 03050 ENDOSCOPY		0. 16174			
76. 02 03051 CARDI AC REHAB		0. 20957	78 127, 769	26, 778	76. 02
OUTPATIENT SERVICE COST CENTERS		2 00440	28 493	57 111	1 00 0
			1/1 /N 493		

2. 004402

0. 114456

0.048522

0.000000

28, 493

85, 118

1, 668, 459

61, 601, 363

61, 601, 363

57, 111

190, 965

4, 130

0

8, 183, 576 200. 00

90. 00 91. 00

92.00

95.00

96. 00

201. 00

202. 00

90.00

91.00

92.00

95.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net Charges (line 200 minus line 201)

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

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

	Financial Systems ATION OF ORGAN ACQUISITION COSTS AND CHARGES	FOR HOSPITALS			CCN: 150017	Peri od:	worksheet D-4	
WHI CH	ARE CERTIFIED TRANSPLANT CENTERS		Со	mponent	CCN:	From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
				Ki	dney	Hospi tal	PPS	
	Cost Center Description	Worksheet D-1	Inpat		Per Diem Cost		Cost (col. 2 x	
		Line Numbers	Routine		(from Wkst.	Acqui si ti on	col. 3)	
		0	Char		D-1, Part II		4.00	
	DART I COMPUTATION OF ORCAN ACQUISITION CO	0 DCTC (INDATIENT	1. (2.00	3. 00	4. 00	
	PART I - COMPUTATION OF ORGAN ACQUISITION CO Computation of Inpatient Routine Service Co					CES)		
1.00	ADULTS & PEDI ATRI CS	38.00		45, 172	835. 9	98 25	20, 900	1.00
2.00	INTENSIVE CARE UNIT	43. 00	1	43, 172	0. 0		20, 700	2.00
2. 01	PEDIATRIC INTENSIVE CARE UNIT	43. 01	1	0	1, 887. <i>6</i>		Ö	2. 01
2. 02	NEONATAL INTENSIVE CARE UNIT	43. 02	1	0	1, 149. 8		Ö	2. 02
2. 03	CARDIO INTENSIVE CARE UNIT	43. 03	1	0	806. 9		0	2. 03
3.00	CORONARY CARE UNIT	44. 00		0	1, 131. 7	77 0	0	3. 00
4.00	BURN INTENSIVE CARE UNIT	45. 00		0	0.0	00	0	4. 00
5.00	SURGICAL INTENSIVE CARE UNIT	46. 00		0	0.0	00	0	5. 00
6.00	OTHER SPECIAL CARE (SPECIFY)	47. 00		0	0.0		0	6. 00
7.00	TOTAL (sum of lines 1-6)			45, 172		25	20, 900	7. 00
	Cost Center Description		Worksh		Ratio of	0rgan	0rgan	
			Line Nu	umbers	Cost/Charges		Acquisition Ancillary	
					(from Wkst. (C) Ancillary Charges	Costs	
			0		1.00	2. 00	3. 00	
	Computation of Ancillary Service Cost Applic	able to Organ A			1.00	2.00	3.00	
8. 00	OPERATI NG ROOM	ioner o de di gani i		50.00	0. 11103	1, 199, 092	133, 139	8.00
9.00	RECOVERY ROOM			51.00	0.00000		0	9. 00
10.00	DELIVERY ROOM & LABOR ROOM			52.00	0. 28577	74 0	0	10.00
11.00	ANESTHESI OLOGY			53.00	0. 01434	104, 025	1, 493	11. 00
12.00	RADI OLOGY-DI AGNOSTI C			54.00	0. 13053		32, 039	1
12. 01	PET SCAN			54. 01	0. 19002		0	12. 01
13.00	RADI OLOGY-THERAPEUTI C			55.00	0.00000		0	13.00
14.00	RADI OI SOTOPE			56.00	0. 08805		79, 924	14.00
15. 00 16. 00	CT SCAN MRI			57. 00 58. 00	0. 02882		17, 799 0	15. 00 16. 00
17. 00	CARDI AC CATHETERI ZATI ON			59.00	0. 00000 0. 00000		0	17. 00
18. 00	LABORATORY			60.00	0. 13580		181, 184	18. 00
19. 00	PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00	0. 00000		0	19. 00
20. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS			62. 00	0. 00000		Ö	20.00
21.00	BLOOD STORING, PROCESSING & TRANS.			63.00	0.00000		0	21.00
22.00	INTRAVENOUS THERAPY			64.00	0.00000	00	0	22. 00
23. 00	RESPI RATORY THERAPY			65.00	0. 13781	134, 290	18, 507	23. 00
24. 00	PHYSI CAL THERAPY			66. 00	0. 33271		0	24. 00
25. 00	OCCUPATI ONAL THERAPY			67. 00	0. 00000		0	25. 00
26. 00	SPEECH PATHOLOGY			68. 00	0.00000		0	26. 00
27. 00	ELECTROCARDI OLOGY			69.00	0. 05732		16, 790	1
	ELECTROENCEPHALOGRAPHY			70.00	0. 31287		72 701	
	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS			71. 00 72. 00	0. 24992 0. 13460		73, 791 842	
31. 00	DRUGS CHARGED TO PATIENTS			73.00	0. 13214		48, 885	1
32. 00	RENAL DIALYSIS			74. 00			0	32.00
33. 00	ASC (NON-DISTINCT PART)			75. 00	0. 00000		Ö	33.00
34. 00	CARDIO CATH LAB			76. 00	0. 07684		0	34. 00
34. 01	ENDOSCOPY			76. 01	0. 16174		5, 513	
34. 02	CARDI AC REHAB			76. 02	0. 20957		0	1
35.00	RURAL HEALTH CLINIC			88. 00	0. 00000	00	0	35. 00
36. 00	FEDERALLY QUALIFIED HEALTH CENTER			89. 00	0. 00000		0	36. 00
37. 00	CLINIC			90.00	2. 00440		156, 526	
38. 00	EMERGENCY			91. 00	0. 11445		201	38. 00
39. 00	OBSERVATION BEDS (NON-DISTINCT PART			92.00	0. 04852	25, 555	1, 240	
40.00	OTHER OUTPATIENT SERVICE COST CENTER TOTAL (sum of lines 8-40)					5, 645, 936	767, 873	40.00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

	TAL OF INDIANA			eu of Form CMS-2	
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS	Provider Componen		Period: From 07/01/2013 Fo 06/30/2014	Worksheet D-4 Date/Time Pre	pared:
	K	i dney	Hospi tal	12/1/2014 9: 5 PPS	o alli
Cost Center Description	Worksheet D-2, Part I Line	Average Cost Per Day (from	0rgan	Organ Acqui si ti on	
	Numbers	Wkst. D-2, Part I, col.		Costs (col. 1 x col. 2)	
	0	4) 1.00	2. 00	3. 00	
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER T					
Computation of the Cost of Inpatient Services of Interns					1
42. 00 ADULTS & PEDIATRICS	2.00				
43. 00 INTENSIVE CARE UNIT	3.00	•			1
43. 01 PEDIATRIC INTENSIVE CARE UNIT	3. 0	•		1	
43. 02 NEONATAL INTENSIVE CARE UNIT	3. 02	•			
43. 03 CARDIO INTENSIVE CARE UNIT 44. 00 CORONARY CARE UNIT	3. 03	•		0	
45. 00 BURN INTENSIVE CARE UNIT	5.00	•			
46. 00 SURGI CAL INTENSI VE CARE UNI T	6. 00	1		0	
47. 00 OTHER SPECIAL CARE (SPECIFY)	7. 00			o o	
48.00 TOTAL (sum of lines 42 through 47)			25	0	
Cost Center Description	Worksheet D-2,	Organ Charges	Ratio of Cost	0rgan	
	Part I Line Numbers	(see instructions)	To Charges from Wkst.	Acquisition Costs (col. 1	
			D-2, Part I,	x col. 2)	
		1.00	col . 4	0.00	
Computation of the Cost of Outpatient Services of Interns	ond Dooi donts I	1.00	2. 00	3.00	
49.00 RURAL HEALTH CLINIC	21.00		0. 000000		49. 00
50. 00 FEDERALLY QUALIFIED HEALTH CENTER	22. 00			0	
51. 00 CLINIC	23. 00	•			
52. 00 EMERGENCY	24. 00	•		0	1
53.00 OBSERVATION BEDS (NON-DISTINCT PART	25. 00	25, 55	0. 000000	0	53.00
54.00 OTHER OUTPATIENT SERVICE COST CENTER	26. 00		0. 000000	0	54. 00
55.00 TOTAL (sum of lines 49 through 52)		105, 40		0	55. 00
	I Co	ost	Cha	rges	
Cost Contor Doscription					
Cost Center Description	Part A	Part B	Part A	Part B	
Cost Center Description PART III - SUMMARY OF COSTS AND CHARGES					
·	Part A	Part B 2.00	Part A	Part B 4.00	56. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient)	Part A 1.00	Part B 2.00	Part A 3.00	Part B 4.00	57. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient)	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions)	Part A 1.00	Part B 2.00	Part A 3.00 5,691,108	Part B 4.00	57. 00 58. 00 59. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions)	Part A 1.00 788, 773	Part B 2.00	Part A 3.00 5,691,108 0 0 2,451,721	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60)	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions)	Part A 1.00 788, 773	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Fr.00 F	Part A 1.00 788, 773	Part B 2.00	Part A 3. 00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958	Part B 2.00	Part A 3. 00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958 2, 248, 818	Part B 2.00	Part A 3. 00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold	Part A 1.00 788, 773 ((2, 147, 18) (2, 935, 955 2, 248, 815 100, 676	Part B 2.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958 2, 248, 818	Part B 2.00 3 3 4 3 0.76595	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 11 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00	Part A 3.00 5,691,108 0 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions)	Part A 1.00 788, 773 ((2, 147, 18) (2, 935, 955 2, 248, 815 100, 676	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 80.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Total (sum of lines 56 thru 60) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of p	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00	Part B 4.00 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Excised in Provider (1)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveric 2.00	Part B 4.00 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospitals (2)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 5.00 Li vi ng Rel ater 1.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Non-Transplant Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 5.60 Li vi ng Rel atector 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) Total (sum of lines 56 thru 60) Ratio of Medicare Usable Organs (see instructions) 63. 00 Redicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 3 0.76595 5 6 6 6 6 6 6 6 6 6 7 1.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 19 0 0 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching hospital (see intructions) Total (sum of lines 56 thru 60) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Acquisition of Medicare Usable Organs (see instructions) Acquisition of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) Medicare Cost/Charges (see instructions) Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS Organs Excised in Provider (1) Organs Purchased from Other Transplant Hospitals (2) Organs Purchased from OPOS Total (sum of lines 70 thru 73)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 6 1.00 1:00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 15 3 34	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 Li vi ng Rel ater 1.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 15 3 34	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 08. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 71. 00 Organs Purchased from OPOs 72. 00 Organs Purchased from OPOs 73. 00 Organs Transplanted 76. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 3 19 0 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to OPOs	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from Other Transplant Hospitals 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Sent Outside the U.S. (no revenue received)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 6 0.10 1:00 1:00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 15 3 4 15 0 0 19 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to OPOs 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold Outside the U.S. 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Used for Research	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 6.00 Li vi ng Rel ater 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 8 34 15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from Other Transplant Hospitals 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Sent Outside the U.S. (no revenue received)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 6.00 Li vi ng Rel ater 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 3 19 0 0 15 3 34 5 0 0 0 17 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 80. 00 81. 00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

Uool +h	Financial Systems	LITHEDAN HOSDIT	TAL OF INDIANA		المانما	u of Form CMC	2552 10
	Financial Systems I FATION OF ORGAN ACQUISITION COSTS AND CHARGES	_UTHERAN HOSPIT		CCN: 150017	Peri od:	u of Form CMS-2 Worksheet D-4	
	ARE CERTIFIED TRANSPLANT CENTERS	TOR HOSET TALS	Componen		From 07/01/2013 To 06/30/2014	Date/Time Pre	pared:
				leart	Hospi tal	12/1/2014 9: 5 PPS	5 am
	Cost Center Description	Worksheet D-1	Inpati ent	Per Diem Cost		Cost (col. 2 x	
		Line Numbers	Routine Organ		Acqui si ti on	col. 3)	
			Charges	D-1, Part II		,	
		0	1.00	2.00	3. 00	4. 00	
	PART I - COMPUTATION OF ORGAN ACQUISITION COS	STS (INPATIENT	ROUTINE AND AN	ICI LLARY SERVI	CES)		
	Computation of Inpatient Routine Service Cos						
1.00	ADULTS & PEDI ATRI CS	38. 00		1		0	
2.00	INTENSIVE CARE UNIT	43.00				0	
2. 01 2. 02	PEDIATRIC INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	43. 01 43. 02				0	
2. 02	CARDIO INTENSIVE CARE UNIT	43. 02		1		0	
3. 00	CORONARY CARE UNIT	44. 00				0	
4. 00	BURN INTENSIVE CARE UNIT	45. 00		0.0		0	
5. 00	SURGICAL INTENSIVE CARE UNIT	46. 00				0	
6.00	OTHER SPECIAL CARE (SPECIFY)	47.00		0.0	00	0	6.00
7.00	TOTAL (sum of lines 1-6)				0	0	7. 00
	Cost Center Description		Worksheet C	Ratio of	0rgan	0rgan	
			Line Numbers	Cost/Charges		Acquisition	
				(from Wkst. ('	Ancillary	
			0	1.00	Charges	Costs	
	Computation of Ancillary Service Cost Applica	abla ta Organ A	0	1.00	2. 00	3. 00	
8. 00	OPERATING ROOM	abre to organi P	50.00	0. 11103	3 0	0	8. 00
9. 00	RECOVERY ROOM		51.00			0	
10. 00	DELIVERY ROOM & LABOR ROOM		52.00			0	
11. 00	ANESTHESI OLOGY		53.00	1		0	
12.00	RADI OLOGY-DI AGNOSTI C		54.00			0	12. 00
12. 01	PET SCAN		54. 01	0. 19002	25 0	0	12. 01
13.00	RADI OLOGY-THERAPEUTI C		55.00	1		0	
14. 00	RADI OI SOTOPE		56.00	1		0	
15. 00	CT SCAN		57.00	1		0	
16.00	MRI		58. 00 59. 00			0	
17. 00 18. 00	CARDI AC CATHETERI ZATI ON LABORATORY		60.00	l .		0	
19. 00	PBP CLINICAL LAB SERVICES-PRGM ONLY		61.00	•		0	
20. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS		62.00	1		0	
21. 00	BLOOD STORING, PROCESSING & TRANS.		63.00			0	
22. 00	I NTRAVENOUS THERAPY		64.00	0. 00000	0 0	0	22. 00
23. 00	RESPI RATORY THERAPY		65.00	0. 13781	3 0	0	23. 00
24. 00	PHYSI CAL THERAPY		66.00	1		0	
25. 00	OCCUPATIONAL THERAPY		67.00	1		0	1
26. 00	SPEECH PATHOLOGY		68.00	1		0	1
27. 00 28. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY		69. 00 70. 00	1		0	
	MEDICAL SUPPLIES CHARGED TO PATIENT		70.00	1		0	
30.00	IMPL. DEV. CHARGED TO PATIENTS		71.00			0	
31. 00	DRUGS CHARGED TO PATIENTS		73.00			0	
32. 00	RENAL DIALYSIS		74.00			0	
33.00	ASC (NON-DISTINCT PART)		75.00	0. 00000	0 0	0	33. 00
34.00	CARDIO CATH LAB		76.00	0. 07684	3 0	0	34. 00
34. 01	ENDOSCOPY		76. 01	1		0	
34. 02	CARDI AC REHAB		76. 02	1		0	
35.00	RURAL HEALTH CLINIC		88.00	1		0	1
36.00	FEDERALLY QUALIFIED HEALTH CENTER		89.00	1		0	
37. 00 38. 00	CLINIC EMERGENCY		90.00	1		0	
39. 00	OBSERVATION BEDS (NON-DISTINCT PART		92.00	1		0	
40. 00	OTHER OUTPATIENT SERVICE COST CENTER		72.00	0.04002			40.00
	TOTAL (sum of lines 8-40)				0	0	41. 00
			•	•	•		

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

	UTHERAN HOSPITAL O				u of Form CMS-2	
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES WHICH ARE CERTIFIED TRANSPLANT CENTERS	FOR HOSPITALS	Provider Component	1	Period: From 07/01/2013 To 06/30/2014	Worksheet D-4 Date/Time Pre	pared:
		Н	eart	Hospi tal	12/1/2014 9: 5 PPS	o alli
Cost Center Description	Par	ssheet D-2, rt I Line Numbers	Average Cost Per Day (from Wkst. D-2, Part I, col.	0rgan	Organ Acquisition Costs (col. 1 x col. 2)	
			4)			
		0	1.00	2. 00	3. 00	
PART II - COMPUTATION OF ORGAN ACQUISITION CO						
Computation of the Cost of Inpatient Services	of Interns and Re					
42. 00 ADULTS & PEDIATRICS		2.00	0.00		0	
43. 00 INTENSIVE CARE UNIT		3.00	0. 00			
43. 01 PEDIATRIC INTENSIVE CARE UNIT		3. 01	0.00		0	43. 01
43. 02 NEONATAL INTENSIVE CARE UNIT		3. 02	0.00		0	43. 02
43. 03 CARDIO INTENSIVE CARE UNIT		3. 03	0.00		0	43. 03
44. 00 CORONARY CARE UNIT		4.00	0.00		0	44.00
45. 00 BURN INTENSIVE CARE UNIT		5. 00	0.00		0	45. 00
46. 00 SURGICAL INTENSIVE CARE UNIT		6.00	0.00		0	46.00
47. 00 OTHER SPECIAL CARE (SPECIFY)		7. 00	0.00	0	0	47. 00 48. 00
48.00 TOTAL (sum of lines 42 through 47) Cost Center Description	Mork	choot D 2	Organ Charges	Ratio of Cost	Organ	48.00
COST CENTER DESCRIPTION	Par	rt I Line Numbers	(see instructions)	To Charges from Wkst. D-2, Part I,	Acquisition Costs (col. 1 x col. 2)	
		0	1. 00	col . 4	2.00	
Computation of the Cost of Outpatient Service	oc of Intorns and D	O Dosidonts N		2.00	3. 00	
49. 00 RURAL HEALTH CLINIC	es of fifteeris and R	21.00	ot ili Approved	0. 000000		49. 00
50. 00 FEDERALLY QUALIFIED HEALTH CENTER		22. 00			0	50.00
51. 00 CLINIC		23. 00	Ò		Ö	51.00
52. 00 EMERGENCY		24. 00	Ò		Ö	52. 00
53. 00 OBSERVATION BEDS (NON-DISTINCT PART		25. 00	ì		Ö	53. 00
54. 00 OTHER OUTPATIENT SERVICE COST CENTER		26. 00	`	0.00000	Ö	54. 00
55.00 TOTAL (sum of lines 49 through 52)		20.00	ì		0	55. 00
				4		00.00
		Co	st	Chai	raes	
Cost Center Description	_	Co Part A	st Part B	Part A	rges Part B	
Cost Center Description						
PART III - SUMMARY OF COSTS AND CHARGES		Part A	Part B	Part A	Part B	
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I		Part A	Part B	Part A	Part B	56. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient)		Part A 1.00	Part B	Part A 3.00	Part B	57. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient) 1 Interns and Residents (outpatient)		Part A 1.00 0 0	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions)		Part A 1.00	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00 59. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he		Part A 1.00 0 0	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 For unit and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching heintructions)		Part A 1.00 0 0 0 964,332 0	Part B	Part A 3.00 0 0 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) Total (sum of lines 56 thru 60)		Part A 1.00 0 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions)		Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions)	ospi tal (see	Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal	ospi tal (see	Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 70 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62)	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions)	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) Revenue for Organs Sold	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 1nterns and Residents (outpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66)	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 2 7 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 0 783,058 0 783,058	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see Cost Center Description	ospital (see ole Organs	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 1 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Organs Excised in Provider (1)	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 1 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 57. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospic	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 57. 00 Interns and Residents (inpatient) Interns and Residents (outpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from Non-Transplant Hospital 73. 00 Organs Purchased from OPOS Total (sum of lines 70 thru 73)	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1: 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00
PART III - SUMMARY OF COSTS AND CHARGES 75.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 1 Interns and Residents (outpatient) 1 Direct Organ Acquisition (see instructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost Ogans (see instructions) 1 Cost Ogans (see instructions) 1 Cost Office (see instructions) 1 Cost Ogans (see instructions) 1 Cost Ogans Sold 1 Cost Ogans Sold 1 Cost Ogans Furnished Part B 1 Cost Center Description	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Fr.	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Part III - Summary of Costs and Charges Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching he intructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) Organs Transplanted 76. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching he intructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 0 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching he intructions) 61. 00 Total (sum of lines 56 thru 60) 70 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Transplanted 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B 4.00 0 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 78. 00 Organs Sold to Military or VA Hospitals 79. 00 Organs Sold to Military or VA Hospitals 0. Organs Sold Outside the U.S.	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 78. 00 79. 00 80. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Fart III - SUMMARY OF COSTS AND CHARGES Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching heintructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Action of Medicare Usable Organs to Total Usal (line 63 + line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Revenue for Organs Sold Roudicare Usable Organs Inne 66) Organs Furnished Part B Medicare Cost/Charges (see instructions) Revenue for Organs Sold Total (line 65 minus line 66) Organs Furnished Part B Medicare Cost/Charges (see instructions) Total (sum of lines from Other Transplant Hospital) Organs Purchased from Other Transplant Hospital Organs Purchased from OPOs Total (sum of lines 70 thru 73) Total (sum of lines 70 thru 73) Organs Sold to Other Hospitals Organs Sold to Other Hospitals Organs Sold to Transplant Hospitals Organs Sold to Transplant Hospitals Organs Sold to Military or VA Hospitals Organs Sold Outside the U.S. Organs Sold Outside the U.S. Organs Sold Outside the U.S. (no revenue received)	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 70. 00 71. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 77. 00 78. 00 79. 00 80. 00 81. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. (no revenue recomposition or the search or the	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1: 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 0 1,174,586 0 1,174,586 0 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 70 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospital 73.00 Organs Purchased from Mon-Transplant Hospital 73.00 Organs Transplanted 76.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Transplant Hospitals 78.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Military or VA Hospitals 80.00 Organs Sold Outside the U.S. 81.00 Organs Sent Outside the U.S. (no revenue reco	ospital (see ole Organs nstructions) tals (2) s	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 77. 00 78. 00 79. 00 80. 00 81. 00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Pre 12/1/2014 9:5	pared: 5 am
		Ti tl	e XVIII	Hospi tal	PPS	
			before 1/1	on/after 1/1	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS	0	1. 00	1. 01	2. 00	
1.00	DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges		12, 653, 05	i3		1. 01
4 00	occurring prior to October 1, 2013 (see instructions)					
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		39, 408, 52	!5		1. 02
1. 03	DRG for Federal specific operating payment for Model 4			0		1. 03
	BPCI (see instructions)					
2.00	Outlier payments for discharges. (see instructions)		3, 207, 04	8		2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0		2. 02
3.00	Managed Care Simulated Payments		29, 440, 32	23		3. 00
4. 00	Bed days available divided by number of days in the cost		383. 9			4. 00
	reporting period (see instructions)					
	Indirect Medical Education Adjustment			_1		
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before		10. 1	3		5. 00
	12/31/1996. (see instructions)					
6.00	FTE count for allopathic and osteopathic programs which		0.0	00		6. 00
	meet the criteria for an add-on to the cap for new					
7.00	programs in accordance with 42 CFR 413.79(e)			20		7 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.0	00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as		0.0	00		7. 01
	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
	cost report straddles July 1, 2011 then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated		0.0	00		8. 00
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12,					
	1998, page 26340 and Vol. 67 Federal Register, page 50069,					
0.01	August 1, 2002.			20		0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report		0.0	10		8. 01
	straddles July 1, 2011, see instructions.					
8.02	The amount of increase if the hospital was awarded FTE cap		0.0	00		8. 02
	slots from a closed teaching hospital under section 5506					
9. 00	of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		10. 1	2		9. 00
7.00	lines (8, 8,01 and 8,02) (see instructions)		10. 1	3		7.00
10.00	FTE count for allopathic and osteopathic programs in the		8. 1	4		10. 00
	current year from your records					
11. 00 12. 00	FTE count for residents in dental and podiatric programs.		0. 0 8. 1			11. 00 12. 00
13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		9. 5			13.00
14. 00	' '		9. 3			14. 00
	year ended on or after September 30, 1997, otherwise enter					
	zero.					
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program		9. C 0. C			15. 00 16. 00
17. 00	Adjusment for residents displaced by program or hospital		0.0			17. 00
	closure					17.00
18. 00	Adjusted rolling average FTE count		9. 0			18. 00
19. 00	Current year resident to bed ratio (line 18 divided by		0. 02349	93		19. 00
20. 00	line 4). Prior year resident to bed ratio (see instructions)		0. 02453	30		20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0. 02349			21. 00
22. 00	IME payment adjustment (see instructions)		1, 039, 63			22. 00
	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of t				
23. 00	Number of additional allopathic and osteopathic IME FTE		0.0	00		23. 00
24. 00	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)		-1.9	00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter		0.0			25. 00
	the lower of line 23 or line 24 (see instructions)					
26. 00	Resident to bed ratio (divide line 25 by line 4)		0. 00000			26. 00
27. 00	IME payments adjustment factor. (see instructions)		0.00000			27. 00
28. 00 29. 00	IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28)		1, 039, 63	0		28. 00 29. 00
£ 7. UU	Di sproporti onate Share Adjustment		1, 037, 03			27.00
30.00	Percentage of SSI recipient patient days to Medicare Part		3. 7	4		30.00
	A patient days (see instructions)					
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31		17. 8 21. <i>6</i>			31. 00 32. 00
JZ. UU	Jouin of Titles to alla St		J ∠1. C	· · (l	J JZ. UU

86.077

69, 837, 719

4, 777, 664

281.088

120, 052

78,034

60.00

61.00

62.00

63.00

64.00

65.00

instructions)

58)

Primary payer payments

Total amount payable for program

beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries

Allowable bad debts (see instructions)

Adjusted reimbursable bad debts (see

Coinsurance billed to program beneficiaries

60.00

61.00

62.00

63.00

64.00

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150017

						12/1/2014 9:5	55 am
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
				October 1		October 1	
		0		1.00	1. 01	2.00	
66. 00	Allowable bad debts for dual eligible	0		0		2.00	66. 00
67. 00	beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines			64, 857, 001			67. 00
68. 00	62 and 63) Credits received from manufacturers for			15, 200			68. 00
	replaced devices applicable to MS-DRG (see instructions)						
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96) (For SCH see			0			69. 00
70. 00	instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70. 00
70. 50	(SPECIFY) RURAL DEMONSTRATION PROJECT			0			70. 50
70. 92	Bundled Model 1 discount amount			٥			70. 92
	1						
70. 93	HVBP incentive payment (see instructions)			-44, 949			70. 93
70. 94	Hospital readmissions reduction adjustment (see instructions)			-69, 815			70. 94
70. 95	Recovery of accelerated depreciation			0			70. 95
70. 96	Low volume adjustment for federal fiscal		0	0			70. 96
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	prior to 10/1)						
70. 97	Low volume adjustment for federal fiscal		0	,			70. 97
70. 97			U	0			70.97
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			0			70. 98
71.00	Amount due provider (line 67 minus lines 68			64, 727, 037			71.00
	plus/minus lines 69 & 70)			.,,,			
71. 01	Sequestration adjustment (see instructions)			1, 294, 541			71. 01
	, , , , , , , , , , , , , , , , , , , ,						72.00
72. 00	Interim payments			62, 802, 157			
73. 00	Tentative settlement (for contractor use			0			73. 00
	onl y)						
74.00	Balance due provider (Program) line 71 minus			630, 339			74.00
	lines 71.01, 72 and 73						
75.00	Protested amounts (nonallowable cost report			3, 738, 092			75. 00
	items) in accordance with CMS Pub. 15-2,			, ,			
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR			l .	l .	l .	1
90. 00	Operating outlier amount from Worksheet E,			0	I	ı	90.00
90.00				U			90.00
	Part A line 2 (see instructions)						
91. 00	Capital outlier from Worksheet L, Part I,			0			91. 00
	line 2						
92.00	Operating outlier reconciliation adjustment			0			92. 00
	amount (see instructions)						
93.00	Capital outlier reconciliation adjustment			1 0			93. 00
70.00	amount (see instructions)			Ĭ			70.00
94. 00	The rate used to calculate the time value of			0.00			94.00
74. 00] 0.00			74.00
05.05	money (see instructions)			_			05.00
95. 00	Time value of money for operating expenses			0			95. 00
	(see instructions)						1
96. 00	Time value of money for capital related			0			96. 00
	expenses (see instructions)						1
	·						

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pi	rovi der (CCN: 150017	Peri od: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 12/1/2014 9:55 am

			10 00/30/2014	12/1/2014 9:5	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			19, 874	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		21, 153, 602	2. 00
3.00	PPS payments	23, 579, 591	3. 00		
4.00	Outlier payment (see instructions)			134, 994	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 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 Worksheet D, Pa	rt IV, column 13, line	e 200	27, 335	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			19, 874	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12. 00	Ancillary service charges			150, 045	
13. 00	Organ acquisition charges (from Worksheet D-4, Part III, line 6	9, col. 4)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			150, 045	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for page 1975			0	
16. 00	Amounts that would have been realized from patients liable for	payment for services o	on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	17.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	if lime 10 evenede li	no 11) (ooo	150, 045	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds II	ne II) (See	130, 171	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	no 10) (soo	0	20. 00
20.00	instructions)	II IIIle II exceeds II	11e 10) (See	0	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		19, 874	21. 00
22. 00	Interns and residents (see instructions)	riisti deti olis)		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			23, 741, 920	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions))	4, 605, 520	26. 00
27. 00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the			19, 156, 274	
	see instructions)				
28. 00	Direct graduate medical education payments (from Worksheet E-4,	line 50)		93, 085	28. 00
29. 00	ESRD direct medical education costs (from Worksheet E-4, line 3	6)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			19, 249, 359	30. 00
31. 00	Primary payer payments			5, 988	
32. 00	Subtotal (line 30 minus line 31)			19, 243, 371	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)			
33. 00	Composite rate ESRD (from Worksheet I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			67, 261	
35. 00	Adjusted reimbursable bad debts (see instructions)			43, 720	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	
37. 00	Subtotal (see instructions)			19, 287, 091	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	d daylaga (aga i natny	n+: ono)	0	
39. 98	Partial or full credits received from manufacturers for replace	a devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			10 207 001	39. 99
40.00	Subtotal (see instructions)			19, 287, 091	40.00
40. 01	Sequestration adjustment (see instructions)			385, 742	
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			19, 051, 989 0	1
43.00	Balance due provider/program (see instructions)			-150, 640	
44. 00	Protested amounts (nonallowable cost report items) in accordance	a with CMS Dub 15_2	chanter 1	- 130, 040	
44.00	§115. 2	C WI III GWG FUD. 19-2,	спарты Т,		44.00
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			ő	
92. 00	The rate used to calculate the Time Value of Money			-	92. 00
93. 00	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)			0	
				•	•

| Peri od: | Worksheet E-1 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared: | 12/1/2014 9:55 am Health Financial Systems LUTHE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150017

					12/1/2014 9: 5	5 am
			e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		62, 464, 057		19, 051, 989	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	07/01/2013	60, 800		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	02/11/2014	704, 100		0	3. 02
3. 03		0271172011	0		o o	3. 03
3. 04			Ö		l ő	3. 04
3. 05			ĺ		l ő	3. 05
0.00	Provider to Program				J	0.00
3.50	ADJUSTMENTS TO PROGRAM	06/30/2014	426, 800		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		338, 100		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		62, 802, 157		19, 051, 989	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR	I		1		г оо
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
5. 02	TEMMINE TO THORISEN		Ö		l ol	5. 02
5. 03			0		l ol	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		630, 339		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		150, 640	6. 02
7.00	Total Medicare program liability (see instructions)		63, 432, 496		18, 901, 349	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	INGINE OF COTTE ACTO	I		I	ı	0.00

Heal th	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10	
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150017	Peri od:	Worksheet E-1 Part II		
	From 07/01/201 To 06/30/201					
	Date/Time Pre 12/1/2014 9:5					
	Title XVIII Hospital					
			noopi tui	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14					
2.00						
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			18, 262	3. 00	
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		92, 401	4.00	
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			1, 984, 598, 649	5. 00	
6.00	Total hospital charity care charges from Wkst S-10, column 3 l	ine 20		8, 063, 005	6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HIT technology	Worksheet S-2,	0	7. 00	
	Part I line 168					
8.00	Calculation of the HIT incentive payment (see instructions)			1, 442, 766	8. 00	
9.00	Sequestration adjustment amount (see instructions)			28, 855	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1, 413, 911	10. 00	
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)			1, 336, 152		
	Other Adjustment (specify)			0	31. 00	
22 00	Dalamas dua maggidam (lima O (am lima 10) minus lima 20 and li	no 21) (coo i notruction	- N	77 750	22 00	

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

1, 336, 152 30. 00 0 31. 00 77, 759 32. 00

Heal th	Financial Systems LUTHERAN HOSPITAL O	F INDIANA		In lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS			Peri od: From 07/01/2013 To 06/30/2014	Worksheet E-4 Date/Time Prep 12/1/2014 9:55	pared:
-		Ti tl	e XVIII	Hospi tal	PPS	J alli
				•		
					1. 00	
4 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT				0.05	4 00
1. 00	Unweighted resident FTE count for allopathic and osteopathic pr	ograms for	cost reporti	ng perioas	8. 95	1. 00
2.00	ending on or before December 31, 1996. 2.00 Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					2. 00
3. 00	Amount of reduction to Direct GME cap under section 422 of MMA		., (55551	401.01.0)	0. 00 0. 00	
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance w	ith 42 CFR	§413.79 (m).	(see	0. 00	3. 01
4 00	instructions for cost reporting periods straddling 7/1/2011)				0.00	4 00
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	steopatni c	programs due	to a Medicare	0. 00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instru	uctions for	cost reporti	na periods	0. 00	4. 01
	straddl i ng 7/1/2011)	.01.00 .0.	000t . opo. t.	ing point due	0.00	
4.02	ACA Section 5506 number of additional direct GME FTE cap slots	(see inst	ructions for	cost reporting	0.00	4. 02
	peri ods straddling 7/1/2011)				0.05	
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus	or minus	line 4 plus l	ines 4.01 and	8. 95	5. 00
6. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic pr	roorams for	the current	vear from vour	8. 14	6. 00
0.00	records (see instructions)	ogranis roi	the current	year from your	0. 14	0.00
7. 00	Enter the lesser of line 5 or line 6				8. 14	7. 00
			Primary Care		Total	
	lw		1.00	2. 00	3. 00	0.00
8. 00	Weighted FTE count for physicians in an allopathic and osteopat program for the current year.	hi c	8. 1	4 0.00	8. 14	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwis	se	8. 1	4 0.00	8. 14	9. 00
	multiply line 8 times the result of line 5 divided by the amour					
	6.					
10.00	Weighted dental and podiatric resident FTE count for the currer	nt year		0.00		10. 00
11.00	Total weighted FTE count	V005 (000	8. 1			11.00
12. 00	Total weighted resident FTE count for the prior cost reporting instructions)	year (see	8. 9	0.00		12. 00
13. 00	Total weighted resident FTE count for the penultimate cost repo	orti ng	8. 9	0.00		13. 00
	year (see instructions)	Ü				
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided b	y 3).	8. <i>6</i>			14. 00
15.00	Adjustment for residents in initial years of new programs		0.0			15. 00
16. 00 17. 00	Adjustment for residents displaced by program or hospital closu Adjusted rolling average FTE count	ire	0. 0 8. 6			16. 00 17. 00
18. 00	Per resident amount		93, 854. 3			18.00
19. 00	Approved amount for resident costs		814, 65	· ·	814, 656	
			·			
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FTE	resi dent	cap slots rec	eived under 42	0. 00	20. 00
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruct	ione)			0.00	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instruc					22.00
23. 00	Enter the locally adjustment national average per resident amou		structions)			23. 00
	Multiply line 22 time line 23				0	24. 00
25. 00	Total direct GME amount (sum of lines 19 and 24)		l	.1	814, 656	25. 00
			Inpatient Par	t Managed care		
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
26. 00	Inpatient Days (see instructions)		30, 28	18, 262		26. 00
27. 00	Total Inpatient Days (see instructions)		92, 40			27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 32771			28. 00
29. 00 30. 00	Program direct GME amount Reduction for direct GME payments for Medicare Advantage		266, 97	161, 008 22, 750		29. 00 30. 00
	Net Program direct GME amount			22, 750	405, 231	
	, ,		•			

	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10
DI REC	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 150017	Peri od:	Worksheet E-4	
MEDI CA	AL EDUCATION COSTS		From 07/01/2013 To 06/30/2014	Date/Time Prepared: 12/1/2014 9:55 am	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	`		CAL	
32. 00	1	d 23, lines 74	0	32. 00	
	and 94)				
33. 00			74 and 94)	9, 098, 177	ı
34. 00	3	e 32 ÷ line 33)		0. 000000	1
	Medicare outpatient ESRD charges (see instructions)		0		
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII Part A Reasonable Cost	UNLY			
37. 00				68, 385, 629	27.00
38.00	·			2, 774, 080	
	Cost of physicians' services in a teaching hospital (see instr	ructions)		2, 774, 080	1
	Primary payer payments (see instructions)	uctions)		86, 077	1
	Total Part A reasonable cost (sum of lines 37 through 39 minus	line 40)		71, 073, 632	
41.00	Part B Reasonable Cost	11116 40)		71,073,032	41.00
42. 00				21, 200, 811	42.00
43. 00	·			5, 988	
	Total Part B reasonable cost (line 42 minus line 43)			21, 194, 823	
	Total reasonable cost (sum of lines 41 and 44)			92, 268, 455	1
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	41 ÷ line 45)		0. 770292	46. 00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line	44 ÷ line 45)		0. 229708	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	ТВ			
	Total program GME payment (line 31)			405, 231	48. 00
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		312, 146	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		93, 085	50.00

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

Provider CCN: 150017

| Peri od: | From 07/01/2013 | To 06/30/2014 | Worksheet G | Date/Time Prepared: | 12/1/2014 9:55 am

					12/1/2014 9:5	5 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund	0.00	4 00	
	CHIPDENT ACCETC	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	-10, 013, 009			0	1.00
2. 00	Temporary investments	-10,013,009			0	2.00
3. 00	Notes receivable				0	3.00
4. 00	Accounts recei vabl e	99, 647, 317	1	, i	0	4. 00
5. 00	Other receivable	0		o o	Ō	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-20, 492, 586		0	0	6. 00
7.00	Inventory	12, 596, 484	. (0	0	7. 00
8.00	Prepai d expenses	2, 756, 010)	0	0	8. 00
9.00	Other current assets	2, 475, 545	6	0	0	9. 00
10.00	Due from other funds	0) (0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	86, 969, 761		0	0	11. 00
	FI XED ASSETS				_	
12.00	Land	14, 006, 167	1			12.00
13.00	Land improvements	3, 905, 311	1	-	0	13.00
14.00	Accumulated depreciation	-1, 052, 509	1		0	14.00
15. 00	Buildings	234, 764, 800	1	-	0	15. 00 16. 00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-31, 205, 041 19, 997, 319	1	-	0	17. 00
18. 00	Accumulated depreciation	-4, 556, 926		-	0	18.00
19. 00	Fi xed equipment	4, 036, 185	1	-	0	19.00
20. 00	Accumulated depreciation	-2, 238, 849	1		0	20.00
21. 00	Automobiles and trucks	1, 058, 149	1		0	21.00
22. 00	Accumulated depreciation	-816, 872	1	-	0	22.00
23. 00	Major movable equipment	62, 749, 391	1	-	0	23. 00
24. 00	Accumulated depreciation	-40, 796, 887		-	0	24.00
25. 00	Mi nor equipment depreciable	30, 903, 349	1	-	Ö	25. 00
26. 00	Accumulated depreciation	-22, 530, 173		-	ő	26.00
27. 00	HIT designated Assets	0		0	Ō	27. 00
28. 00	Accumulated depreciation	0		0	Ō	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		o o	Ō	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	268, 223, 414		0	0	30.00
	OTHER ASSETS					
31.00	Investments	0) (0	0	31. 00
32.00	Deposits on Leases	0) (0	0	32. 00
33.00	Due from owners/officers	0) (0	0	33. 00
34.00	Other assets	9, 879, 985	i (0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	9, 879, 985	5	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	365, 073, 160)	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	11, 002, 626	1			37. 00
38. 00	Salaries, wages, and fees payable	11, 165, 777	1	-	0	38. 00
39. 00	Payroll taxes payable	1, 204, 556	1	0	0	39. 00
40. 00	Notes and Loans payable (short term)	16, 668		0	0	40.00
41.00	Deferred income	0)	0	0	41.00
42.00	Accel erated payments	0)			42.00
43.00	Due to other funds	-601, 984, 426	1	0	0	43.00
44.00	Other current liabilities	6, 632, 076	1	1		
45. 00	Total current liabilities (sum of lines 37 thru 44)	-571, 962, 723		0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable				0	46. 00
47. 00	Notes payable	1		, i		47.00
48. 00	Unsecured Loans	-4			0	48. 00
49. 00	Other long term liabilities			-	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	_4		-		50.00
51. 00	Total liabilites (sum of lines 45 and 50)	-571, 962, 727		o o		51.00
01.00	CAPITAL ACCOUNTS	0,1,,02,,2		,		0 00
52.00	General fund balance	937, 035, 887	'			52. 00
53. 00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			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	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion		1			
59. 00	Total fund balances (sum of lines 52 thru 58)	937, 035, 887		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	365, 073, 160) (0	0	60. 00
	[59]		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 LUTHERAN HOSPITAL OF INDIANA Peri od: From 07/01/2013 Provider CCN: 150017

					To	06/30/2014		epared: 55 am
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0 0 0 0	783, 211, 215 153, 824, 682 937, 035, 897 0 937, 035, 897		0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
	sheet (line 11 minus line 18)	5						17.00
		Endowment Fund	PI ant	Funa				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0		0 0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 0 0 0 0		0			12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150017 Peri od: Worksheet G-2 From 07/01/2013 Parts I & II 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 86, 536, 342 86, 536, 342 1.00 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 0 0 5.00 Swing bed - NF 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 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) 86, 536, 342 86, 536, 342 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 0 11.01 PEDIATRIC INTENSIVE CARE UNIT 2, 394, 923 2, 394, 923 11.01 NEONATAL INTENSIVE CARE UNIT 11.02 14, 166, 369 14, 166, 369 11 02 64, 441, 705 11.03 CARDIO INTENSIVE CARE UNIT 64, 441, 705 11.03 12.00 CORONARY CARE UNIT 24, 974, 258 24, 974, 258 12.00 13.00 BURN INTENSIVE CARE UNIT 13.00 14.00 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 105, 977, 255 105, 977, 255 16.00 Total intensive care type inpatient hospital services (sum of lines 16.00 11-15) 192. 513, 597 17.00 Total inpatient routine care services (sum of lines 10 and 16) 192, 513, 597 17.00 18.00 Ancillary services 974, 703, 308 706, 468, 261 1, 681, 171, 569 18.00 19.00 Outpatient services 30, 354, 065 80, 459, 418 110, 813, 483 19.00 RURAL HEALTH CLINIC 20.00 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 Λ 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 C 23.00 24.00 CMHC 24.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 25, 00 26.00 HOSPI CE 26.00 27.00 OTHER (SPECIFY) 27.00 28 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 1, 197, 570, 970 786, 927, 679 1, 984, 498, 649 28 00 line 1) PART II - OPERATING EXPENSES 29.00 29.00 Operating expenses (per Wkst. A, column 3, line 200) 372, 465, 795 30.00 ADD (SPECIFY) 0 30.00 0 31.00 31.00 0 32.00 32.00 33.00 0 33.00 0 34.00 34.00 0 35.00 35.00 36.00 Total additions (sum of lines 30-35) 36.00 37.00 DEDUCT (SPECIFY) 37.00 0 38.00 38.00 39.00 39.00 40.00 40.00

0

372, 465, 795

41.00

42.00

43.00

41.00

42.00

Total deductions (sum of lines 37-41)

to Wkst. G-3, line 4)

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer

Heal th	Financial Systems LUTHERAN HOSPITAL C		In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 150017	Peri od:	Worksheet G-3	
			From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1, 984, 498, 649	1, 00
2. 00	Less contractual allowances and discounts on patients' accounts			1, 467, 008, 280	
3. 00	Net patient revenues (line 1 minus line 2)	,		517, 490, 369	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		372, 465, 795	
5. 00	Net income from service to patients (line 3 minus line 4)	-,		145, 024, 574	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other that	an patients		0	
17. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				17. 00
18. 00					18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER REVENUE			8, 800, 108	
	Total other income (sum of lines 6-24)			8, 800, 108	
	Total (line 5 plus line 25)			153, 824, 682	
	OTHER EXPENSES (SPECIFY)			0	
28 00	Total other expenses (sum of line 27 and subscripts)			Λ	28 00

28.00

153, 824, 682 29. 00

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)

:ALCIII	Financial Systems LUTHERAN HOSPITAL ATION OF CAPITAL PAYMENT	Provi der CCN: 150017	Peri od:	u of Form CMS-2 Worksheet L	2002
JALOUI	ATTON OF CALLIAL PAINENT	Trovider con. 130017	From 07/01/2013 To 06/30/2014	Parts I-III Date/Time Pre 12/1/2014 9:5	
		Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			4, 126, 700	1.0
. 01	Model 4 BPCI Capital DRG other than outlier			0	1. C
2. 00	Capital DRG outlier payments			690, 393	2. 0
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
3. 00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	253. 15	3.0
. 00	Number of interns & residents (see instructions)			9. 02	4. 0
. 00	Indirect medical education percentage (see instructions)			1. 01	5. 0
. 00	Indirect medical education adjustment (multiply line 5 by the			41, 680	6. 0
. 00	Percentage of SSI recipient patient days to Medicare Part A p. 30) (see instructions)	atient days (Worksheet E	, part A line	3. 74	7. (
. 00	Percentage of Medicaid patient days to total days (see instru	ctions)		17. 87	8. 0
. 00	Sum of lines 7 and 8	Ct1 0113)		21. 61	9. (
0. 00	Allowable disproportionate share percentage (see instructions)		4. 48	
1. 00	Disproportionate share adjustment (line 10 times the sum of I	184, 876			
2. 00				5, 043, 649	12.
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1. (
. 00	Program inpatient ancillary capital cost (see instructions)			0	2.
. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.
. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 5.
. 00	Total Tripatrent program capital cost (Trie 3 x Trie 4)				ا ن
			,	_	
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	2.
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2)	es (see instructions)		0 0	2. 3.
.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	es (see instructions)		0 0 0 0.00	2. 3. 4.
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0 0 0 0.00	2. 3. 4. 5.
. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	structions)	line 6)	0 0 0 0.00 0	2. 3. 4. 5. 6.
00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	structions)	line 6)	0 0 0 0.00 0.00	2. 3. 4. 5. 6. 7.
00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	structions) circumstances (line 2 x	line 6)	0 0 0 0.00 0 0.00	2. 3. 4. 5. 6. 7. 8.
00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	structions) circumstances (line 2 x cable)	,	0 0 0 0.00 0.00	2. 3. 4. 5. 6. 7. 8.
.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applications) Current year comparison of capital minimum payment level to concarryover of accumulated capital minimum payment level over concarryover.	structions) circumstances (line 2 x cable) apital payments (line 8	less line 9)	0 0 0 0.00 0 0.00 0	5.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri	less line 9) or year	0 0 0 0.00 0 0.00 0 0	2. (3. (4. (5. (6. (7. (8. (9. (10. (11. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin	less line 9) or year e 11)	0 0 0 0.00 0.00 0 0 0	2. (3. (4. (5. (6. (7. (8. (9. (10. (11. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over c	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line	less line 9) or year e 11)	0 0 0 0.00 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over c (if line 12 is negative, enter the amount on this line)	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line apital payment for the f	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over c	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line apital payment for the f	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.

Health Financia	al Syst	ems	LUTHERAN HOSPITAL O	F INDIANA			In Lie	u of Form	CMS-	2552-10
This report is	requi	red by I aw (42 USC 1395	g; 42 CFR 413.20(b)). Failu	ure to report ca	an resul	t in all	interim	FORM APP	ROVED	
payments made	si nce	the beginning of the co	st reporting period being o	deemed overpayme	ents (42	USC 1395	g).	OMB NO.	0938-	0050
HOSPITAL AND H	OSPI TA	L HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN:	150017	Peri od:		Workshee		
AND SETTLEMENT	SUMMA	RY						Parts I -		
						To 06/	30/2014	Date/Tim 12/1/201		
DART I COOT	DEDODE	0747110		1				12/1/201	4 1. Z	трш
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	12/1/20	14 Tir	ne: 1	1:21 pm
use only	2. [] Manually submitted co	st report							
			l report enter the number o Enter "F" for full or "L"		vider re	esubmitted	d this co	ost repor	t	
Contractor use only	(1) (2) (3)	Settled with Audit		this Provider his Provider CC	11. C CCN 12. [ne 5, co			
	(4)	Reopened			1					

PART II - CERTIFICATION

(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 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 the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN HOSPITAL OF INDIANA (150017) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
Date	

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	630, 339	-150, 640	77, 759	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing bed - SNF	0	0	0		0	5. 00
6.00 Swing bed - NF	0				0	6. 00
200. 00 Total	0	630, 339	-150, 640	77, 759	0	200. 00
The above amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above compl	ex indicated.	

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

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150017 Peri od: Worksheet S-2 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7950 WEST JEFFERSON BLVD 1.00 PO Box: 1.00 State: IN 2.00 City: FT WAYNE Zip Code: 46804 County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 LUTHERAN HOSPITAL OF 150017 23060 1 07/01/1966 Ν 0 3.00 NDI ANA Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2013 06/30/2014 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for ves or "N" for no In-State In-State Out-of Out-of Medicai d Other Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2. 00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 6, 455 2,066 216 63 8,064 24 00 in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state 0 0 0 0 0 25.00 Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27.00 enter the effective date of the geographic reclassification in column 2.

If this is a sole community hospital (SCH), enter the number of periods SCH status in

35.00

effect in the cost reporting period.

1.00 2.00	OSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	F	Period: From 07/01 To 06/30 Beginni	/2014	Workshe Part I Date/Ti 12/1/20 Endi	me Pre	epared:
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7.00 If this is a Medicare dependent hospital (M6H), enter the number of periods MBH status in effect in the cost reporting period. 8.00 Enter applicable beginning and ending dates of MBH status. Subscript line 38 for number of periods in excess of view and enter subsequent dates. 9.00 Dees this Facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 1 "Y" for yes or "N" for no. Does the facility meet the all-eage regularements in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 1 "Y" for yes or "N" for no. Does the facility meet the all-eage regularements in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 2 "Y" for yes or "N" for no. (See Instructions) 9.00 Prospective Payment System (PPS) -Capital Deplied to the subscript of	6. 00			Subscript line	36 for number					36. 0
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Prespective Payment System (PPS)-Capital 5.00 Does this Facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.300? (see instructions) 6.00 Is this Facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.300? (see instructions) 7.00 Is this racility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no. 8.00 Is the facility electing full rederal capital payment? Enter "Y for yes or "N" for no. 9.01 Is the facility electing full rederal capital payment? Enter "Y" for yes or "N" for no. 1.20 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no. 1.20 Is the facility electing full rederal capital payment? Enter "Y" for yes or "N" for no. 1.20 Is this a hospital involved in training residents in approved GME programs rained at this facility? Enter "Y" for yes or "N" for no in column 1. I'r column 1 is "Y" did residents start training in the first month or this cost reporting period? Enter "Y" for yes or "N" for no in column 2. I'r column 2 is "Y" complete Worksheet E-4. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 3 is "Y" for yes or "N" for no in column 3. I'r column 4. See instructions) 1.00 Id your hospital receive FFE slots under ACA section 55037 Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 In the fee average number of unwelghted primary care FIEs from the hospital"s 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the average number of unwelghted pr	9. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req)? Ente Jui remen	er in column 1 nts in accordar	"Y" for yes nce with 42	_				39. 0
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8.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	6. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Work			,		N	N	N	46. 0
Sthis a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. Or "N" for no. Till films 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "N", complete Worksheet E4. If column 2 is "N", complete Worksheet D4. If column 2 is "N, column 2 is "N, column 2 is "N, column 2 is "N, column 2		Is the facility electing full federal capital payment							1	47. C 48. C
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.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents		g.: (Pr		0	FTE Co	ount	Direct (Cou	GME FTE	-
column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE	. 10	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the		1.00	2.00	3.00				61.

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150017 Peri od: Worksheet S-2 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am Program Code Unweighted IME Program Name Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Non-Provider Settings 63.00 Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) N 63.00 Unwei ghted Unwei ghted Ratio (col. 1/ FTEs in FTES (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident 0. 00 0. 00 0.000000 66.00

FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

	instructions) Enter "Y" for yes or "N" for no in the applicable column.			
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter	N	N	93. 00
	"Y" for yes or "N" for no in the applicable column.			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00
	applicable column.			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N	N	96. 00
	applicable column.			
97. 00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	97. 00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105. 00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment			106. 00
	for outpatient services? (see instructions)			

Health Financial Systems LUTHERAN HOSPIT. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150017	Period: From 07/01 To 06/30	/2013	w of For Workshoper Part I Date/Ti 12/1/20	et S-: me Pro	2 epared:
			1. 00	`	XI		4
107.00 Column 1: If this facility qualifies as a CAH, is it eligil for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on We 25 and the program would be cost reimbursed. If yes complete Column 2: If this facility is a CAH, do I&Rs in an approved train in the CAH's excluded IPF and/or IRF unit? Enter "Y' column 2. (see instructions)	o in column 1. Orksheet B, Pa e Worksheet D- d medical educa " for yes or "I	(see rt I, column 2, Part II. ation program N" for no in		J	2.(<u>JU</u>	107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				a b	Docni r	atony	108.00
	Physi cal 1.00	Occupationa 2.00	3. 00		Respir 4.		+
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.							109.00
				1. 00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of enter the method used (A, B, or E only) in column 2. If column it is in the provider "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital providers 15-1. \$2208.1.	umn 2 is "E", e for long term	enter in colu care (includ	mn 3 les	N		0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insulan			"N" for	N N			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i			1			118. 00
		Premiums	Losse	es	Insur	ance	
		1. 00	2.00)	3. (00	
118.01 List amounts of malpractice premiums and paid losses:		617, 3	74 18	39, 118			0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.			1. 00 N)	2. (00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies the Hold Harmless provision in ACA §3121 and applicable amendments.	n column 1 "Y" ualifies for tl	for yes or he Outpatient			N	I	119. 00 120. 00
Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y				121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	for yes and "N"	for no. If	Y				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification date				2008			126. 00
yes, enter certification date(s) (mm/dd/yyyy) below.		fication date					
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2	2. ter the certifi 2.	ication date	02/16/1				
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ender in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, ender in column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, ender in column 1 and termination date, if applicable, in column 1	 ter the certifi ter the certifi . 	ication date	02/16/1				128. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, entocolumn 1 and termination date, if applicable, in column 2.130.00 If this is a Medicare certified pancreas transplant center,	2. ter the certifi 2. ter the certifi 2. er the certifi enter the certifi	ication date ication date cation date i	02/16/1				128. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.	2. ter the certifi 2. ter the certifi 2. er the certifi enter the certifi tumn 2. r, enter the certifi	ication date ication date cation date i tification	02/16/1				128. 00 129. 00 130. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, encolumn 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 101	2. ter the certification the certification the certification the certification the certification that the certification the certification that the certification	ication date ication date cation date itification date itification	02/16/1				128. 00 129. 00 130. 00 131. 00
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yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ender in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 and	2. ter the certification the certification and the certification are the certification as the certification are the certification as the certification are the certification as the certification are the certification and the certification are	ication date ication date cation date itification ertification ication date ication date in column 1	02/16/1		449008		128. 00 129. 00 130. 00 131. 00 132. 00 133. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	LUTHERAN HOSP X IDENTIFICATION DATA			l: 15001	7 Perio		u of Form CMS Worksheet S-	
						07/01/2013	Part I	ononod.
					То	06/30/2014	Date/Time Pr 12/1/2014 9:	
1.00		. 00			<u>'</u>	3. 00		
If this facility is part of a chai				143 th	ne name a	ind address	of the	
home office and enter the home off 41.00 Name: COMMUNITY HEALTH SYSTEMS	Contractor name and		number.	Contr	actor's l	Number: 1030	.1	
42.00 Street: 4000 MERIDIAN BLVD	PO Box:	WF3		COITE	actor 5 i	Number . 1030	'1	142. 0
43. 00 Ci ty: FRANKLI N		TN		Zip C	ode:	3706	7	143. 0
							1 00	
44.00 Are provider based physicians' cos	ts included in Workshop	+ 12					1. 00 Y	144. 0
45.00 f costs for renal services are cl			hev co	sts for	inpatie	nt	Y	145. 0
services only? Enter "Y" for yes o		71, 410 1		313 101	Theatro		•	1 10. 0
						1 00	2.00	_
46.00 Has the cost allocation methodolog	v changed from the previ	iously filed	cost r	enort?		1. 00 N	2. 00	146. 0
Enter "Y" for yes or "N" for no in					es,	IV		140.0
enter the approval date (mm/dd/yyy		,		-, ,	.			
47.00 Was there a change in the statisti						N		147. 0
48.00 Was there a change in the order of					_	N		148. 0
49.00 Was there a change to the simplifino.	ea cost finding method?	Enter "Y" To	or yes	or "N"	Tor	N		149. 0
ITO.		Part A		Part		Title V	Title XIX	
		1.00		2.00		3. 00	4. 00	
Does this facility contain a provi								
or charges? Enter "Y" for yes or " 55.00Hospital	N for no for each comp	N	t A an	<u>u Part</u> N	в. (See	42 CFR 9413 N	N N	 155. 0
56.00 Subprovider - IPF		N N	İ	N		N	N N	156. 0
57.00 Subprovi der - IRF		N	İ	N		N	N	157. 0
58. 00 SUBPROVI DER								158. 0
59. 00 SNF		N		N		N	N	159. 0
60. OO HOME HEALTH AGENCY 61. OO CMHC		N		N N		N N	N N	160. 0 161. 0
81. OO CMITC				IN		IN	IV	161. 0
							1. 00	
Mul ti campus						0001.0		۱.,. ۵
65.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus nospitai that has o	one or more c	ampuse	s in ai	rrerent	CBSAS?	N	165. C
Enter 1 for yes of 10 for no.	Name	County		State	Zip Cod	e CBSA	FTE/Campus	
	0	1. 00		2. 00	3.00	4. 00	5. 00	
66.00 If line 165 is yes, for each							O. C	00 166. C
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								
							1. 00	+
Health Information Technology (HIT) incentive in the Amer	i can Recovery	and R	ei nvest	ment Act		1.00	
67.00 s this provider a meaningful user	under Section §1886(n)	? Enter "Y"	for ye	s or "N	l" for no		Y	167. C
68.00 If this provider is a CAH (line 10			line 1	67 is "	Y"), ent	er the		0168.0
reasonable cost incurred for the H 69.00 of this provider is a meaningful u			AU (I:	00 10F	ic "N")	ontor the	0.5	50169. 0
transition factor. (see instruction)		u is not a C	AH (II	ie 105	15 N),	enter the	0.5	04104. (
12. district ractor. (300 matractic	,					Beai nni na	Endi na	_

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)

Begi nni ng

1. 00

10/01/2012

Endi ng

2.00

09/30/2013

	Financial Systems L AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	LUTHERAN HOSPITAL OF			Peri od:	eu of Form CMS- Worksheet S-2	
					From 07/01/2013 To 06/30/2014	Date/Time Pre	
					Y/N	12/1/2014 9:5 Date	5 a
	<u> </u>				1.00	2.00	
	General Instruction: Enter Y for all YES responded/yyyy format. COMPLETED BY ALL HOSPITALS	ponses. Enter N for	all NO re	sponses. Enter	all dates in	the	
0	Provider Organization and Operation Has the provider changed ownership immediate	Ly prior to the heai	nni ng of	the cost	N	<u> </u>	1
,,,	reporting period? If yes, enter the date of			instructions)			
				1. 00	2. 00	V/I 3. 00	-
0	Has the provider terminated participation in			N N	2.00	3.00	
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3,	"V" for				
0	Is the provider involved in business transact	tions, including man	agement	Y			;
	contracts, with individuals or entities (e.g.						
	or medical supply companies) that are related officers, medical staff, management personnel						
	of directors through ownership, control, or						
	relationships? (see instructions)			Y/N	Type	Date	
				1.00	2. 00	3. 00	
	Financial Data and Reports	normal by - Co. LLCL.	Dut-1:	N.		0/ /20 /2012	
0	Column 1: Were the financial statements prepaccountant? Column 2: If yes, enter "A" for			N		06/30/2013	
	or "R" for Reviewed. Submit complete copy or	enter date availabl					
0	column 3. (see instructions) If no, see instructions are the cost report total expenses and total		from	l N			
U	those on the filed financial statements? If			IN IN			
					Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
0	Column 1: Are costs claimed for nursing scho	ool? Column 2: If y	es, is th	ne provider is	N		1
0	the legal operator of the program? Are costs claimed for Allied Health Programs'	2 lf "V" coo instruc	tions		Υ		
0	Were nursing school and/or allied health produced			I during the	N		
0	cost reporting period? If yes, see instruction						
0	Are costs claimed for Intern-Resident program yes, see instructions.	ms claimed on the cu	rrent cos	st report? If	Y		
00	Was an Intern-Resident program been initiated	d or renewed in the	current c	ost reporting	N		1
00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & P	in an ∧nn	roved	N		1
00	Teaching Program on Worksheet A? If yes, see		ін ан Арр	n oved	IN		'
						Y/N 1. 00	
	Bad Debts						
	Is the provider seeking reimbursement for back					Y	
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del				st reporting		
00	Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	bt collection policy	change c	luring this cos		Y	1
00	Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	bt collection policy and/or co-payments w	change c	luring this cos	ructions.	Y N	1
00	Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	bt collection policy and/or co-payments w	change c	luring this cos yes, see inst	ructions.	Y N	1
00	Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	bt collection policy and/or co-payments w or cost reporting pe Description	change o	yes, see instructions yes, yes, yes, yes, yes, yes, yes, yes	ructions. rt A Date	Y N N Part B Y/N	1
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior	bt collection policy and/or co-payments w or cost reporting pe	change o	yes, see instructions	ructions.	Y N N	1:
00	Is the provider seeking reimbursement for bactering line 12 is yes, did the provider's bad deleperiod? If yes, submit copy. If line 12 is yes, were patient deductibles and Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R	bt collection policy and/or co-payments w or cost reporting pe Description	change o	yes, see instructions yes, yes, yes, yes, yes, yes, yes, yes	ructions. rt A Date	Y N N Part B Y/N	1 1
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00 00 00	Is the provider seeking reimbursement for bacteristic line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns	bt collection policy and/or co-payments w or cost reporting pe Description 0	change o	yes, see instruction of the second of the se	ructions. ructions. The Date 2.00	Y N N Part B Y/N 3.00	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1
00 00 00 00	Is the provider seeking reimbursement for bacteristic line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments	bt collection policy and/or co-payments w or cost reporting pe Description 0	change o	yes, see instruction of the second of the se	ructions. ructions. The Date 2.00	Y N N Part B Y/N 3.00	11 11 11 11 11 11 11 11 11 11 11 11 11
00 00 00 00	Is the provider seeking reimbursement for bacteristic line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional	bt collection policy and/or co-payments w or cost reporting pe Description 0	change o	yes, see instruction with the second with the	ructions. ructions. The Date 2.00	Y N N N Part B Y/N 3.00	1 1 1 1 1 1
00 00 00 00	Is the provider seeking reimbursement for bacteristic line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 . (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not	bt collection policy and/or co-payments w or cost reporting pe Description 0	change o	yes, see instruction with the second with the	ructions. ructions. The Date 2.00	Y N N N Part B Y/N 3.00	1 1 1 1 1 1
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	bt collection policy and/or co-payments w or cost reporting pe Description 0	change o	yes, see instruction with the second with the second with th	ructions. ructions. The Date 2.00	Y N N N Part B Y/N 3.00 Y N	1:
00 00 00 00	Is the provider seeking reimbursement for bacteristic line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments	bt collection policy and/or co-payments w or cost reporting pe Description 0	change o	yes, see instruction with the second with the	ructions. ructions. The Date 2.00	Y N N N Part B Y/N 3.00	1:
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	bt collection policy and/or co-payments w or cost reporting pe Description 0	change o	yes, see instruction with the second with the second with th	ructions. ructions. The Date 2.00	Y N N N Part B Y/N 3.00 Y N	1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1
00 00 00 00	Is the provider seeking reimbursement for bact of line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles as Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	bt collection policy and/or co-payments w or cost reporting pe Description 0	change o	yes, see instruction with the see instruction of the see instruction	ructions. ructions. The Date 2.00	Y N N N Part B Y/N 3.00 Y N N	1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1
00 00 00 00	Is the provider seeking reimbursement for back of line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report data for corrections of other PS&R Report information? If yes, see	and/or co-payments wor cost reporting pe Description 0	change o	yes, see instruction with the second with the second with th	ructions. ructions. The Date 2.00	Y N N N Part B Y/N 3.00 Y N	12 13 14 15 16 17 18 18 19 20

Heal th	Financial Systems	LUTHERAN HOSPITAL O	F INDIANA		In lie	eu of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		Provi der C		Period: From 07/01/2013 To 06/30/2014	Worksheet S Part II	i-2 Prepared:
				Pa	rt A	Part B	
		Descriptio	n	Y/N	Date	Y/N	
		0		1. 00	2.00	3.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT C	HILDRENS HOS	SPI TALS)			
22.00	Capital Related Cost	0.16	A			1	
22. 00 23. 00	3						22. 00 23. 00
24. 00							24. 00
25. 00							25. 00
26. 00							26. 00
27. 00	Has the provider's capitalization policy charcopy.	nged during the cos	t reporting	period? If y	/es, submit		27. 00
28 00	Interest Expense Were new Loans, mortgage agreements or letter	rs of credit entere	d into duri	na the cost r	reporting		28. 00
20.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					20.00	
29. 00							29. 00
30. 00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.						30. 00
31. 00							31. 00
	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.						32. 00
33. 00						33. 00	
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34. 00	
35. 00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			s with the pr	rovi der-based		35. 00
	private and during the door reporting period:	,05, 500 1115114	01.0110.		Y/N	Date	
					1. 00	2. 00	
	Home Office Costs						
	Were home office costs claimed on the cost re				Y		36. 00
37. 00	If line 36 is yes, has a home office cost stallf yes, see instructions.	atement been prepar	ed by the ho	ome office?	Υ		37. 00

36.00	Were home office costs claimed on the cost report?				36. 00	
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office?				37. 00	
	If yes, see instructions.					
38. 00	If line 36 is yes , was the fiscal year end of the home office different from that of			12/31/2013	38. 00	
	the provider? If yes, enter in column 2 the fiscal year en					
39. 00	If line 36 is yes, did the provider render services to other chain components? If yes,				39. 00	
	see instructions.					
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see				40. 00	
	instructions.					
		1.00	2.	00		
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	LISA	PARRI SH		41. 00	
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
42.00	Enter the employer/company name of the cost report	CHS			42.00	
	preparer.					
43.00	Enter the telephone number and email address of the cost	elephone number and email address of the cost (615) 465-7554 LISA_PARRISH@CHS.NET		HS. NET	43.00	
	report preparer in columns 1 and 2, respectively.					

From 07/01/2013 To 06/30/2014 Part II Date/Time Prepared: 12/1/2014 9:55 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 11/04/2014 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer.

43.00

43.00

Enter the telephone number and email address of the cost

report preparer in columns 1 and 2, respectively.

 Heal th Financial
 Systems
 LUTHERAN

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared:

					To	06/30/2014	Date/Time Prep 12/1/2014 9:5	
							I/P Days / 0/P) alli
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Davs	CAH Hours	Title V	
	Component	Line Number	INO.	OI BCGS	Avai I abl e	CAIT HOULS	TI LIC V	
		1.00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		234	85, 410	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			234	85, 410	0. 00	0	7. 00
0.00	beds) (see instructions)	21.00			0	0.00		0.00
8.00	INTENSIVE CARE UNIT	31.00		0	7 200	0.00	0	8. 00
8. 01 8. 02	PEDIATRIC INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 01 31. 02		20 24	7, 300 8, 760	0. 00 0. 00	0	8. 01 8. 02
8. 02 8. 03	CARDIO INTENSIVE CARE UNIT	31. 02 31. 03		24 84	30, 660	0.00	0	8. 02 8. 03
9. 00	CORONARY CARE UNIT	32.00		24	8, 760	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	32.00		24	8, 700	0.00	U	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)	10.00		386	140, 890	0.00	0	14. 00
15. 00	CAH visits				,		Ö	15. 00
16. 00	SUBPROVIDER - IPF	40. 00		o	0		Ö	16. 00
17.00	SUBPROVIDER - IRF							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)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			386				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF				0			31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room			0	0			32. 00 32. 01
32. UI	outpatient days (see instructions)							32. UI
33 00	LTCH non-covered days			ŀ				33. 00
55. 00	21011 Horr covered days		ı	ı				55.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

outpatient days (see instructions)

LTCH non-covered days

0

0

32.00

32.01

33.00

12/1/2014 9:55 am Full Time Equivalents I/P Days / O/P Visits / Trips Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 20, 460 3, 758 51, 738 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 18.262 10, 186 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 20, 460 3, 758 51, 738 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 8.00 PEDIATRIC INTENSIVE CARE UNIT 8.01 0 88 906 8.01 8.02 NEONATAL INTENSIVE CARE UNIT 0 674 4,545 8.02 7, 379 8.03 CARDIO INTENSIVE CARE UNIT 1, 590 28,006 8.03 9.00 CORONARY CARE UNIT 425 7, 206 9.00 2.442 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 NURSERY 1, 969 13.00 143 13.00 Total (see instructions) 2, 031. 33 14.00 30, 281 6,678 94, 370 8.14 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 0 0.00 0.00 16.00 17 00 SUBPROVIDER - IRF 17 00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 20.00 OTHER LONG TERM CARE 21 00 21 00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 0 0 Ω 24.10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26, 25 26, 25 2,031.33 27 00 Total (sum of lines 14-26) 8 14 27 00 28. 00 Observation Bed Days 752 28.00 29.00 Ambul ance Trips 29.00 0 Employee discount days (see instruction) 30.00 0 30.00 31.00 Employee discount days - IRF 0 31.00

32.00

32.01

33.00

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared:
 Heal th Financial
 Systems
 LUTHERAN

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 150017

				To	06/30/2014	Date/Time Prep 12/1/2014 9:5	
		Full Time		Di scha	arges	12/1/2014 7.3	Jani
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
4 00		11. 00	12. 00	13.00	14.00	15.00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	5, 667	1, 028	18, 500	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			3, 098	o		2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
8. 01 8. 02	PEDIATRIC INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT						8. 01 8. 02
8. 03	CARDIO INTENSIVE CARE UNIT						8. 03
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	5, 667	1, 028	18, 500	
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - I PF	0. 00	0	0	0	0	16. 00
17. 00	SUBPROVI DER - I RF						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	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						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 29. 00	Observation Bed Days Ambulance Trips						28. 00 29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provi der CCN: 150017

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared:

					T	06/30/2014	Date/Time Pre 12/1/2014 9:5	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷	
				Worksheet A-6)	3)	col. 4	col. 5)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1.00	SALARIES Total salaries (see	200. 00	104, 079, 412	0	104, 079, 412	4, 188, 065. 00	24. 85	1.00
	instructions)	2001.00	.0.,0,,,		101/07//112	.,,	233	
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3.00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
	В		_					
4. 00	Physician-Part A -		0	0	0	0. 00	0.00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	4. 01
5.00	Physician-Part B		0	0	0	0. 00		
6. 00 7. 00	Non-physician-Part B	21. 00	0	0	0	0. 00 0. 00		
7.00	Interns & residents (in an approved program)	21.00	0	0	U	0.00	0.00	7.00
7. 01	Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office personnel		0	0	0	0.00	0.00	8. 00
9.00	SNF	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		2, 481, 758	475, 001	2, 956, 759	115, 517. 72	25. 60	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		13, 595	0	13, 595	519. 75	26. 16	11. 00
12. 00	Care Contract Labor: Top Level		95, 689	0	95, 689	429. 82	222, 63	12.00
	management and other		•					
	management and administrative services							
13. 00	Contract Labor: Physician-Part		539, 437	0	539, 437	3, 601. 00	149. 80	13. 00
14.00	A - Administrative		0		0	0.00	0.00	14.00
14. 00	Home office salaries & wage-related costs		Ü	0	0	0. 00	0.00	14. 00
15. 00	Home office: Physician Part A		7, 895, 360	0	7, 895, 360	110, 010. 00	71. 77	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16. 00
	Physicians Part A - Teaching]
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		21, 545, 122	0	21, 545, 122			17. 00
	instructions)		2.70.07.122		2.70.07.122			
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		672, 743	0	672, 743			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
	В		_					
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25.00	approved program)				<u> </u>			25.00
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	720, 074	0	720, 074	25, 196. 00	28. 58	26. 00
27. 00	Administrative & General	5. 00	10, 280, 456			·		
28. 00	Administrative & General under		0	0	0	0.00		1
20.00	contract (see inst.)	4 00	0		0	0.00	0.00	29. 00
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	1, 697, 225	0	1, 697, 225	0. 00 72, 469. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32.00	Housekeepi ng	9. 00	1, 748, 247	0	1, 748, 247	144, 010. 00		
33. 00	Housekeeping under contract (see instructions)		0	١	U	0. 00	0.00	33. 00
34.00	Di etary	10. 00	2, 737, 970	-1, 507, 680	1, 230, 290			
35. 00	Di etary under contract (see instructions)		0	0	0	0. 00	0. 00	35. 00
36. 00	Cafeteri a	11. 00	0	1, 544, 259	1, 544, 259	114, 187. 41	13. 52	
37. 00	Maintenance of Personnel	12.00	0	0	0	0.00		
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	4, 442, 002 1, 359, 737		1, 525, 972 1, 760, 071	39, 563. 00 105, 846. 00		38. 00 39. 00
40. 00		15. 00	5, 636, 234		5, 636, 234			40.00
		'		'				

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA				In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3		
					From 07/01/2013			
				'	To 06/30/2014			
						12/1/2014 9: 5	<u>am</u>	
	Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly		
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
			(from	(col.2 ± col.	Salaries in	col . 5)		
			Worksheet A-6)	3)	col. 4			
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00		
41.00 Medical Records & Medical	16. 00	1, 895, 941	812, 151	2, 708, 09	2 135, 125. 00	20. 04	41.00	
Records Li brary								
42.00 Social Service	17. 00	0	1, 956, 174	1, 956, 17	4 62, 764. 00	31. 17	42.00	
43.00 Other General Service	18. 00	0	0		0.00	0.00	43.00	

HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 07/01/2013 To 06/30/2014		
		Worksheet A		Recl assi fi cati	,		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col . 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		104, 079, 412	0	104, 079, 41:	2 4, 188, 065. 00	24. 85	1.00
	instructions)							
2. 00	Excluded area salaries (see instructions)		2, 481, 758	475, 001	2, 956, 75	9 115, 517. 72	25. 60	2. 00
3.00	Subtotal salaries (line 1		101, 597, 654	-475, 001	101, 122, 65	3 4, 072, 547. 28	24. 83	3. 00
	minus line 2)							
4. 00	Subtotal other wages & related costs (see inst.)		8, 544, 081	0	8, 544, 08	1 114, 560. 57	74. 58	4. 00
5.00	Subtotal wage-related costs (see inst.)		21, 545, 122	0	21, 545, 12:	0.00	21. 31	5. 00
6.00	Total (sum of lines 3 thru 5)		131, 686, 857			6 4, 187, 107. 85	31. 34	6. 00
7. 00	Total overhead cost (see instructions)		30, 517, 886	-475, 000	30, 042, 88	6 1, 377, 671. 00	21. 81	7. 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150017	From 07/01/2013	Worksheet S-3 Part IV Date/Time Prepared:

PART IV - WAGE RELATED COSTS Part A - Core List		To 06/30/2014	Date/Time Prep 12/1/2014 9:5	pared: 5 am
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST				
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 2, 258, 144 1.00 401K Empl oyer Contribution 2, 258, 144 1.00 401K Empl oyer Contribution 2, 258, 144 1.00 3.00 1.00 401K Empl oyer Contribution 2, 258, 144 1.00 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 4.00 4.			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 0 0 0 0 0 0 0 0 0	1.00	401K Employer Contributions	2, 258, 144	1. 00
A. 00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration Fees 0 6.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST Health Insurance (Purchased or Self Funded) 10,711,851 8.00 9.00 Prescription Drug Plan 0 9.00 203,327 10.00 200 200,00	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
5.00	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
Legal / Accounting / Management Fees - Pension Plan		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
To be	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST 10,711,851 8.00 Heal th Insurance (Purchased or Self Funded) 10,711,851 8.00 10,000 10,	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
Heal th Insurance (Purchased or Self Funded) 10,711,851 8.00 9.00 10	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 203,327 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 89,033 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) -1,231 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 33,639 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 "Workers' Compensation Insurance 913,039 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 IRCA-Employers Portion Only 6,026,920 17.00 18.00 Medicare Taxes - Employers Portion Only 1,409,522 18.00 19.00 Unemployment Insurance 0 1,003,776 20.00 State or Federal Unemployment Taxes 1,003,776 20.00 0THER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 22.00 Day Care Cost and Allowances <td< td=""><td></td><td>HEALTH AND INSURANCE COST</td><td></td><td></td></td<>		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 203, 327 10.00	8.00	Health Insurance (Purchased or Self Funded)	10, 711, 851	8. 00
11.00 Life Insurance (If employee is owner or beneficiary) 89,033 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) -1,231 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 33,639 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 913,039 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion)	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	203, 327	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 17.00 Non cumulative portion) 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 10.00 Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	89, 033	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only Redicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	-1, 231	12. 00
15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost in Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Heal th Care Cost (Non Only 16.00 16. 00 16. 00 16. 00 16. 00 17. 00 19. 00 21. 00 21. 00 22. 00 22. 00 24. 00 Part B - Other than Core Related Cost 24. 00	13.00	Disability Insurance (If employee is owner or beneficiary)	33, 639	13.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuit ion Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion TAXES 17.00 FI CA-Employers Portion Only 6,026,920 17.00 18.00 Medicare Taxes - Employers Portion Only 1,409,522 18.00 19	15.00	'Workers' Compensation Insurance	913, 039	15. 00
TAXES 17. 00 FI CA-Empl oyers Portion Only 17. 00 18. 00 Medi care Taxes - Empl oyers Portion Only 18. 00 Medi care Taxes - Empl oyers Portion Only 18. 00 19. 00	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00 Fi CA-Employers Portion Only 6, 026, 920 17. 00 18. 00 Medicare Taxes - Employers Portion Only 1, 409, 522 18. 00 19. 00				
18.00 Medicare Taxes - Employers Portion Only 1, 409, 522 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 1,003,776 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 22,648,020 24.00 Part B - Other than Core Related Cost				
19.00 Unemployment Insurance 0 19.00 State or Federal Unemployment Taxes 0 1,003,776 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuit ion Reimbursement 0 23.00 Tuit ion Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 22,648,020 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 1,003,776 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 22,648,020 Part B - Other than Core Related Cost			1, 409, 522	18. 00
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			0	19. 00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20.00		1, 003, 776	20. 00
instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost		* · · · = · ·		
22. 00	21. 00		0	21. 00
23. 00	00.00		0	00.00
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 22,648,020 24.00				
Part B - Other than Core Related Cost				
	24.00		22, 648, 020	24.00
25. UU UI HEK EMPLUYEE BENEFI I S	25 00		420 452	25 00
	∠5. UÜ	UITEK EMPLOTEE DENEFITS	-430, 153	25.00

Heal th	Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150017	Peri od:	Worksheet S-3	
			From 07/01/2013		
			To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	Cost Center Description		Contract Labor		Jani
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ident	i fi cati on:			1
1.00	Total facility's contract labor and benefit	cost	0	0	1.00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - IPF		0	0	3. 00
4.00	Subprovi der - I RF				4. 00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospital-Based SNF				8. 00
9.00	Hospital-Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospital-Based HHA				11. 00
12. 00	Separately Certified ASC				12. 00
13.00	Hospi tal -Based Hospi ce				13. 00
14.00	Hospital-Based Health Clinic RHC				14. 00
	Hospital-Based Health Clinic FQHC				15. 00
16. 00	Hospi tal -Based-CMHC				16. 00
17. 00	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

HOSPITAL UNCOMPRISATED AND INDIGENT CARE DATA	Heal th	Financial Systems LUTHERAN HOSPITAL OF	I NDI ANA		In Lie	u of Form CMS-2	2552-10		
Incorporated and Indigent care cost computation	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150017		Worksheet S-10	0		
Incompensated and indigent care cost computation 1.00						D . /T' D			
Uncompensated and Indigent care cost computation					10 06/30/2014				
Uncompensated and indigent care cost computation 0.00						127 17 2011 7. 0	o din		
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)						1. 00			
Medicaid (See Instructions for each line) 47,171,837 2.0									
Net revenue from Medicaid 47,171,837 2.00 2	1.00		ded by li	ne 202 column	8)	0. 161561	1. 00		
3.00 10 you receive DSH or supplemental payments from Medicaid?	0.00					47 474 007	0.00		
1			navmonts	from Modicaio	12	IN			
Medical d charges		1	, ,	II olii wedi carc	1 :	0			
Medical d cost (line 1 times line 6) 34,543,150 7.00 8.00 0 1 1 1 1 1 1 1 1		11 13	wear car a			-			
8.00		1							
State Children's Heal th Insurance Program (SCHIP) (see instructions for each line) 9, 00 0.00 0.00 0.00 0.00 0.10 0.00	8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	es 2 and 5; if		8. 00		
9.00 Not revenue from stand-alone SCHIP 0 0 0 0 0 0 0 0 0									
10.00 Stand-alone SCHIP charges 0 10.00 11.00 Stand-alone SCHIP cost (line 1 times line 10) 0 11.00 12.00 0 11.00 0 0 11.00 0 0 11.00 0 12.00 0 0 12.00 0 0 12.00 0 0 0 12.00 0 0 0 12.00 0 0 0 0 0 0 0 0 0			ons for e	ach line)					
11. 00 Stand-al one SCHIP cost (line 1 times line 10) 11. 00 12. 00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero) 12. 00 20. 00 13. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 15. 00 15. 00 16. 913, 445 14. 00 15. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 16. 00 16. 913, 445						-			
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 1,996,099 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 10) 10.00 10.0						_			
enter zero) Other state or local government indigent care program (see instructions for each line) 13. 00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 16, 913, 445 14. 00 10) 15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unrel mbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 736, 454 19. 00 20. 00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1, 223, 476 8, 063, 005 20. 00 21. 00 Total initial obligation of patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21. 00 22. 00 Partial payment by patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21. 00 23. 00 Cost of charity care (line 21 minus line 22) 1, 088, 847 179, 403 1, 265, 250 23. 00 24. 00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care p		1	l: no 11 m	inua lina O.	if . zono thon	-			
Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included in lines 2, 5 or 9) 1,996,099 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 10) 15.00 State or local indigent care program cost (line 1 times line 14) 2,732,553 15.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17.00 Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations 0 18.00 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 Total initial obligation of patients approved for charity care (at full 6,839,529 1,223,476 8,063,005 10.00 Cost of initial obligation of patients approved for charity care (at full 6,839,529 1,223,476 8,063,005 17.00 Cost of initial obligation of patients approved for charity care (line 1 1,105,001 197,666 1,302,667 17.00 Cost of initial obligation of patients approved for charity care (line 1 1,105,001 197,666 1,302,667 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost of charity care (line 21 minus line 22) 1,085,847 179,403 1,265,250 17.00 Cost	12.00	· ·	ime ii iii	inus iine 9;	ii < Zero then	U	12.00		
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 16, 913, 445 14.00 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) 17.00 Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 18.00 18.01 19.00 2.00 18.00 National patients 0 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 19.00 18.00			uctions f	or each line)					
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 16, 913, 445 14.00 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 10.00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1,223, 476 8, 063, 005 20.00 10.00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1,223, 476 8, 063, 005 20.00 10.00 Total initial obligation of patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21.00 10.00 Total payment by patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21.00 10.00 Total payment by patients approved for charity care 19, 154 18, 263 37, 417 22.00 10.00 Total bad debt systems of the entire hospital complex (see instructions) 29, 475, 391 26.00 10.00 Total bad debts for the entire hospital complex (see instructions) 29, 353, 637 28, 00 11.00 Total bad debts for the entire hospital complex (see instructions) 29, 353, 637 28, 00 11.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 742, 403 29, 00 11.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6, 007, 653 30, 00	13. 00					1, 996, 099	13. 00		
15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 736, 454 16.00 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 Covernment grants, appropriations or transfers for support of hospital operations 0 18.00 Covernment grants, appropriations or transfers for support of hospital operations 0 18.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 19.00 19.00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1, 223, 476 19.00 19.00 19.00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1, 223, 476 19.00 19.00 19.00 Cost of initial obligation of patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 19.00 19.00 19.00 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 21 minus line 22) 19.10 Cost of charity care (line 24 is "yes," charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 19.10 Cost of charity care and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.353, 637 28.00 Cost of on-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4,742,403 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,007,653 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,007,653 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6.00									
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 136, 454 local 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care (overnment grants, appropriations or transfers for support of hospital operations (sum of lines 736, 454 local 19,00 local 20,00 local 20,00 local 30,00 lo		10)							
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18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 736, 454 19.00 Uninsured patients Insured 17 00		ding char	ity care		0	17 00			
Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients patients						-			
8, 12 and 16) Uninsured patients Total (col. 1 patients Pa					s (sum of lines	736, 454			
patients patients + col. 2) 20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20) 22.00 Partial payment by patients approved for charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 2 times line 28) 3.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4.742, 403 29, 00 6.007, 653 30.00		8, 12 and 16)							
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30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,007,653 30.00	28. 00					29, 353, 637	28. 00		
			nse (line	1 times line	28)				
31.00 lotal unreimbursed and uncompensated care cost (line 19 plus line 30) 6,744,107 31.00			20)						
	31.00	liotal unreimbursed and uncompensated care cost (line 19 plus line)	e 30)			6, 744, 107	31.00		

	Financial Systems	LUTHERAN HOSPITAL	OF INDIANA		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	F	Period: From 07/01/2013	Worksheet A	
					o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
						(col. 3 +-	
		1.00	2.00	3. 00	4. 00	<u>col . 4)</u> 5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		6, 356, 295	6, 356, 295			
2.00	00200 CAP REL COSTS-MVBLE EQUIP	700 074	15, 103, 594	15, 103, 594		20, 597, 860	
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMITTING	720, 074 10, 280, 456	1, 138, 217 100, 302, 876	1, 858, 291 110, 583, 332		15, 626, 621 40, 073, 399	4. 00 5. 01
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	10, 280, 430	100, 302, 870	110, 363, 332		48, 494, 448	
7. 00	00700 OPERATION OF PLANT	1, 697, 225	9, 501, 671	11, 198, 896		11, 191, 813	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 319, 950	1, 319, 950	-74	1, 319, 876	
9.00	00900 HOUSEKEEPI NG	1, 748, 247	1, 234, 312	2, 982, 559		2, 982, 559	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 737, 970	3, 442, 272	6, 180, 242 (2, 856, 081 3, 584, 948	
13.00	01300 NURSING ADMINISTRATION	4, 442, 002	1, 017, 420	5, 459, 422		1, 718, 963	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 359, 737	40, 772, 131	42, 131, 868		6, 096, 137	1
15. 00	01500 PHARMACY	5, 636, 234	26, 184, 685	31, 820, 919			•
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 895, 941	1, 084, 027	2, 979, 968		4, 376, 479	
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0 2, 785, 941	2, 785, 941	_,,,	2, 125, 305 0	17. 00 21. 00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		2, 765, 941	2, 700, 941	-2, 785, 941 2, 785, 941	2, 785, 941	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	178, 102	110, 358	288, 460		288, 384	
23. 01	02301 PHARMACY RESIDENCY PROGRAM	156, 737	25, 063	181, 800	0	181, 800	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	17 (00 000		0.4.0.47.005		22 542 222	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	17, 620, 303 14, 350, 394	6, 626, 782 3, 333, 330	24, 247, 085 17, 683, 724		22, 542, 820 0	1
31.00	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 141, 036	620, 542	2, 761, 578		894, 996	
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	2, 141, 030	020, 342	2, 701, 370	2, 752, 477	2, 752, 477	
31. 03	03101 CARDIO INTENSIVE CARE UNIT	0	0	C	12, 296, 057	12, 296, 057	1
32. 00	03200 CORONARY CARE UNIT	0	0	C	4, 486, 796		1
40.00	04000 SUBPROVI DER - I PF	0	0	(4.47	0	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	61, 477	61, 477	272, 240	333, 717	43.00
50. 00	05000 OPERATING ROOM	8, 451, 902	12, 865, 631	21, 317, 533	-3, 963, 051	17, 354, 482	50.00
51.00	05100 RECOVERY ROOM	2, 799, 775	730, 080	3, 529, 855	-3, 529, 855	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		.,	1, 384, 727	1
53.00	05300 ANESTHESI OLOGY	120, 836	3, 990, 324	4, 111, 160		3, 956, 580	1
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 PET SCAN	3, 613, 216 550, 213	2, 136, 340 63, 166	5, 749, 55 <i>6</i> 613, 379		5, 561, 956 196, 887	1
56. 00	05600 RADI OI SOTOPE	353, 944	1, 780, 768	2, 134, 712		1, 564, 130	1
57.00	05700 CT SCAN	642, 653	201, 899	844, 552		837, 452	
58. 00	05800 MRI	374, 374	35, 865	410, 239		0	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	4, 470, 469 3, 709, 962	10, 221, 652 1, 327, 512	14, 692, 121 5, 037, 474		14, 465, 671 4, 408, 187	1
66. 00	06600 PHYSI CAL THERAPY	2, 183, 248	616, 864	2, 800, 112			
	06700 OCCUPATI ONAL THERAPY	515, 108	46, 461	561, 569			67. 00
68. 00	06800 SPEECH PATHOLOGY	228, 996	25, 789	254, 785		0	
69. 00	06900 ELECTROCARDI OLOGY	3, 132, 380	1, 751, 483	4, 883, 863		1, 079, 353	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(1, 393, 284 17, 574, 253	1, 393, 284 17, 574, 253	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	(18, 785, 922	18, 785, 922	
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	Ö	Č	24, 190, 648	24, 190, 648	
74. 00	07400 RENAL DIALYSIS	0	1, 981, 576	1, 981, 57 <i>6</i>		1, 981, 576	1
76.00	03140 CARDIO CATH LAB	0	0	(547.054	2, 131, 659	2, 131, 659	1
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	434, 420	82, 931	517, 351 (4, 482, 693 470, 210	
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		7 470, 210	470, 210	70.02
90.00	09000 CLI NI C	2, 039, 151	857, 964	2, 897, 115			90.00
91.00	09100 EMERGENCY	3, 347, 388	1, 890, 072	5, 237, 460	-225	5, 237, 235	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	2, 114, 068	4, 445, 631	6, 559, 699	-267, 163	6, 292, 536	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	1, 815, 524	1, 815, 524	0	1, 815, 524	96. 00
10E 0	SPECIAL PURPOSE COST CENTERS		ما		1 / 4 / 544	1 / 4/ 544	105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	0	(1, 646, 511 757, 277	
118.00		104, 046, 561	267, 888, 475	371, 935, 036			
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	313	313			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT		456, 341 0	456, 341 (456, 341 0	194. 00
	07950 CLOSED PSTCH UNIT		0	(2, 055, 843	2, 055, 843	
	207952 SENI OR CI RCLE	32, 851	41, 254	74, 105			194. 02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	183, 135	183, 135	194. 03
200.00	TOTAL (SUM OF LINES 118-199)	104, 079, 412	268, 386, 383	372, 465, 795	0	372, 465, 795	<u> </u> 200. 00

 Health Financial
 Systems
 LUTHERAN HOR

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 150017 | Peri od: From 07/01/2013 To 06/30/2014

Worksheet A
Date/Time Prepared: 12/1/2014 9:55 am

				am
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	6, 725, 632	17, 103, 083		1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	690, 762	21, 288, 622		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-7, 868	15, 618, 753	l de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	4. 00
5. 01 00540 ADMITTING	-32, 983, 137	7, 090, 262		5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	-2, 935, 557	45, 558, 891	Ę	5. 02
7.00 00700 OPERATION OF PLANT	-70, 120	11, 121, 693	l e e e e e e e e e e e e e e e e e e e	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	90, 501	1, 410, 377		8. 00
9. 00 00900 HOUSEKEEPI NG	0	2, 982, 559		9. 00
10. 00 01000 DI ETARY	0	2, 856, 081		0.00
11. 00 01100 CAFETERI A	-2, 134, 940	1, 450, 008	l e e e e e e e e e e e e e e e e e e e	1.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-15, 700	1, 703, 263		3.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	6, 096, 137		4. 00 5. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-20, 136	7, 214, 551 4, 356, 343		6. 00
17. 00 01700 SOCIAL SERVICE	20, 130	2, 125, 305		7. 00
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRV	o	2, 120, 000	l e	1. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o	2, 785, 941		2. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	288, 384		3. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	0	181, 800	23	3. 01
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-2, 805, 240	19, 737, 580	l e e e e e e e e e e e e e e e e e e e	0.00
31.00 03100 INTENSIVE CARE UNIT	0	0		1. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	894, 996	l e e e e e e e e e e e e e e e e e e e	1. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	-90, 080	2, 662, 397		1. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	0	12, 296, 057		1. 03
32. 00 03200 CORONARY CARE UNIT	0	4, 486, 796	l e	2.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	0	0 330, 037		0.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	-3, 680	330, 037	4.	3. 00
50. 00 05000 OPERATING ROOM	-450, 006	16, 904, 476	50	0. 00
51. 00 05100 RECOVERY ROOM	0	0		1. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	l o	1, 384, 727		2. 00
53. 00 05300 ANESTHESI OLOGY	-3, 822, 768	133, 812		3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-7, 016	5, 554, 940		4. 00
54. 01 05401 PET SCAN	0	196, 887	54	4. 01
56. 00 05600 RADI 0I SOTOPE	0	1, 564, 130	56	6. 00
57.00 05700 CT SCAN	0	837, 452		7. 00
58. 00 05800 MRI	0	0		8. 00
60. 00 06000 LABORATORY	-202, 500	14, 263, 171		0.00
65. 00 06500 RESPIRATORY THERAPY	0	4, 408, 187		5. 00
66. 00 06600 PHYSI CAL THERAPY	0	3, 321, 235		6.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	O O		7. 00 8. 00
69. 00 06900 ELECTROCARDI OLOGY		1, 079, 353	l e	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		1, 393, 284	l de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	0.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	17, 574, 253		1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	18, 785, 922	l e e e e e e e e e e e e e e e e e e e	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	24, 190, 648	73	3.00
74.00 07400 RENAL DIALYSIS	o	1, 981, 576	74	4. 00
76.00 03140 CARDIO CATH LAB	0	2, 131, 659	76	6. 00
76. 01 03050 ENDOSCOPY	0	4, 482, 693	l e	6. 01
76. 02 03051 CARDI AC REHAB	0	470, 210	76	6. 02
OUTPATIENT SERVICE COST CENTERS	000 41	0.400.45=		0.00
90. 00 09000 CLI NI C	-203, 136	3, 403, 455	l e	0.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	-174, 600	5, 062, 635	l e e e e e e e e e e e e e e e e e e e	1.00
OTHER REIMBURSABLE COST CENTERS			9,	2. 00
95. 00 09500 AMBULANCE SERVI CES	-3, 059, 970	3, 232, 566	OI	5. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	-1, 815, 524	3, 232, 300		6. 00
SPECIAL PURPOSE COST CENTERS	1,015,524	<u> </u>	^^	0. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	1, 646, 511	109	5. 00
106. 00 10600 HEART ACQUISITION		757, 277	l e e e e e e e e e e e e e e e e e e e	6. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-43, 295, 083	326, 400, 975		8. 00
NONREI MBURSABLE COST CENTERS		, , , , , , , ,		-
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	313	190	0. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	456, 341		2. 00
194.00 07950 CLOSED PSYCH UNIT	0	O		4. 00
194. 01 07951 MARKETI NG	0	2, 055, 843	l e	4. 01
194. 02 07952 SENI OR CI RCLE	0	74, 105		4. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	0	183, 135		4. 03
200.00 TOTAL (SUM OF LINES 118-199)	-43, 295, 083	329, 170, 712	200	0. 00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 07/01/2013 | To 06/30/2014 | Date/Time Prepared: 12/1/2014 9:55 am Provider CCN: 150017

	1				12/1/2014 9: 55 at	m
		Increases	6.1	0.11		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFITS	3.00	4.00	5.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 773, 222	1	1. 00
	TOTALS			13, 773, 222		
	B - OXYGEN					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	877, 894	1	1. 00
2. 00	PATI ENT	0. 00	0	0		2. 00
3. 00		0.00	o	Ö		3. 00
0.00	TOTALS — — — —	— — 	o			
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	5, 409, 093		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0	•	3. 00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	o	0		5. 00
7. 00		0.00	0	Ö		7. 00
8.00		0.00	O	0	8	3. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0	1	0.00
11. 00 12. 00		0. 00 0. 00	0	0	1	1. 00 2. 00
13. 00		0.00	0	0		2. 00 3. 00
14. 00		0.00	o	Ö		4. 00
15. 00		0.00	0	O		5. 00
16.00		0.00	0	0		5. 00
17. 00		0.00	0	0		7. 00
18.00		0.00	0	0		3. 00
19. 00 20. 00		0. 00 0. 00	0	0		9. 00 0. 00
21. 00		0.00	0	0		1. 00
22. 00		0.00	o	Ö		2. 00
23.00		0.00	0	0	23	3. 00
24. 00		0.00	0	0		4. 00
25. 00		0.00	0	0		5. 00
26. 00			0	5, 409, 093	26	5. 00
	D - OTHER CAPITAL COSTS		<u> </u>	3, 407, 073		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	314, 624	1	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	О	3, 757, 152	2	2. 00
3.00	CAP REL COSTS-MVBLE EQUIP		0	8 <u>5, 1</u> 73	3	3. 00
	TOTALS		0	4, 156, 949		
1. 00	E - MARKETING DEPARTMENT MARKETING	194. 01	307, 237	1, 746, 856		1. 00
1.00	TOTALS		307, 237	1, 746, 856	'	1.00
	F - CNO RECLASS	L	00.720.7	177107000		
1.00	NURSING ADMINISTRATION	1300	274, 624	0	1	1.00
	TOTALS		274, 624	0		
1 00	G - MEDICAL SUPPLIES	71 00	ما	1/ /0/ 250		
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	16, 696, 359	'	1. 00
2.00	IMPL. DEV. CHARGED TO	72.00	o	18, 785, 922	2	2. 00
	PATIENTS			,		
3.00	OPERATI NG ROOM	5000	0	77 <u>7, 5</u> 69	3	3. 00
	TOTALS		0	36, 259, 850		
1. 00	H - DRUGS / IVS DRUGS CHARGED TO PATIENTS	73. 00	0	24, 190, 648		1. 00
1.00	TOTALS			24, 190, 648	'	1.00
	I - A&G COSTS		<u> </u>	21/170/010		
1.00	OTHER ADMINISTRATIVE AND	5. 02	5, 332, 548	61, 025, 108		1.00
	GENERAL					
2.00	DI ETARY	10.00	36, 579	259, 413		2. 00
3. 00 4. 00	CENTRAL SERVICES & SUPPLY MARKETING	14. 00 194. 01	400, 334 1, 249	1, 204, 654 501		3. 00 4. 00
5. 00	OTHER NONREIMBURSABLE COST	194.01	166, 515	16, 620		i. 00 5. 00
	CENTERS					
	TOTALS		5, 937, 225	62, 506, 296		
	J - RADI OLOGY COSTS					
1.00	RADI OLOGY-DI AGNOSTI C	54. 00 54. 01	924, 587 35, 040	99, 031		1.00
2. 00 3. 00	PET SCAN	54. 01 0. 00	35, U40	161, 847 0		2. 00 3. 00
5.00	TOTALS — — — —		959, 627		3	. 00
	· · ·	ı	/ 52/	, 0, 0	ı	

						0 06/30/20	14 Date/IIme Prepar 12/1/2014 9:55 a	
		Increases					127 17 20 11 71 00 0	
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	K - DIETARY							
1.00	CAFETERI A	<u>11.</u> 00	<u>1, 544, 2</u> 59	<u>2, 040, 6</u> 89			1	1.00
	TOTALS		1, 544, 259	2, 040, 689				
	L - MISC DEPARTMENT							
1.00	OTHER ADMINISTRATIVE AND	5. 02	422, 330	35, 961			1	1.00
	GENERAL							
2.00	MEDICAL RECORDS & LIBRARY	16. 00	812, 151	615, 647				2.00
3.00	SOCI AL SERVI CE	17. 00	1, 956, 174	169, 131				3.00
4.00	OPERATING ROOM	50.00	2, 799, 774	730, 080				4.00
5.00	CARDI AC REHAB	76. 02	407, 559	62, 651				5.00
6.00	PHYSI CAL THERAPY	66. 00	744, 104	72, 250			· ·	6. 00
7.00	ELECTROENCEPHALOGRAPHY	70.00	939, 717	453, 567				7.00
8.00	CARDIO CATH LAB	76. 00	1, 188, 201	943, 458				8.00
9.00	ENDOSCOPY	<u>76.</u> 01	2, 890, 456	<u>1, 592, 2</u> 37				9.00
	TOTALS		12, 160, 466	4, 674, 982				
	M - ORGAN ACQUISITION							
1.00	KIDNEY ACQUISITION	105.00	0	1, 646, 511				1.00
2.00	HEART ACQUISITION	106. 00	0	757, 277			•	2.00
3.00	CLINIC	90.00	<u>463, 3</u> 42	<u>269, 1</u> 00			3	3.00
	TOTALS		463, 342	2, 672, 888				
	N - ICU COSTS		-1					
1. 00	PEDIATRIC INTENSIVE CARE UNIT	31. 01	761, 018	133, 978				1. 00
2.00	NEONATAL INTENSIVE CARE UNIT	31. 02	2, 141, 036	611, 441			2	2.00
3.00	CARDIO INTENSIVE CARE UNIT	31. 03	9, 915, 162	2, 380, 895				3.00
4.00	CORONARY CARE UNIT	32.00	3, 674, 214	812, 582				4.00
	TOTALS		16, 491, 430	3, 938, 896				
	O - LABOR AND DELIVERY							
1.00	NURSERY	43.00	267, 764	4, 476				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 111, 063	273, 664				2.00
	TOTALS		1, 378, 827	278, 140				
	P - INTERNS AND RESIDENTS							
1.00	I&R SERVICES-OTHER PRGM	22. 00	0	2, 785, 941			-	1.00
	COSTS APPRV							
	TOTALS		0	2, 785, 941				
500.00	Grand Total: Increases		39, 517, 037	165, 573, 222			500	0.00

Health Financial Systems RECLASSIFICATIONS

CLASSIFICATIONS Provider CCN: 150017

Peri od: Worksheet A-6 From 07/01/2013 To 06/30/2014 Date/Ti me Prepared:

In Lieu of Form CMS-2552-10

12/1/2014 9:55 am

Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - EMPLOYEE BENEFITS 5.02 OTHER ADMINISTRATIVE AND 13, 773, 222 0 1.00 GENERAL TOTALS o 13, 773, 222 B - OXYGEN 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 94, 027 0 1.00 ANESTHESI OLOGY 0 2.00 53.00 154, 580 0 2.00 3.00 RESPIRATORY THERAPY 65. 00 0 629, 287 0 3.00 TOTALS 877.894 C - RENTAL AND LEASE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 50, 620 10 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 2.00 4.00 4.892 0 2.00 3.00 ADMITTING 5.01 0 12, 319 0 3.00 116, 704 4.00 OTHER ADMINISTRATIVE AND 5.02 0 0 4.00 GENERAL 5.00 OPERATION OF PLANT 7.00 0 7,083 0 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 8.00 74 6.00 7.00 DI ETARY 10.00 0 35, 205 0 7.00 NURSING ADMINISTRATION o 0 8.00 13.00 3,690 8.00 0 CENTRAL SERVICES & SUPPLY 0 9 00 14 00 1 361 387 9 00 0 10.00 PHARMACY 15.00 0 415, 720 10.00 11.00 MEDICAL RECORDS & LIBRARY 16.00 o 31, 287 0 11.00 PARAMED ED PRGM-(SPECIFY) 0 12.00 23.00 0 12.00 76 ADULTS & PEDIATRICS 0 0 30 00 47, 298 13 00 13 00 14.00 INTENSIVE CARE UNIT 31.00 0 5, 875 0 14.00 PEDIATRIC INTENSIVE CARE 0 15.00 31.01 9, 101 15.00 UNI T 0 16,00 OPERATING ROOM 50.00 0 651, 551 16, 00 RADI OLOGY-DI AGNOSTI C 0 0 17.00 54.00 989, 534 17.00 18.00 RADI OI SOTOPE 56.00 0 570, 582 0 18.00 0 19.00 CT SCAN 57.00 7, 100 19.00 0 LABORATORY 60.00 0 226, 450 20.00 20.00 PHYSICAL THERAPY 0 21.00 66.00 0 295, 231 21.00 ELECTROCARDI OLOGY 69.00 273, 386 0 22.00 22.00 0 23.00 **ENDOSCOPY** 76.01 o 3, 574 23.00 CLINIC 90.00 0 24.00 22, 966 0 24.00 25.00 **EMERGENCY** 91.00 0 225 0 25.00 26.00 AMBULANCE SERVICES 95.00 0 267, 163 0 26.00 TOTALS 5, 409, 093 D - OTHER CAPITAL COSTS 1.00 OTHER ADMINISTRATIVE AND 5.02 0 4, 156, 949 12 1.00 GENERAL 2.00 0.00 2.00 0 0 13 3.00 0.00 0 12 3.00 TOTALS 4, 156, 949 - MARKETING DEPARTMENT ADMI TTI NG 5. 01 307, 237 1, 746, 856 1.00 1.00 0 TOTALS 307, 237 1, 746, 856 CNO RECLASS OTHER ADMINISTRATIVE AND 1.00 5.02 274, 624 0 1.00 GENERAL TOTALS 0 274, 624 G - MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY 1.00 14. 00 36, 185, 305 0 1.00 RADI OLOGY-DI AGNOSTI C 0 24, 797 2.00 54.00 0 2.00 ELECTROCARDI OLOGY 4<u>9, 7</u>48 3.00 69.00 0 3.00 **TOTALS** 0 36, 259, 850 H - DRUGS / IVS 1 00 PHARMACY 15. 00 0 24, 190, 648 0 1 00 24, 190, 648 TOTALS - A&G COSTS 1.00 ADMI TTI NG 5. 01 5, 937, 225 62, 506, 296 0 1.00 2 00 0 00 2 00 0 0 3.00 0.00 0 0 0 3.00 0 4.00 0.00 0 4.00 0.00 5 00 5 00 0 TOTALS 5, 937, 225 62, 506, 296 J - RADIOLOGY COSTS 1.00 RADI OLOGY-DI AGNOSTI C 54.00 35, 040 161, 847 0 1.00 2. 00 2 00 PET SCAN 54 01 550, 213 63, 166 0 3.00 MRI 58.00 374, 374 35, 865 0 3.00 TOTALS 959, 627 260, 878

Provider CCN: 150017

Peri od: From 07/01/2013 To 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Decreases

	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6, 00	7, 00	8.00	9. 00	10.00		
	K - DIETARY						
1.00	DI ETARY	10.00	1, 544, 259	2, 040, 689	0		1.00
	TOTALS — — — — —		1, 544, 259	2, 040, 689			
	L - MISC DEPARTMENT						
1.00	RECOVERY ROOM	51.00	2, 799, 775	730, 080	0		1. 00
2.00	ELECTROCARDI OLOGY	69.00	2, 101, 057	1, 380, 319	O		2. 00
3.00	OCCUPATIONAL THERAPY	67.00	515, 108	46, 461	0		3. 00
4.00	SPEECH PATHOLOGY	68.00	228, 996	25, 789	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	3, 190, 654	820, 739	0		5. 00
6.00	OPERATING ROOM	50.00	2, 890, 456	1, 592, 237	0		6. 00
7.00	ENDOSCOPY	76. 01	434, 420	79, 357	0		7. 00
8.00		0.00	0	0	0		8. 00
9.00		0.00	0_	0	0		9. 00
	TOTALS		12, 160, 466	4, 674, 982			
	M - ORGAN ACQUISITION						
1.00	OPERATING ROOM	50.00	463, 342	2, 672, 888	0		1.00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0_	0	0		3. 00
	TOTALS		463, 342	2, 672, 888			
	N - ICU COSTS						
1.00	PEDIATRIC INTENSIVE CARE	31. 01	2, 141, 036	611, 441	0		1.00
	UNI T						
2.00	INTENSIVE CARE UNIT	31. 00	14, 350, 394	3, 327, 455	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0_	0	0		4. 00
	TOTALS		16, 491, 430	3, 938, 896			
	O - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30. 00	1, 378, 827	278, 140	0		1. 00
2.00		0.00	•	0	0		2. 00
	TOTALS		1, 378, 827	278, 140			_
	P - INTERNS AND RESIDENTS						1
1.00	I&R SERVICES-SALARY &	21. 00	0	2, 785, 941	0		1. 00
	FRI NGES APPRV				<u> </u>		
	TOTALS		0	2, 785, 941			
500.00	Grand Total: Decreases		39, 517, 037	165, 573, 222			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150017 Peri od: Worksheet A-7 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 9, 573, 476 0 1.00 541, 192 10, 539, 929 0 541, 192 2.00 Land Improvements 0 2.00 152, 714, 654 0 3. 00 3.00 28, 724 28, 724 Buildings and Fixtures 0 0 4.00 Building Improvements 17, 075, 613 2, 794, 210 2, 794, 210 0 4.00 5.00 Fixed Equipment 45, 986, 381 110, 697 110, 697 0 5.00 124, 459, 167 0 6.00 Movable Equipment 9, 530, 358 9, 530, 358 0 6.00 0 7.00 21, 351 21, 351 HIT designated Assets 1, 482, 299 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 361, 831, 519 13, 026, 532 13, 026, 532 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 361, 831, 519 13, 026, 532 O 13, 026, 532 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 9, 573, 476 0 1.00 2.00 Land Improvements 11, 081, 121 0 2.00 152, 743, 378 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 19, 869, 823 4.00 5.00 Fi xed Equipment 46, 097, 078 0 5.00 Movable Equipment 133, 989, 525 0 6.00 6.00 7.00 HIT designated Assets 1,503,650 0 7.00

374, 858, 051

374, 858, 051

0

0

8.00

9.00

10.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

Heal th	Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150017	Peri od: From 07/01/2013 To 06/30/2014	Worksheet A-7 Part II Date/Time Pre 12/1/2014 9:5	pared: 5 am	
			SU	JMMARY OF CAP	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	6, 356, 295	0		0 0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	15, 103, 594	0		0 0	0	2. 00	
3.00	Total (sum of lines 1-2)	21, 459, 889	0		0 0	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 356, 295		·	·	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	15, 103, 594				2.00	
	T 1 1 (C11 1 C)	1	04 450 000	I .				

0 0 0

6, 356, 295 15, 103, 594 21, 459, 889

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 07/01/2013 To 06/30/2014		
		COMI	COMPUTATION OF RATIOS			OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 - col. 2)	instructions)		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	193, 267, 797	0	193, 267, 797	0. 515576	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	181, 590, 253	0	181, 590, 253			2.00
3.00	Total (sum of lines 1-2)	374, 858, 050		374, 858, 050			3. 00
		ALLOCATION OF OTHER CAPITAL			SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT		1 0	,	4 215 072	F0 (20	1 00
1.00	CAP REL COSTS-BLDG & FIXI	0	1	(1,010,770		1.00
2. 00 3. 00	Total (sum of lines 1-2)	0	ļ ~		14, 707, 198 19, 023, 171	5, 409, 093 5, 358, 473	2. 00 3. 00
3.00	Total (Sull of Titles 1-2)	0	·	IU JMMARY OF CAPI		5, 358, 473	3.00
			30	JIVIIVIART OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI					47.400	4 00
1.00	CAP REL COSTS-BLDG & FIXT	8, 765, 954				,,	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 087, 158			,		2.00
3.00	Total (sum of lines 1-2)	9, 853, 112	399, 797	3, 757, 152	2 0	38, 391, 705	3. 00

| Period: | Worksheet A-8 | From 07/01/2013 | To 06/30/2014 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 150017

Expense Classification on North-Seet A 1.00 1					To	06/30/2014	Date/Time Prep 12/1/2014 9:55	
Cost Center Description Resis/Cade (2) Amount Cent Center I nee P Next A.2 Set							12/1/2014 9.33	o alli
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00								
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00								
Triving trained Triving trained Copy Copy		Cost Center Description						
Investment Income = CAP RTL OCCAP RTL COSTS-MOWILL FIDURP 2.00 0 2.00	1.00		1.00					1. 00
Investment income - other	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
Chapter 2) Chapter 3) Chapter 4) Col Irade, quantity, and time of scanners (chapter 8) Col Chapter 5) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 7) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col	3 00			0		0.00	0	3 00
0 0 0 0 0 0 0 0 0 0		(chapter 2)						
Color Colo		di scounts (chapter 8)		U			0	
Sentral of provider space by Sentral	5. 00			0		0. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Stations excluded) (chapter 21) 0 0.00 0.	6.00	Rental of provider space by	В	-1, 204, 307	CAP REL COSTS-BLDG & FIXT	1. 00	9	6. 00
21)	7.00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
Chapter 21 0		, , ,						
Parking of (chapter 21) A -8-2 -13,575,430 0 0.00 0	8. 00			0		0.00	О	8. 00
adjustment		Parking Lot (chapter 21)				0.00	_	
Chapter 23)	10. 00	1 3	A-8-2	-13, 575, 430			0	10. 00
12.00 Related organization 13.00 Laundry and I linen service 0 13.00 Laundry and I linen service 0 0 0 0 0 15.00 1	11. 00		В	-7, 016	RADI OLOGY-DI AGNOSTI C	54. 00	0	11. 00
13.00 Laundry and I linen service 0 0.00 0.13.00 15.00 1	12. 00	Related organization	A-8-1	7, 783, 577			0	12. 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 17.00 0 17.00 0 17.00 0 18.00 0	13. 00			0		0.00	0	13. 00
and others				-2, 134, 940	CAFETERI A			
Supplies to other than Datients 17.00 Sale of drugs to other than Datients 17.00 Sale of drugs to other than Datients 18.00 Sale of medical records and Datients Da		and others		0				
17. 00 Sale of drugs to other than patients 0 0 0 0 0 0 0 0 17. 00 18. 00 Sale of medical records and abstracts 0 0 0 0 0 0 0 0 18. 00 19. 00 Nursing school (tuition, fees, books, etc.) 0 0 0 0 0 0 0 0 20. 00 Vending machines B -31,850 OTHER ADMINISTRATIVE AND 5. 02 0 20. 00 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 22. 00 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 0 22. 01 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 0 22. 02 0 0 0 0 0 0 0 0 0	16.00			U		0.00	U	16.00
patients	17. 00			0		0. 00	0	17. 00
abstracts	18 00	patients		0		0.00	0	18 00
books_ etc.) vending machines B		abstracts		0				
CENERAL Content Cont	19.00			U		0.00	0	19.00
Interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of I imitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of I imitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OSTS-MUBLE EQUIP A - 8-78, 287 CAP REL COSTS-MUBLE EQUIP 2.00 9 27.00 27.00 28.00 Non-physicians' assistant 0 0.00 0.29.00 0.00 0.90 0.00 0.90 0.00 0.90 0.00 0.00 0.90 0.00 0.	20. 00	Vending machines	В	-31, 850		5. 02	0	20. 00
Charges (chapter 21)	21. 00			0		0.00	o	21. 00
overpayments and borrowings to repay Medicare overpayments 23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26. 00 (costSS-BLDG & FIXT 27. 00 (costS-BLDG & FIXT 28. 00 No-physician Anoshemists 1.00 (costSS-BLDG & FIXT 29. 00 (costSSS-BLDG & FIXT 29. 00 (costSSSS-BLDG & FIXT 29. 00 (costSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS		charges (chapter 21)						
23.00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) A-8-3 OPHYSICAL THERAPY 66.00 24.00	22. 00	overpayments and borrowings to		Ü		0.00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00 (Chapter 21) 27.00 Depreciation - CAP REL A 243, 605 CAP REL COSTS-MVBLE EQUIP 2.00 9 27.00 (COSTS-BLDG & FIXT 5.00) 28.00 Non-physician Anesthetist 0 0*** Cost Center Deleted *** 19.00 28.00 (Physicians' assistant 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00		A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	20.00	therapy costs in excess of		J		33. 33		20.00
1 imitation (chapter 14) Utilization review -	24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00 27.00 Depreciation - CAP REL A 243, 605 CAP REL COSTS-MVBLE EQUIP 2.00 9 27.00 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29.00 2								
Chapter 21) Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00	25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest A 243, 605 CAP REL COSTS-MVBLE EQUIP 2. 00 9 27. 00 28. 00 0 **** Cost Center Deleted *** 19. 00 0 29. 00 0 0 29. 00 0 30. 00 4-8-3 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 99 31. 00 ADULTS & PEDIATRICS 30. 00 31. 00 31. 00 32. 00 OCAH HIT Adjustment for Depreciation and Interest	07.00	(chapter 21)		070 007	OAD DEL COCTO DI DO A FLYT	1 00		0/ 00
COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest O**** Cost Center Deleted **** 19. 00 28. 00 0 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 00 30. 99 A-8-3 OSPEECH PATHOLOGY 68. 00 31. 00 0 32. 00	26.00	COSTS-BLDG & FLXT	A	-878, 287	CAP REL COSIS-BLDG & FIXI	1.00	9	
28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 0 **** Cost Center Deleted **** 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	27. 00		A	243, 605	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 OCCUPATIONAL THERAPY 67.00 30.00		Non-physician Anesthetist		0	*** Cost Center Deleted ***		0	
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY		-	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 SPEECH PATHOLOGY 68. 00 31. 00 0 0 0 0 0 32. 00								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest								
	32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
	33. 00		A	-31, 502, 516	ADMI TTI NG	5. 01	0	33. 00

Heal th	Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10		
ADJUST	MENTS TO EXPENSES				eriod: rom 07/01/2013	Worksheet A-8	
					o 06/30/2014		pared:
						12/1/2014 9:5	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	TRALLIU NO DEVENUES	1.00	2.00	3.00	4. 00	5. 00	00.01
33. 01	TRAI NI NG REVENUES	В		NURSI NG ADMI NI STRATI ON	13. 00	0	00.01
33. 02	OTHER MISC REVENUES	В		OTHER ADMINISTRATIVE AND	5. 02	0	33. 02
33. 03	PATIENT PHONES WAGE COST	A		GENERAL OTHER ADMINISTRATIVE AND	5. 02	0	33. 03
33. 03	PATTENT PHONES WAGE COST	A		GENERAL	5.02	0	33.03
33. 04	PATIENT PHONES BENEFITS COST	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	n	33. 04
33. 05	PATIENT PHONES EXPENSE	A	·	ADMITTING	5. 01	o O	33. 05
33. 06	PATIENT PHONES DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 06
00.00	COST		3, 55 .	NEE	2.00	ĺ	00.00
33. 07	PATIENT TV - CABLE EXPENSE	A	-70, 120	OPERATION OF PLANT	7. 00	0	33. 07
33. 08	PATIENT TV DEPRECIATION	A	-10, 736	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 08
33. 09	MARKETI NG	A	-73, 979	OTHER ADMINISTRATIVE AND	5. 02	0	33. 09
				GENERAL			
33. 10	LEGAL FEES	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 10
				GENERAL		_	
33. 11	PHYSICIAN RECRUITING	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 11
33. 12	LOBBYING IN ASSOCIATION DUES	A		GENERAL OTHER ADMINISTRATIVE AND	5. 02	0	33. 12
33. 12	LUBBTING IN ASSOCIATION DUES	A		GENERAL	5.02	0	33. 12
33. 13	CHARI TABLE CONTRIBUTIONS	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 13
				GENERAL		_	
33. 14	PENALTI ES	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 14
				GENERAL			
33. 15	EQUITY IN AFFILIATES	Α	110, 131	OTHER ADMINISTRATIVE AND	5. 02	0	33. 15

GENERAL

GENERAL

GENERAL

-43, 295, 083

-679, 467 OTHER ADMINISTRATIVE AND

-29, 251 OTHER ADMINISTRATIVE AND

GENERAL 2, 369, 841 OTHER ADMINI STRATI VE AND

5. 02

5.02

5.02

33. 16

33. 17

33. 18

50.00

TOTAL (sum of lines 1 thru 49)

INTERCOMPANY LEASE RECEIPTS

(Transfer to Worksheet A,

NON-COMEPETE AGREEMENT

EXPENSES

VALET SERVICE

33. 16

33. 17

33. 18

50.00

column 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: 150017 Peri od: Worksheet A-8-1 From 07/01/2013
To 06/30/2014 Date/Time Prepared: OFFICE COSTS

				To 06/30/2014	Date/Time Pre	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
1 00	HOME OFFICE COSTS:	CAD DEL COCTO DI DO A FLYT	DI DECT CADITAL INTEDECT	0 (20 242		1 00
1.00	l control of the cont	l e e e e e e e e e e e e e e e e e e e	DIRECT CAPITAL INTEREST	8, 630, 242	0	1.00
2.00			PASI CAPITAL - BLDG	42, 272	0	2.00
3. 00 4. 00			PASI CAPITAL - EQUIP PASI OPERATING	21, 147	0	3.00
4. 00 4. 01		-	POOLED CAPITAL - BLDG	763, 134	0	4. 00 4. 01
			POOLED CAPITAL - BLDG	135, 712	0	4. 01
4. 02				1, 087, 158	U	
4. 03		OTHER ADMINISTRATIVE AND GEN		8, 262, 148	0 410 222	4. 03
4. 04	1			1, 047, 460		
4. 05	1		CIG ASSETS	737, 600		4. 05
4.06			HLS - CAPITAL	149, 474	0	4. 06
4. 07			HLS - OPERATING	1, 257, 941	1, 316, 914	4. 07
4. 08		OTHER ADMINISTRATIVE AND GEN		0	3, 257, 739	4. 08
4. 09		OTHER ADMINISTRATIVE AND GEN		0	5, 432	4. 09
4. 10		OTHER ADMINISTRATIVE AND GEN		0	105, 644	4. 10
4. 11	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	1, 199, 847	4. 11
4. 12	1	OTHER ADMINISTRATIVE AND GEN		0	251, 942	4. 12
4. 13	1	OTHER ADMINISTRATIVE AND GEN		0	313, 108	4. 13
4. 14	1	OTHER ADMINISTRATIVE AND GEN		0	20, 202	4. 14
4. 15	1	OTHER ADMINISTRATIVE AND GEN		0	180, 064	4. 15
4. 16	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	37, 867	4. 16
4. 17	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	88, 620	4. 17
4. 18	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	49, 791	4. 18
4. 19			PASI COLLECTION FEES	0	1, 949, 012	4. 19
4. 21			EBOS FEES	0	10, 670	
4. 22			PASI LIEN UNIT COLLECTION FE	0	273, 155	4. 22
4. 23		OTHER ADMINISTRATIVE AND GEN	INTEREST EXPENSE	0 404 555	1, 487, 500	
5. 00	TOTALS (sum of lines 1-4).			22, 134, 288	14, 350, 711	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.			1		

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 COMMUNITY HEALT 100.00	6. 00
7.00	В	0. 00 PASI 100. 00	7. 00
8.00	E	0. 00 HOSPI TAL LAUNDR 100. 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

2.00 42, 272 9 3.00 21, 147 9 4.00 763, 134 0 4.01 135, 712 11 4.02 1, 087, 158 11 4.03 8, 262, 148 0 4.04 -1, 370, 763 0 4.05 -647, 381 9 4.06 149, 474 9 4.07 -58, 973 0 4.08 -3, 257, 739 0 4.09 -5, 432 0 4.10 -105, 644 0 4.11 -1, 199, 847 0 4.12 -251, 942 0 4.13 -313, 108 0 4.14 -20, 202 0 4.15 -180, 064 0 4.16 -37, 867 0	OTTTOL	00313				To 06/30/2014	Date/Time Pre 12/1/2014 9:5	epared: 55 am
COJ		Net	Wkst. A-7 Ref.					
Col. 5)* Col. 50 7.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED		Adjustments						
A. COSTS NOURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00		(col. 4 minus						
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00		col. 5)*						
HOME OFFICE COSTS:		6. 00	7. 00					
1. 00 8, 630, 242 11 2. 00 42, 272 9 3. 00 21, 147 9 4. 00 763, 134 0 4. 01 135, 712 11 4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0				MENTS REQUIRED AS A RESULT OF TRAN	SACTIONS WITH RELATED C	RGANIZATIONS OR (CLAIMED	
2.00 42, 272 9 3.00 21, 147 9 4.00 763, 134 0 4.01 135, 712 11 4.02 1, 087, 158 11 4.03 8, 262, 148 0 4.04 -1, 370, 763 0 4.05 -647, 381 9 4.06 149, 474 9 4.07 -58, 973 0 4.08 -3, 257, 739 0 4.09 -5, 432 0 4.10 -105, 644 0 4.11 -1, 199, 847 0 4.12 -251, 942 0 4.13 -313, 108 0 4.14 -20, 202 0 4.15 -180, 064 0 4.16 -37, 867 0								
3.00 4.00 763,134 0 4.01 135,712 11 4.02 1,087,158 11 4.03 8,262,148 0 4.04 -1,370,763 0 4.05 -647,381 9 4.06 149,474 9 4.07 -58,973 0 4.08 -3,257,739 0 4.09 -5,432 0 4.10 -105,644 0 4.11 -1,199,847 0 4.12 -251,942 0 4.13 -313,108 0 4.14 14.14 -20,202 0 4.15 -180,064 0 4.16 -37,867	1.00							1. 00
4. 00 763, 134 0 4. 01 135, 712 11 4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	2.00							2. 00
4. 01 135, 712 11 4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	3.00							3. 00
4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0				I .				4. 00
4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0				I .				4. 01
4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 02
4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 03
4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 04
4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	4.05							4. 05
4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 06
4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	4.07							4. 07
4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	4.08	-3, 257, 739	0					4. 08
4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0 4. 1 -37, 867 0	4.09							4. 09
4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0 4. 1 -4. 1 4. 1 -37, 867 0	4. 10	-105, 644	0					4. 10
4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0 4. 1 4. 1	4. 11	-1, 199, 847	0					4. 11
4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 12
4. 15								4. 13
4.16 -37,867 0 4.1								4. 14
								4. 15
4 17 _88 620 0 4 1	4. 16							4. 16
	4. 17	-88, 620						4. 17
	4. 18	-49, 791	0					4. 18
								4. 19
								4. 21
		-273, 155	0					4. 22
								4. 23
5.00 7,783,577 5.0	5.00	7, 783, 577						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.

 	cordinate i dilaret 27 the dimedite difference of card a se final cated in cordinat for this parti	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

Termbur Schieft under titte XVIII.						
6.00	HOSP COMPANY		6. 00			
7.00	COLLECTI ONS		7. 00			
8.00	LAUNDRY		8. 00			
9.00			9. 00			
10.00			10.00			
100.00			100.00			

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10 Peri od: Worksheet A-8-2 From 07/01/2013 Date/Time Prepared: 12/1/2014 P. 55 am Provider CCN: 150017

					1	o 06/30/2014	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	JJ alli
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		OTHER ADMINISTRATIVE AND	934, 300	922, 503	11, 797	171, 400	79	1. 00
2. 00		GENERAL MEDICAL RECORDS & LIBRARY	44, 692	0	44, 692	171, 400	298	2. 00
3. 00		ADULTS & PEDIATRICS	2, 805, 240		·	0		3. 00
4. 00		NEONATAL INTENSIVE CARE UNIT	90, 080	90, 080		0		4. 00
5.00	1	NURSERY	3, 680			0	0	5. 00
6.00	50.00	OPERATING ROOM	450, 006	450, 006	0	0	0	6. 00
7.00	53. 00	ANESTHESI OLOGY	3, 822, 768	3, 822, 768	0	0	0	7. 00
8.00	60.00	LABORATORY	202, 500	202, 500	0	0	0	8. 00
9.00	90. 00	CLI NI C	203, 136	203, 136	0	0	0	9.00
10.00	91. 00	EMERGENCY	174, 600	174, 600	0	0	0	10.00
11. 00		AMBULANCE SERVICES	3, 059, 970	3, 059, 970	0	0	0	11.00
12.00	96. 00	DURABLE MEDICAL EQUIP-RENTED	1, 815, 524	1, 815, 524	0	0	0	12.00
200.00			13, 606, 496				377	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	9.00	Educati on	12 13. 00	14.00	
1 00	1.00	2.00 OTHER ADMINISTRATIVE AND	8.00		12.00		14.00	1. 00
1. 00		GENERAL	6, 510	320	0	0	J	1.00
2.00		MEDICAL RECORDS & LIBRARY	24, 556	1, 228	0	0	0	2. 00
3.00		ADULTS & PEDIATRICS	0	1		0	0	3. 00
4.00	31. 02	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	4. 00
5.00	43. 00	NURSERY	0	0	0	0	0	5.00
6.00	50. 00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	7. 00
8.00		LABORATORY	0	0	0	0	0	8.00
9. 00		CLI NI C	0	0	0	0	0	9. 00
10. 00		EMERGENCY	0	0	0	0	0	10. 00
11. 00		AMBULANCE SERVICES	0	0	0	0		11. 00
12. 00	96. 00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	_	12. 00
200.00			31, 066			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16, 00	17. 00	18. 00		
1.00		OTHER ADMINISTRATIVE AND	0			927, 790		1. 00
		GENERAL	_	,,,,,,	, ===	,		
2.00	16. 00	MEDICAL RECORDS & LIBRARY	0	24, 556	20, 136	20, 136		2.00
3.00	30. 00	ADULTS & PEDIATRICS	0	0	0	2, 805, 240		3.00
4.00	31. 02	NEONATAL INTENSIVE CARE UNIT	0	0	0	90, 080		4. 00
5.00		NURSERY	0	0	0	3, 680		5. 00
6.00		OPERATING ROOM	0	0	0	450, 006		6. 00
7.00		ANESTHESI OLOGY	0	0	0	3, 822, 768		7. 00
8.00		LABORATORY	0	0	0	202, 500		8. 00
9.00		CLINIC	0	0	0	203, 136		9. 00
10.00		EMERGENCY	0	0	0	174, 600		10.00
11. 00		AMBULANCE SERVICES	0	0	0	3, 059, 970		11. 00
12.00	96. 00	DURABLE MEDICAL EQUIP-RENTED	0	· -	0	1, 815, 524		12.00
200. 00	1		0	31, 066	25, 423	13, 575, 430	I	200. 00

	Financial Systems	LUTHERAN HOSPIT		001 450047 5		u of Form CMS-	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150017 F	eriod: rom 07/01/2013	Worksheet B Part I	
					o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
			CAPI TAL REI	LATED COSTS		12/1/2014 7.3	Jam
			DI DO A FLAT	I 18/81 5 5011 8		45.41.771.110	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	ADMITTING	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1.00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	17, 103, 083	17, 103, 083	8			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	21, 288, 622		21, 288, 622	1		2. 00
4. 00 5. 01	OO400 EMPLOYEE BENEFITS DEPARTMENT OO540 ADMITTING	15, 618, 753 7, 090, 262	447, 218 368, 630			8, 112, 355	4. 00 5. 01
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	45, 558, 891	741, 439			0, 112, 333	5. 02
7. 00	00700 OPERATION OF PLANT	11, 121, 693	3, 697, 478			0	1
8.00	00800 LAUNDRY & LINEN SERVICE	1, 410, 377	21, 444			0	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 982, 559 2, 856, 081	71, 997 692, 892			0	7.00
11. 00	01100 CAFETERI A	1, 450, 008	072, 072			0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 703, 263	163, 838		237, 518	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 096, 137	299, 212			0	14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	7, 214, 551 4, 356, 343	171, 289 182, 942			0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	2, 125, 305	123, 243			0	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0) c	o	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	2, 785, 941	0 000	0	0	0	22. 00
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PHARMACY RESIDENCY PROGRAM	288, 384 181, 800	69, 060 0	403	l	0	
20.01	INPATIENT ROUTINE SERVICE COST CENTERS	101,000		1	21,070		20.01
30.00	03000 ADULTS & PEDI ATRI CS	19, 737, 580	2, 532, 461			399, 833	
31.00	03100 I NTENSI VE CARE UNI T	004.004	104 (17	0	1	0 700	
31. 01 31. 02	02080 PEDIATRIC INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	894, 996 2, 662, 397	104, 617 264, 300			9, 790 57, 912	•
31. 03	03101 CARDIO INTENSIVE CARE UNIT	12, 296, 057	944, 392			263, 438	•
32. 00	03200 CORONARY CARE UNIT	4, 486, 796	367, 747	83, 510	571, 891	102, 095	
40.00	04000 SUBPROVI DER - I PF	0	12.020	0	-	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	330, 037	13, 038	1, 521	41, 677	6, 891	43. 00
50.00	05000 OPERATI NG ROOM	16, 904, 476	2, 468, 392	4, 512, 882	1, 229, 305	1, 475, 377	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	1, 384, 727 133, 812	1, 910		172, 937 18, 808	28, 595 172, 273	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 554, 940	378, 421	1		370, 372	
54. 01	05401 PET SCAN	196, 887	41, 192	1		23, 447	54. 01
56.00	05600 RADI OI SOTOPE	1, 564, 130		1		118, 229	
57. 00 58. 00	05700	837, 452	47, 449 0	49, 366	100, 029	301, 516 0	1
	06000 LABORATORY	14, 263, 171	406, 933	731, 447	695, 828	669, 659	
	06500 RESPI RATORY THERAPY	4, 408, 187	137, 189	236, 823	577, 456	216, 945	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 321, 235	290, 377	220, 749	455, 642	72, 472	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	1, 079, 353	323, 521	326, 061	160, 525	249, 224	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 393, 284	35, 915	501, 459	146, 267	35, 393	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 574, 253 18, 785, 922	0		0	400, 802 828, 977	
73. 00	07300 DRUGS CHARGED TO PATIENTS	24, 190, 648	0		0	1, 323, 555	
74. 00	07400 RENAL DIALYSIS	1, 981, 576	189, 604	3, 954	. 0	37, 193	•
76. 00	03140 CARDIO CATH LAB	2, 131, 659	154, 549			315, 032	
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	4, 482, 693	166, 107 0			200, 363	1
76. 02	OUTPATIENT SERVICE COST CENTERS	470, 210	0	32, 762	63, 437	14, 082	76. 02
90.00	09000 CLI NI C	3, 403, 455	487, 909	12, 668	389, 513	12, 975	90. 00
91. 00	09100 EMERGENCY	5, 062, 635	481, 724	356, 459	521, 021	359, 133	1
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	3, 232, 566	11, 032	293, 088	329, 055	27, 933	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	1
105 5	SPECIAL PURPOSE COST CENTERS	4 () = - 1	F0 0:=				105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	1, 646, 511 757, 277	50, 267 0				105. 00 106. 00
118.00		326, 400, 975	_				
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	313	57, 407				190.00
194.00 194.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT	456, 341 0	0	3, 024			192. 00 194. 00
	07951 MARKETI NG	2, 055, 843	o	1	-		194. 01
	•	· · · · · · · · · · · · · · · · · · ·		<u> </u>	·		-

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014	Part Date/Time Pre	narod.
				10 00/30/2014	12/1/2014 9:5	
		CAPI TAL REI	ATED COSTS			
		DI DO 4 FINT			45111 771 110	
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	
	for Cost Allocation			BENEFITS DEPARTMENT		
	(from Wkst A			DEPARTMENT		
	col. 7)					
	0	1. 00	2.00	4. 00	5. 01	
194. 02 07952 SENI OR CI RCLE	74, 105	0		0 5, 113	0	194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	183, 135	0	88, 08	25, 918	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0 0		201. 00
202.00 TOTAL (sum lines 118-201)	329, 170, 712	17, 103, 083	21, 288, 62	2 16, 087, 843	8, 112, 355	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150017 Peri

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2013 | Part | | To 06/30/2014 | Date/Time Prepared: |

			1	0 06/30/2014	Date/lime Pre 12/1/2014 9:5	
Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE		
	5A. 01	5. 02	7.00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS		,	,			
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	52, 492, 986	52, 492, 986				5. 01 5. 02
7. 00 00700 OPERATION OF PLANT	15, 442, 094					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 431, 821	271, 654	33, 251			8.00
9. 00 00900 HOUSEKEEPI NG	3, 353, 192				4, 101, 018	9. 00
10. 00 01000 DI ETARY	3, 806, 659				241, 735	10.00
11. 00 01100 CAFETERI A	1, 690, 372			0	0	11. 00
13. 00 01300 NURSING ADMINISTRATION	2, 111, 757	400, 655	254, 046	0	57, 160	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	7, 038, 843				104, 388	1
15. 00 01500 PHARMACY	8, 370, 112				59, 759	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	5, 008, 059				63, 824	16.00
17. 00 01700 SOCIAL SERVICE	2, 553, 026	484, 375	191, 099	0	42, 997	17. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	2 705 041	528, 565	0	0	0	21.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	2, 785, 941 385, 569			4, 594	24, 093	23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	206, 196		107,004	4, 374	24, 073	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	200, 170	07, 121				20.01
30. 00 03000 ADULTS & PEDI ATRI CS	28, 202, 908	5, 350, 854	3, 926, 802	623, 113	883, 520	30.00
31. 00 03100 INTENSIVE CARE UNIT	0		0		0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 151, 359	218, 443	162, 217	11, 816	36, 498	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	3, 438, 965	652, 461	409, 820	13, 525	92, 208	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	15, 268, 405	2, 896, 813	1, 464, 364	213, 665	329, 478	31. 03
32. 00 03200 CORONARY CARE UNIT	5, 612, 039	1, 064, 750	570, 224	71, 259		32. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40. 00
43. 00 04300 NURSERY	393, 164	74, 593	20, 217	0	4, 549	43. 00
ANCILLARY SERVICE COST CENTERS	24 500 422	E 044 004	2 027 450	242.270	0/1 1/7	
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	26, 590, 432 0		3, 827, 459 0		861, 167 0	50. 00 51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	1, 586, 259	1	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	326, 803		l ~	0	666	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 553, 313				132, 023	54.00
54. 01 05401 PET SCAN	824, 551				14, 371	1
56. 00 05600 RADI OI SOTOPE	1, 843, 684				33, 474	1
57. 00 05700 CT SCAN	1, 335, 812					57.00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	16, 767, 038	3, 181, 143	630, 986	2, 326	141, 970	60.00
65. 00 06500 RESPI RATORY THERAPY	5, 576, 600				47, 862	65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 360, 475	827, 295	450, 254	11	101, 306	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 138, 684					
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 112, 318				12, 530	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 975, 055 19, 614, 899			0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	25, 514, 203			0	0	73.00
74. 00 07400 RENAL DIALYSIS	2, 212, 327			0	66, 149	74.00
76. 00 03140 CARDI O CATH LAB	4, 210, 236		239, 642		53, 919	76.00
76. 01 03050 ENDOSCOPY	5, 817, 813					ı
76. 02 03051 CARDI AC REHAB	580, 491		0	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	4, 306, 520	817, 059	756, 546	26, 643	170, 221	90.00
91. 00 09100 EMERGENCY	6, 780, 972	1, 286, 527	746, 956	202, 835	168, 063	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
OTHER REIMBURSABLE COST CENTERS	0.000.474	700 704	47.407		0.040	05.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	3, 893, 674 0		17, 107 0		3, 849	95. 00
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	96. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	1, 713, 914	325, 174	77, 943	0	17 537	105. 00
106. 00 10600 HEART ACQUISITION	786, 151			0		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	326, 165, 691	51, 922, 856		1, 736, 726		
NONREI MBURSABLE COST CENTERS	0207.007071	0177227000	10/202/01/	1,700,720	1,000,770	1 101 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	62, 324	11, 824	89, 014	0	20, 028	190. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	459, 365			0		192. 00
194.00 07950 CLOSED PSYCH UNIT	0	0	0	0	0	194. 00
194. 01 07951 MARKETI NG	2, 106, 979	399, 749	0	0		194. 01
194. 02 07952 SENI OR CI RCLE	79, 218		0	0		194. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	297, 135		0	0	0	194. 03
200.00 Cross Foot Adjustments	0	•				200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 07/01/2013 Fo 06/30/2014		
Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5A. 01	5. 02	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118-201)	329, 170, 712	52, 492, 986	18, 371, 86°	1, 736, 726	4, 101, 018	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2013 | Part |
| To 06/30/2014 | Date/Time Prepared: | 12/1/2014 9:55 am | Provider CCN: 150017

				06/30/2014	12/1/2014 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11 00	10.00	SUPPLY	45.00	
CENEDAL CEDVICE COCT CENTEDS	10. 00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP			•			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			•			4.00
5. 01 00540 ADMI TTI NG						5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
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	5, 845, 006					10.00
11. 00 01100 CAFETERI A	0	2, 011, 080				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	o	23, 795	1			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	Ö	63, 666		9, 006, 304		14. 00
15. 00 01500 PHARMACY	o	91, 927	1	220, 601	10, 596, 025	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	o	81, 268	1	7, 509	0	16.00
17. 00 01700 SOCIAL SERVICE	o	37, 757	1	1, 315	0	17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	o	0.,	o o	0	0	21. 00
22. 00 02200 Lar Services-Other Prom Costs Apprv	o	0	o o	5	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	o	3, 428	o	342	0	23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	o	3, 453	1	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	-,			-1		
30. 00 03000 ADULTS & PEDIATRICS	2, 431, 753	408, 188	804, 659	335, 523	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0	0	0	0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	52, 129	14, 349	37, 704	11, 773	0	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	335, 831	43, 073		54, 636	0	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	1, 155, 855	217, 507	491, 237	204, 425	0	31. 03
32.00 03200 CORONARY CARE UNIT	227, 484	74, 375		81, 599	0	32.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	114, 670	5, 417	13, 266	9, 018	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	186, 406	391, 293	1, 064, 934	0	50. 00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	22, 506	55, 047	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	5, 780	0	337	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	104, 049	223, 085	73, 732	0	54.00
54. 01 05401 PET SCAN	0	863	1, 736	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	7, 056	17, 536	4, 835	0	56. 00
57. 00 05700 CT SCAN	0	16, 101	31, 840	11, 790	0	57. 00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0	114, 008	0	607, 235	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	87, 523	0	64, 638	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	54, 058	0	18, 230	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	26, 835	1	4, 573	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	21, 643	1	63, 490	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2, 638, 225	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 968, 405	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	10, 596, 025	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	7, 486	0	74. 00
76. 00 03140 CARDI O CATH LAB	0	23, 620		118, 645	0	76. 00
76. 01 03050 ENDOSCOPY	0	71, 547		175, 159	0	76. 01
76. 02 03051 CARDI AC REHAB	0	11, 973	0	2, 511	0	76. 02
OUTPATIENT SERVICE COST CENTERS	اه	15 440	100.004	70.004		
90. 00 09000 CLI NI C	0	45, 113		70, 921	0	90.00
91. 00 09100 EMERGENCY	0	81, 193	165, 843	166, 695	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	ام	44 275		1/ 01	0	05 00
95. 00 09500 AMBULANCE SERVICES	0	44, 375		16, 815	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS	ما	F 070	l ol	ما	0	105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	5, 279	1	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	4 217 722	3, 015	1	0 005 400		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	4, 317, 722	2, 001, 146	2, 847, 413	9, 005, 402	10, 596, 025	1118.00
NONREI MBURSABLE COST CENTERS	^I	^		T _x ,	^	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 212 505	0		46		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 312, 585	0	0	0		192.00
194. 00 07950 CLOSED PSYCH UNIT	O O	((10		0		194.00
194. 01 07951 MARKETI NG	O O	6, 618		768		194. 01
194. 02 07952 SENI OR CI RCLE	214 400	726		88		194. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	214, 699	2, 590	0	O	0	194. 03
200.00 Cross Foot Adjustments		^			^	200.00
201.00 Negative Cost Centers	0	0	0	· υ	0	201. 00

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150017 I	Peri od:	Worksheet B	
				From 07/01/2013		
				To 06/30/2014		
					12/1/2014 9:5	<u>5 am </u>
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OI	N SERVICES &		
				SUPPLY		
	10.00	11. 00	13.00	14.00	15. 00	
202.00 TOTAL (sum lines 118-201)	5, 845, 006	2, 011, 080	2, 847, 41	9, 006, 304	10, 596, 025	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150017 Peri

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2013 | Part | | To 06/30/2014 | Date/Time Prepared: | 12/1/2014 9:55 am

				LUTERNO	DEGL DENTO	12/1/2014 9:5	5 am
				INTERNS &	RESIDENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES_OTHER	PARAMED ED	
	oost center bescription	RECORDS &	SOUTHE SERVICE	Y & FRINGES	PRGM COSTS	PRGM	
		LI BRARY		APPRV	APPRV		
		16.00	17. 00	21.00	22. 00	23. 00	
<u> </u>	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMI TTI NG						5. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
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	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 394, 487					16. 00
17. 00	01700 SOCI AL SERVI CE	0	3, 310, 569	7			17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	3, 314, 511		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	598, 262	23. 00
23. 01	02301 PHARMACY RESIDENCY PROGRAM	0	0	0	0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00	03000 ADULTS & PEDIATRICS	315, 133	163, 141	0	380, 104	435, 119	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	7, 716	3, 995		15, 204	2, 250	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	45, 644	1		288, 879	10, 126	1
31. 03	03101 CARDIO INTENSIVE CARE UNIT	207, 631	107, 489		0	42, 530	1
32.00	03200 CORONARY CARE UNIT	80, 467	41, 657		0	21, 377	32. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
43. 00	04300 NURSERY	5, 432	2, 812	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS	T					
50. 00	05000 OPERATING ROOM	1, 163, 481	602, 525		897, 047	15, 977	50.00
51. 00	05100 RECOVERY ROOM	0	0	1	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	22, 538	l		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	135, 779	l		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	291, 913	l		0	0	54.00
54. 01	05401 PET SCAN	18, 480	l		0	0	54. 01
56. 00	05600 RADI OI SOTOPE	93, 183	l		0	0	56. 00
57. 00	05700 CT SCAN	237, 643	123, 026	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	527, 799			0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	170, 987	88, 518		30, 408	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	57, 120	29, 570	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	196, 428	1	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	27, 895	14, 441	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	315, 897			0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	653, 367			0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 043, 174	l		0	0	73. 00
74.00	· ·	29, 314	l		0	0	74.00
76. 00	03140 CARDI O CATH LAB	248, 296			121, 633	4, 501	76. 00
76. 01	03050 ENDOSCOPY	157, 918	l		0	0	76. 01
76. 02	03051 CARDI AC REHAB	11, 099	5, 746	0	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS	10.00/			4 400 404	00.050	
90.00	09000 CLI NI C	10, 226			1, 429, 194	29, 253	90.00
91.00	09100 EMERGENCY	283, 055	146, 535	0	O	26, 328	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS				ام		
95. 00		22, 016			0	0	95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96. 00
105 0	SPECIAL PURPOSE COST CENTERS	4.633	0.500		51	~	105 00
	10500 KIDNEY ACQUISITION	4, 833			0		105. 00
	10600 HEART ACQUISITION	10, 023	l		0 1/2 4/2	10, 801	
118. 00		6, 394, 487	3, 310, 569	0	3, 162, 469	598, 262	JI 18. 00
100 0	NONREI MBURSABLE COST CENTERS	_			ما	^	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES				152, 042		192.00
	07950 CLOSED PSYCH UNIT	0	0	<u>0</u>	0		194. 00
	07951 MARKETI NG	0	0	<u>0</u>	0		194. 01
	207952 SENIOR CIRCLE	0	1	J O	0		194. 02
194.03	3 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	O	0	194. 03

Heal th Finar	ncial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der	CCN: 150017	Peri od:	Worksheet B		
					From 07/01/2013	Part I		
				[To 06/30/2014			
						12/1/2014 9:5	<u>5 am</u>	
				I NTERNS 8	RESIDENTS			
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALA	R SERVI CES-OTHER	PARAMED ED		
	·	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM		
		LI BRARY		APPRV	APPRV			
		16.00	17.00	21.00	22.00	23. 00		
200.00	Cross Foot Adjustments				0 0	0	200. 00	
201. 00	Negative Cost Centers		0		0 0	0	201. 00	
202.00	TOTAL (sum lines 118-201)	6, 394, 487	3, 310, 569		0 3, 314, 511	598, 262	202. 00	

In Lieu of Form CMS-2552-10 Health Financial Systems LUTHERAN HOSPITAL OF INDIANA COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150017 Peri od: Worksheet B From 07/01/2013 Part I 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Intern & Cost Center Description **PHARMACY** Subtotal Total RESI DENCY Residents Cost **PROGRAM** & Post Stepdown Adjustments 23.01 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMITTING 5.01 5. 01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 02301 PHARMACY RESIDENCY PROGRAM 248, 770 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 44, 260, 817 -380, 104 43, 880, 713 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 0 0 1, 725, 453 -15, 204 1, 710, 249 31.01 02060 NEONATAL INTENSIVE CARE UNIT 5, 514, 873 -288, 879 5, 225, 994 31 02 31 02 31. 03 03101 CARDIO INTENSIVE CARE UNIT 22, 599, 399 0 22, 599, 399 31.03 03200 CORONARY CARE UNIT 0 8, 155, 565 0 8, 155, 565 32.00 32.00 0 04000 SUBPROVI DER - I PF 0 40.00 40.00 04300 NURSERY 0 643, 138 643, 138 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 40, 987, 895 -897, 047 40, 090, 848 50 00 51.00 05100 RECOVERY ROOM 00000000000000000 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 1, 998, 973 0 1, 998, 973 52 00 52 00 53.00 05300 ANESTHESI OLOGY 604, 621 604, 621 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 11, 826, 071 0 11, 826, 071 54.00 05401 PET SCAN 1, 089, 879 0 1, 089, 879 54.01 54.01 0 05600 RADI OI SOTOPE 56.00 2, 546, 579 2, 546, 579 56.00 57.00 05700 CT SCAN 2, 126, 328 0 2, 126, 328 57.00 58.00 05800 MRI 0 58.00 22, 245, 742 06000 LABORATORY n 22, 245, 742 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 7, 343, 930 -30, 408 7, 313, 522 65.00 66.00 06600 PHYSI CAL THERAPY 5, 898, 319 5, 898, 319 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 495, 048 3, 495, 048 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 708, 768 0 2, 708, 768 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 24, 503, 049 0 24, 503, 049 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 27, 296, 369 0 27, 296, 369 72.00 07300 DRUGS CHARGED TO PATIENTS 42, 782, 921 0 42, 782, 921 73.00 248, 770 73.00 07400 RENAL DIALYSIS 3.044.186 3. 044. 186 74.00 0 74.00 0 03140 CARDIO CATH LAB 76.00 0 6, 043, 353 -121, 633 5, 921, 720 76.00 76.01 03050 ENDOSCOPY 0 7, 927, 673 7, 927, 673 76.01 03051 CARDI AC REHAB 76.02 0 721, 954 721, 954 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 7, 790, 974 -1, 429, 194 6, 361, 780 90.00 10, 055, 002 09100 EMERGENCY 0 10, 055, 002 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 4, 747, 964 0 4, 747, 964 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105 00 2, 147, 182 2, 147, 182 0 0 106.00 10600 HEART ACQUISITION 0 964, 332 0 964, 332 106.00 SUBTOTALS (SUM OF LINES 1-117) 248, 770 -3, 162, 469 320, 633, 888 118.00 323, 796, 357 118.00 NONREI MBURSABLE COST CENTERS

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014	Part I	narad.
					Date/Time Pre 12/1/2014 9:5	pareu: <u>5 am</u>
Cost Center Description	PHARMACY	Subtotal	Intern &	Total		
	RESI DENCY		Residents Cos	t		
	PROGRAM		& Post			
			Stepdown			
			Adjustments			
	23. 01	24. 00	25.00	26.00		
200.00 Cross Foot Adjustments	0	0		0 0		200. 00
201.00 Negative Cost Centers	0	0		0 0		201. 00
202.00 TOTAL (sum lines 118-201)	248, 770	329, 170, 712	-3, 314, 51	1 325, 856, 201		202. 00

| Peri od: | Worksheet B | From 07/01/2013 | Part | I | To 06/30/2014 | Date/Time Prepared: Provider CCN: 150017

Cost Center Description					То	06/30/2014	Date/Time Pre 12/1/2014 9:5	
Accidence Received Reliable Control				CAPI TAL REI	LATED COSTS		1	<u> </u>
BRIENTS PRINTENT		Coot Contar Decemintion	Di mantin	DIDC 0 FLVT	M/DLE FOULD	Cubtatal	EMDL OVEE	
CEREBAL SERVICE DOST CENTERS D. 2.00 2.00 2.00 4.00 0.00		cost center bescription		BLDG & FIXI	MARTE EGOLA	Subtotai		
DEBERAL SERVICE COST CENTERS			Capi tal					
Company Comp				1.00	0.00	0.4	4.00	
1.00 001000 CAP MEL COSIS*-BLEG & FINT		GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
4.00 0.000 D.000	1.00							1.00
5.01 DOS-40] ANNI TILIKS 13 361, 630 25, 261 393, 991 18, 315 5 0 7 7 7 7 7 7 7 7 7								ı
5.02 0.0560 OTHER ADMINISTRATIVE AND GENERAL 0 741, 439 5, 339, 654 6, 061, 073 24, 869 5, 00 0.0560 24, 869 5, 00 0.0560 24, 869 5, 00 0.0560 27, 444 26, 70 0.0500			0	l				1
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0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000		00700 OPERATION OF PLANT	0	l			· ·	•
10.00 01000 DETARY		1 1	0	1				1
11.00 01100 CAFETERIA 0			0					•
13.00 01300 NURSH NO ADMINI STRATION 0 10.3 838 7.1 83 170.795 6.925 13.00		1 1	0	1				•
15.00 01500 PARBIACY 0 171, 280 106, 992 228, 281 25, 577 15.00 170, 00 17			0	1	_	-		
16. 00 01-600 MEDI CAL RECORDS & LIBRARY 0 182, 942 47,259 233, 201 12, 289 16. 00 21. 00 21. 00 20. 00 20. 01 23, 243 8, 877 17. 00 21. 00 20. 00			0	l				1
17.00 01700 SOCIAL SERVICE 0 123, 243 0 123, 244 8, 877 17.00 22.00 0200 18R SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 0 0 22.00 23.00 023			0	l				ł
21.00 02100 IAS SERVICES-SALARY S, FRINGES APPRV 0 0 0 0 0 0 0 22 0.00 220.00 02200 IAS SERVICES-STHER PROBLE OSTS APPRV 0 0 0 0 0 0 0 0 0 23.00 0300 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 0 0		I I	0	l				•
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40. 00 040000 SUBPROVI DER - I PF			0	l				1
ANCILLARY SERVICE COST CENTERS 50.00			0	1				ł
50.00	43.00		0	13, 038	1, 521	14, 559	1, 215	43. 00
S1 00 OS 100 RECOVERY ROOM & LABOR ROOM O	50 00		1 0	2 468 392	4 512 882	6 981 274	35 841	50 00
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 5,042 52.00			0				•	•
54.00 05400 RADI OLOGY-DI AGNOSTI C	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	5, 042	52. 00
54.01 DEAD DET SCAN 0 41, 192 557, 571 598, 763 1,59 54. 01			0	l				•
56.00 0500		1 1	0	l				•
57.00 05700 CT SCAN 0 47,449 49,366 96,815 2,916 57.00			0	l				•
60.00 06000 LABORATORY 0 406, 933 731, 447 1, 138, 380 20, 287 60.00	57. 00	I I	0	l		96, 815		1
65.00 06500 RESPIRATORY THERAPY 0 137, 189 236, 823 374, 012 16, 836 65. 00 66.00 06600 PHYSI CAL THERAPY 0 290, 377 220, 749 511, 126 13, 284 66. 00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69.00 06900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69. 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 35, 915 501, 459 537, 374 4, 264 70. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 189, 604 3, 954 193, 558 0 74. 00 76.00 03140 CARDI O CATH LAB 0 154, 549 1, 424, 053 1, 578, 602 5, 392 76. 00 76.01 03050 ENDOSCOPY 0 166, 107 518, 751 684, 858 13, 117 76. 01 76.02 03051 CARDI AC REHAB 0 0 0 32, 762 32, 762 1, 850 76.02 03051 CARDI AC REHAB 0 0 487, 909 12, 668 500, 577 11, 356 90. 00 79.00 09000 CLINIC 0 487, 790 12, 668 500, 577 11, 356 90. 00 79.00 09000 CLINIC 0 0 0 0 0 0 79.00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09500 AMBULANCE SERVICES 0 11, 032 293, 088 304, 120 9, 594 79.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 17, 045, 676 21, 189, 792 38, 235, 468 466, 785 118, 00 79.00 190.00 190.00 PHYSI CI ANS 'PRIVATE OFFICES 0 0 3, 024 3, 024 0 192, 00 79.00 194.00 09750 CLOSED PSYCH UNIT 0 0 0 0 0 0 79.40 0194, 00 09750 LOSED PSYCH UNIT 0 0 0 0 0 0 79.40 0194, 00 0194, 00 0194, 00 79.40 0194, 00 0194, 00 0194, 00 79.40 0194, 00 0194, 00 0194, 00		I I	0	1		- 1		•
66.00 06600 PHYSI CAL THERAPY 0 290, 377 220, 749 511, 126 13, 284 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69.00 70.00 07000 ELECTROCARDI OLOGY 0 35,915 501, 459 537, 374 4, 264 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 75.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 76.00 03140 CARDI O CATH LAB 0 154,549 1,424,053 1,578,602 5,392 76.00 76.01 03050 ENDSCOPY 0 166,107 518,751 684,858 13,117 76.01 76.02 03051 CARDI A C REHAB 0 0 0 32,762 32,762 1,850 76.02 76.00 09000 CLINI IC 0 487,909 12,668 500,577 11,356 90.00 79.00 09000 CLINI IC 0 487,909 12,668 500,577 11,356 90.00 79.00 09000 DEBREGENCY 0 481,724 356,459 838,183 15,190 91.00 79.00 09000 DURBATE ENT SERVI CE COST CENTERS 0 11,032 293,088 304,120 9,594 95.00 79.00 09000 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 70.00 09000 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 70.00 09000 DURBALE MEDI CAL EQUI P-RENTED 0 0 10,000 70.00 09000 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 70.00 09000 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 70.00 09000 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 70.00 09000 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 70.00 09000 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 70.00 09000 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 70.00 09000 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0			0	l				•
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69. 00 06900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 35, 915 501, 459 537, 374 4, 264 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 73. 00		06700 OCCUPATIONAL THERAPY	0	1			0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0	0	0	0		
71. 00			0					1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 189, 604 3, 954 193, 558 0 74. 00 76. 00 03140 CARTH LAB 0 154, 549 1, 424, 053 1, 578, 602 5, 392 76. 00 76. 01 03050 ENDOSCOPY 0 166, 107 518, 751 684, 858 13, 117 76. 01 76. 02 03051 CARDI AC REHAB 0 0 0 32, 762 32, 762 1, 850 76. 00 09000 CLI NI C 0 487, 909 12, 668 500, 577 11, 356 90. 00 79. 00 09000 DEMERGENCY 0 481, 724 356, 459 838, 183 15, 190 79. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 79. 00 09500 AMBULANCE SERVI CES 0 11, 032 293, 088 304, 120 9, 594 79. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79. 00 10500 KI DNEY ACQUI SI TI ON 0 50, 267 11, 004 61, 271 0 105. 00 79. 00 10600 HEART ACQUI SI TI ON 0 70, 045, 676 21, 189, 792 38, 235, 468 466, 785 79. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 3, 024 3, 024 0 192. 00 794. 00 19750 CLOSED PSYCH UNIT 0 0 0 0 0 0 794. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 794. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 794. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 794. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 795. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 796. 00 0 0 0 0 0 0 0 797. 00 0 0 0 0 0 0 798. 00 0 0 0 0 0 0 0 799. 00 0 0 0 0 0 0 799. 00 0 0 0 0 0 0 799. 00 0 0 0 0 0 0 799. 00 0 0 0 0 0 0 799. 00 0 0 0 0 0 799. 00 0 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0		I I	Ö	0 0		0		
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76. 00 03140 CARDI O CATH LAB 0 154,549 1,424,053 1,578,602 5,392 76. 00 76. 01 03050 ENDOSCOPY 0 166,107 518,751 684,858 13,117 76. 01 03050 ENDOSCOPY 0 0 166,107 518,751 684,858 13,117 76. 01 03050 CARDI AC REHAB 0 0 0 32,762 32,762 1,850 76. 02 00 09000 CLI NI C 0 0 487,909 12,668 500,577 11,356 90. 00 09100 EMERGENCY 0 481,724 356,459 838,183 15,190 91. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART OF THER REI MBURSABLE COST CENTERS 0 0 11,032 293,088 304,120 9,594 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 96. 00 9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 50,267 11,004 61,271 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 17,045,676 21,189,792 38,235,468 466,785 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 17,045,676 21,189,792 38,235,468 466,785 118. 00 NONREI MBURSABLE COST CENTERS 0 0 3,024 3,024 0 192. 00 194. 00 107951 MARKETI NG 0 0 0 0 0 0 0 0 194. 00 194. 00 107951 MARKETI NG 0 0 0 0 0 0 0 0 0 0 194. 00 194. 00 107951 MARKETI NG 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	100 (04	0	102 550		
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105. 00	96.00		0		<u> </u>	U	0	96.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 17, 045, 676 21, 189, 792 38, 235, 468 466, 785 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 57, 407 4, 604 62, 011 0 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 024 3, 024 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 194. 00 194. 01 194. 01 197. 01 19	105.00		0	50, 267	11, 004	61, 271	0	105. 00
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190. 00	118.00		0	17, 045, 676	21, 189, 792	38, 235, 468	466, 785	J118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	190. 00		0	57. 407	4.604	62. 011	0	190, 00
194. 01 07951 MARKETI NG 0 0 3, 120 3, 120 1, 400 194. 01			0	0			0	192. 00
194. 01 07951 MARKETING 0 0 3, 120 1, 400 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 0 0 149 194. 02	194.00	07950 CLOSED PSYCH UNIT	0	0	0	0	0	194. 00
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Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B		
				From 07/01/2013 To 06/30/2014		pared:	
					12/1/2014 9:5	5 am	
		CAPI TAL REI	_ATED COSTS				
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE		
	Assigned New				BENEFI TS		
	Capi tal				DEPARTMENT		
	Related Costs						
	0	1. 00	2.00	2A	4. 00		
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	88, 08	88, 082		194. 03	
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0 0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	0	17, 103, 083	21, 288, 62	38, 391, 705	469, 090	202. 00	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150017

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared: |

				'	0 06/30/2014	Date/lime Pre 12/1/2014 9:5	
	Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE		
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	412 207					4.00
5. 01 5. 02	OO540 ADMITTING OO560 OTHER ADMINISTRATIVE AND GENERAL	412, 206					5. 01 5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	31, 599		61, 015		8. 00
9. 00	00900 HOUSEKEEPI NG	Ö	74, 002			207, 220	1
10.00	01000 DI ETARY	0	84, 009			12, 215	1
11. 00	01100 CAFETERI A	0	37, 305		0	0	1
13.00	01300 NURSING ADMINISTRATION	0	46, 604	60, 908	0	2, 888	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0			0	5, 275	1
15. 00	01500 PHARMACY	0			0	3, 020	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0			0	3, 225	
17. 00	01700 SOCIAL SERVICE	0	56, 343	45, 817	0	2, 173	1
21. 00 22. 00	O2100 L&R SERVICES-SALARY & FRINGES APPRV O2200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	61, 483		0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		8, 509		161	0 1, 217	1
23. 00	02301 PHARMACY RESIDENCY PROGRAM			23, 074	0	1, 217	1
20.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1,001				20.01
30.00	03000 ADULTS & PEDIATRICS	20, 344	622, 372	941, 467	21, 893	44, 645	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	498			415	1, 844	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	2, 947	75, 895		475	4, 659	1
31. 03	03101 CARDIO INTENSIVE CARE UNIT	13, 404	336, 958		7, 507	16, 648	1
32.00	03200 CORONARY CARE UNIT	5, 195	123, 852	136, 713		6, 483	
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	
43. 00	04300 NURSERY	351	8, 677	4, 847	0	230	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	74, 511	586, 824	917, 647	12, 025	43, 514	50.00
51. 00	05100 RECOVERY ROOM	74, 311		917, 047	12,023	43, 314	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 455	_		0	Ő	1
53.00	05300 ANESTHESI OLOGY	8, 765		710	0	34	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 845	188, 763	140, 681	3, 066	6, 671	54.00
54.01	05401 PET SCAN	1, 193	18, 197	15, 314	0	726	54. 01
56.00	05600 RADI OI SOTOPE	6, 016	1		0	1, 691	56. 00
57. 00	05700 CT SCAN	15, 341	29, 480	17, 640		836	1
58. 00	05800 MRI	0	0	0	0	0	
60.00	06000 LABORATORY	34, 073			82	7, 174	1
65. 00 66. 00	06500 RESPIRATORY THERAPY	11, 038	l ·		233	2, 418	1
67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	3, 687	96, 231 0	107, 950	0	5, 119 0	1
68. 00	06800 SPEECH PATHOLOGY	0			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	12, 681	47, 199	120, 272	230	5, 703	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 801	46, 617		0	633	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 393			0		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	42, 179		0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	67, 343			0	0	
74. 00	07400 RENAL DI ALYSI S	1, 892				3, 342	1
76. 00	03140 CARDIO CATH LAB	16, 029					
76. 01	03050 ENDOSCOPY	10, 195		61, 752			1
76.02	03051 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	717	12, 811		0	0	76. 02
90. 00	09000 CLINIC	660	95, 041	181, 385	936	8, 601	90.00
	09100 EMERGENCY	18, 273					1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 2/3	147, 047	179,000	7, 120	0, 472	92.00
, 00	OTHER REIMBURSABLE COST CENTERS		1				1
95.00	09500 AMBULANCE SERVICES	1, 421	85, 929	4, 101	0	194	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	312			0		105. 00
	10600 HEART ACQUISITION	647	l ·		0		106. 00
118. 00	,	412, 206	6, 039, 645	4, 383, 381	61, 015	206, 208	J118. 00
100.00	NONREI MBURSABLE COST CENTERS	_	1 275	24 244	^	1 010	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 375 10, 138		0		190. 00 192. 00
	07950 CLOSED PSYCH UNIT		10, 138		0		194. 00
	07951 MARKETI NG		46, 499				194. 00
	07952 SENI OR CI RCLE	0	1, 748		l 0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	l o	6, 557		l		194. 03
200.00]				200. 00
201.00		0	О	0	0	0	201. 00

Health Financial Systems	LUTHERAN HOSPI	TAL OF INDIANA		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014		narod:
				10 00/30/2014	12/1/2014 9:5	
Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE		
		AND GENERAL				
	5. 01	5. 02	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118-201)	412, 206	6, 105, 962	4, 404, 72	22 61, 015	207, 220	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				06/30/2014	12/1/2014 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11. 00	13.00	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
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. 01 00540 ADMITTING						5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
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	1, 118, 479					10. 00
11. 00 01100 CAFETERI A	0	44, 313				11. 00
13.00 O1300 NURSING ADMINISTRATION	0	524	288, 825			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	1, 403	0	949, 991		14. 00
15. 00 01500 PHARMACY	0	2, 026	0	23, 269	580, 571	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1, 791	0	792	0	16. 00
17. 00 01700 SOCI AL SERVI CE	0	832	0	139	0	17. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	76	1	36	0	23. 00
23. 01 O2301 PHARMACY RESIDENCY PROGRAM	0	76	0	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	465, 333	8, 994	81, 637	35, 391	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	_	0	0	31.00
31. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T	9, 975	316		1, 242	0	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	64, 263	949		5, 763	0	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	221, 180	4, 793		21, 563	0	31. 03
32. 00 03200 CORONARY CARE UNIT	43, 530	1, 639		8, 607	0	32. 00
40. 00 04000 SUBPROVI DER - PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	21, 943	119	1, 346	951	0	43. 00
ANCI LLARY SERVI CE COST CENTERS		4.407	00.407	440.000		F0 00
50. 00 05000 OPERATI NG ROOM	0	4, 107		112, 328	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	_	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	496		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	127		36	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 293		7, 777	0	54.00
54. 01 05401 PET SCAN	0	19	1	510	0	54. 01
56. 00 05600 RADI OI SOTOPE	0	155		510	0	56.00
57. 00 05700 CT SCAN	U	355	3, 229	1, 244	-	57. 00
58. 00 05800 MRI	0	2 512	0	(4.051	0	58.00
60. 00 06000 LABORATORY	0	2, 512	1	64, 051	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 929	0	6, 818	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 191		1, 923	0	66.00
	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	U E01	1	402	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	591 477		482 6, 697	0	69. 00 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4//	1	278, 278	0	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		313, 115	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		313, 113	580, 571	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		790	0	74.00
76. 00 03140 CARDI O CATH LAB	0	520	5, 971	12, 515	0	76.00
76. 01 03050 ENDOSCOPY	0	1, 577		18, 476	0	76. 01
76. 02 03051 CARDI AC REHAB	0	264		265	0	76. 01
OUTPATIENT SERVICE COST CENTERS	<u> </u>	204	<u> </u>	200		70.02
90. 00 09000 CLINIC	0	994	12, 575	7, 481	0	90.00
91. 00 09100 EMERGENCY	0	1, 789		17, 583	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o _l	1, 707	10, 021	17, 303	O	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVI CES	0	978	o	1, 774	0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	1	1, 7, 7	0	96.00
SPECIAL PURPOSE COST CENTERS	Ο _Ι		<u> </u>	<u> </u>		70.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	116	ol	nl	Ω	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	66	1	0		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	826, 224	44, 094		949, 896	580, 571	
NONREI MBURSABLE COST CENTERS	020, 224	44, 074	200, 023	747, 070	300, 371	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	<u> </u>	0	E	n	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	251, 171	0	1	0		192.00
194.00 07950 CLOSED PSYCH UNIT	231, 171	0		0		194. 00
194. 01 07951 MARKETI NG	0	146		81		194. 01
194. 02 07952 SENI OR CI RCLE	0	140	1			194. 01
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	41, 084	57		9		194. 02
200.00 Cross Foot Adjustments	41,004	37		٩	Ü	200.00
201.00 Negative Cost Centers	0	0	0	٥	Λ	200.00
	<u> </u>		<u> </u>	9	0	

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014	Part II Date/Time Pre	narod:
					12/1/2014 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI (N SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
202.00 TOTAL (sum lines 118-201)	1, 118, 479	44, 313	288, 82	949, 991	580, 571	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150017

Peri od: Worksheet B From 07/01/2013 Part II To 06/30/2014 Date/Time Prepared:

12/1/2014 9:55 am INTERNS & RESIDENTS PARAMED ED MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Cost Center Description RECORDS & Y & FRINGES PRGM COSTS PRGM LI BRARY **APPRV APPRV** 23.00 16.00 17.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMITTING 5.01 5. 01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 426, 831 16.00 01700 SOCIAL SERVICE 17.00 237, 424 17.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21 00 0 0 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 61, 483 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 C 105, 944 23.00 23.00 02301 PHARMACY RESIDENCY PROGRAM 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 21,028 11, 737 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 515 287 31.01 02060 NEONATAL INTENSIVE CARE UNIT 3.046 31 02 1,700 31 02 31. 03 03101 CARDIO INTENSIVE CARE UNIT 13,855 7, 733 31.03 03200 CORONARY CARE UNIT 32.00 5, 369 2, 997 32.00 04000 SUBPROVI DER - I PF 40.00 0 C 40.00 04300 NURSERY 362 202 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 77, 774 42, 601 50 00 51.00 05100 RECOVERY ROOM 51.00 05200 DELIVERY ROOM & LABOR ROOM 1,504 52 00 839 52 00 05300 ANESTHESI OLOGY 9,060 5,057 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 479 10, 872 54.00 05401 PET SCAN 1, 233 54.01 54.01 688 05600 RADI OI SOTOPE 3, 471 56.00 6, 218 56.00 57.00 05700 CT SCAN 15,858 8,851 57.00 58.00 05800 MRI 58.00 06000 LABORATORY 35, 219 19, 657 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 11, 410 6,368 65.00 66.00 06600 PHYSI CAL THERAPY 3,812 2, 127 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 C 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 13, 107 7, 316 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,861 1, 039 70.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 21.079 11, 765 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 598 24, 334 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 69, 610 38, 852 73.00 07400 RENAL DIALYSIS 1.956 74.00 1, 092 74.00 03140 CARDIO CATH LAB 76.00 16, 568 9, 248 76.00 76.01 03050 ENDOSCOPY 10,538 5, 882 76.01 03051 CARDI AC REHAB 741 413 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 682 381 90.00 09100 EMERGENCY 18,888 10, 542 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 469 820 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 105 00 323 180 106.00 10600 HEART ACQUISITION 669 373 106.00 426, 831 SUBTOTALS (SUM OF LINES 1-117) 118.00 237, 424 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 0 194.00 07950 CLOSED PSYCH UNIT 0 194.00 194. 01 07951 MARKETI NG 194. 01 0 194. 02 07952 SENI OR CIRCLE 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 194.03

Health Financial Systems	LUTHERAN HOSPI	TAL OF INDIANA		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eri od:	Worksheet B	
				rom 07/01/2013 o 06/30/2014	Date/Time Pre	pared:
					12/1/2014 9:5	5 am
			INTERNS &	RESI DENTS		
Cost Center Description	MEDICAL RECORDS &	SOCI AL SERVI CE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	
	LI BRARY		APPRV	APPRV	PRGIVI	
	16.00	17. 00	21.00	22. 00	23. 00	
200.00 Cross Foot Adjustments			C	61, 483	105, 944	200. 00
201.00 Negative Cost Centers	C	0	C	0		201. 00
202.00 TOTAL (sum lines 118-201)	426, 831	237, 424	[C	61, 483	105, 944	202. 00

	Financial Systems	LUTHERAN HUSPITA		001 450047 5		U OF FORM CMS-2552	2-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 07/01/2013 To 06/30/2014		ed:
	Cost Center Description	PHARMACY RESI DENCY PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23. 01	24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMI TTI NG						5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL					· · · · · · · · · · · · · · · · · · ·	5. 02
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE					· · · · · · · · · · · · · · · · · · ·	7. 00 3. 00
9. 00	00900 HOUSEKEEPING					· · · · · · · · · · · · · · · · · · ·	9. 00
10.00	01000 DI ETARY					l .	0. 00
11.00	01100 CAFETERI A					l .	1.00
13. 00 14. 00	O1300 NURSI NG ADMINI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY					l I	3. 00 4. 00
15. 00	01500 PHARMACY						5. 00
	01600 MEDICAL RECORDS & LIBRARY					l I	5. 00
17. 00	01700 SOCIAL SERVICE					l I	7. 00
21. 00 22. 00	O2100 L&R SERVICES-SALARY & FRINGES APPRV O2200 L&R SERVICES-OTHER PRGM COSTS APPRV					l I	1.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)						3. 00
23. 01	02301 PHARMACY RESIDENCY PROGRAM	5, 338				l .	3. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS		7, 886, 138 0	1			0.00
31.00	03100 INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT		214, 791			l .	1. 00 1. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT		663, 832			l I	1. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT		2, 255, 162				1. 03
32. 00	03200 CORONARY CARE UNIT		823, 282	1		l .	2. 00
40. 00 43. 00	04000 SUBPROVI DER - PF 04300 NURSERY		0 54, 802) C		l .	0. 00 3. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		01,002	-1	01,002	10	<i>7.</i> 00
50.00	05000 OPERATI NG ROOM		8, 928, 133			l .	0. 00
51.00	05100 RECOVERY ROOM		40.034	1		l I	1.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		49, 926 33, 459				2. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		2, 368, 653			l .	4. 00
54. 01	05401 PET SCAN		636, 468			l I	4. 01
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN		204, 038	1			6. 00 7. 00
58. 00	05800 MRI		193, 498 0				3. 00
60.00	06000 LABORATORY		1, 842, 748				0. 00
65. 00	06500 RESPI RATORY THERAPY		605, 133		,	l I	5. 00
	06600 PHYSI CAL THERAPY		746, 450				5. 00
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		0				7. 00 3. 00
69. 00	06900 ELECTROCARDI OLOGY		861, 843				9. 00
	07000 ELECTROENCEPHALOGRAPHY		614, 115	1	614, 115		0. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		728, 206 856, 107	1			1.00
73. 00			1, 319, 449		,		3. 00
74.00	07400 RENAL DIALYSIS		321, 941				4. 00
76.00	03140 CARDIO CATH LAB		1, 799, 228	•		l I	5. 00
76. 01	03050 ENDOSCOPY 03051 CARDI AC REHAB		954, 383 49, 823	1		l .	6. 01 6. 02
70.02	OUTPATIENT SERVICE COST CENTERS		47, 023	,	47,023	70). UZ
90.00	09000 CLI NI C		820, 669				0. 00
91.00			1, 281, 621				1.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			C)	92	2. 00
95. 00	09500 AMBULANCE SERVICES		410, 400) C	410, 400	95	5. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		0			l .	5. 00
405.00	SPECIAL PURPOSE COST CENTERS		110 500		110 500	105	
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION		119, 599 35, 262				5. 00
118.00		0				l I	3. 00
	NONREI MBURSABLE COST CENTERS	-	21/211/121		31,311,131		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		85, 744			l I	0.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT		264, 333			l I	2. 00 4. 00
	07950 CLOSED PSYCH UNIT		51, 246				4. 00 4. 01
194. 02	07952 SENI OR CI RCLE		1, 922	: c	1, 922	194	1. 02
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS		136, 536	o C	136, 536	194	1. 03

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B
				From 07/01/2013	Part II
				To 06/30/2014	Date/Time Prepared:
					12/1/2014 9:55 am
Cost Center Description	PHARMACY	Subtotal	Intern &	Total	
	RESI DENCY		Residents Cos	t	
	PROGRAM		& Post		
			Stepdown		
			Adjustments		
	23. 01	24.00	25. 00	26.00	
200.00 Cross Foot Adjustments	5, 338	172, 765		0 172, 765	200. 00
201.00 Negative Cost Centers	0	0)	0 0	201. 00
202.00 TOTAL (sum lines 118-201)	5, 338	38, 391, 705		0 38, 391, 705	202. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	LUTHERAN HOSPI		CCN: 150017 P	<u> </u>	wof Form CMS-2 Worksheet B-1	
COST ALLOCATION - STATISTICAL BASIS		Frovider	F	rom 07/01/2013		
			T	o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	CAPITAL RE	LATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMITTING	Reconciliation	
	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	(GROSS CHAR		
			DEPARTMENT (GROSS	GES)		
			SALARI ES)			
GENERAL SERVICE COST CENTERS	1.00	2. 00	4. 00	5. 01	5A. 02	
1.00 O0100 CAP REL COSTS-BLDG & FIXT	716, 220	ol				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		9, 982, 305				2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	18, 728					4.00
5. 01 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	15, 437 31, 049			1, 984, 598, 649 0	-52, 492, 986	5. 01 5. 02
7. 00 00700 OPERATION OF PLANT	154, 838				02, 172, 700	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	898		0	0	0	8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	3, 015 29, 016				0	9. 00 10. 00
11. 00 01100 CAFETERI A	29,010		1, 544, 259		o o	11. 00
13.00 01300 NURSING ADMINISTRATION	6, 86			0	0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	12, 530 7, 173			0	0 0	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	7, 173				0	16.00
17.00 01700 SOCIAL SERVICE	5, 161		1, 956, 174		0	17. 00
21.00 02100 L&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	(-	0	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)	2, 892	-1	178, 102	0	0	22. 00 23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM		1			0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10/ 051	1 400 004	1/ 2/1 /7/	07 00/ 570	0	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	106, 051	1, 409, 094	16, 241, 476 0	97, 806, 578 0	0	30. 00 31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	4, 38	1 11, 021	761, 018	2, 394, 923	ő	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	11, 068				0	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	39, 548 15, 400					31. 03 32. 00
40. 00 04000 SUBPROVI DER - PF	15, 400		3,074,214		0	40.00
43. 00 04300 NURSERY	546	713	267, 764	1, 685, 765	0	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	103, 368	2, 116, 105	7, 897, 878	361, 071, 239	0	50.00
51. 00 05100 RECOVERY ROOM	103, 300	. 1	0	0 0 0 0 0 0	o o	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		-	1, 111, 063		0	52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	80 15, 847		120, 836 4, 502, 763		0	53. 00 54. 00
54. 01 05400 RADI OLOGI - DI AGNOSTI C	1, 725				0	54. 00
56. 00 05600 RADI OI SOTOPE	4, 018	4, 823	353, 944	28, 920, 949	i e	56. 00
57. 00 05700 CT SCAN 58. 00 05800 MRI	1, 987	7 23, 148	642, 653	73, 756, 438	0 1 0	57. 00 58. 00
60. 00 06000 LABORATORY	17, 041	342, 978	4, 470, 469	163, 810, 992		60.00
65. 00 06500 RESPI RATORY THERAPY	5, 745	111, 047	3, 709, 962	53, 068, 637	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	12, 160		2, 927, 352	17, 728, 066	0 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		1	0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	13, 548	-	1, 031, 323	_	Ö	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 504	235, 136	939, 717		l	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS			0	98, 043, 620 202, 783, 096	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		o o	ő	323, 765, 854	ő	73. 00
74. 00 07400 RENAL DI ALYSI S	7, 940			9, 098, 177	0	74.00
76. 00 03140 CARDI 0 CATH LAB 76. 01 03050 ENDOSCOPY	6, 472 6, 956				0	76. 00 76. 01
76. 02 03051 CARDI AC REHAB	0, 750				0	76. 02
OUTPATIENT SERVICE COST CENTERS			·			
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	20, 432 20, 173					90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	20, 173	107, 143	3, 347, 366	87, 830, 370		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	462					95.00
96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS		0	0	0	0	96. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	2, 105	5, 160	0	1, 500, 085	0	105. 00
106. 00 10600 HEART ACQUISITION	712.01			3, 110, 700		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	713, 816	9, 935, 963	102, 851, 486	1, 984, 598, 649	-52, 492, 986	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 404	2, 159	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES			0	0		192. 00
194. 00 07950 CLOSED PSYCH UNIT 194. 01 07951 MARKETI NG		l .	0 308, 486	0		194. 00 194. 01
	1	-1 1, 403	1 550, 400		<u> </u>	1

Heal th Finan	cial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der	CCN: 150017	Peri od:	Worksheet B-1	
					From 07/01/2013 To 06/30/2014		
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE) BENEFITS	(GROSS CHAR	Reconciliation	
				DEPARTMENT (GROSS SALARI ES)	GES)		
		1. 00	2. 00	4. 00	5. 01	5A. 02	
194. 02 07952	SENIOR CIRCLE	0		0 32, 8	51 0	0	194. 02
194. 03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	41, 30	2 166, 5°	15 0	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	17, 103, 083	21, 288, 62	2 16, 087, 8	8, 112, 355		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	23. 879650	2. 13263	6 0. 1556!	0. 004088		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			469, 0	412, 206		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part II)			0. 0045	0. 000208		205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Provi der CCN: 150017 Peri od: From 07/01/2013 To 06/30/2014 Worksheet B-1 To 06/30/2014 Date/Time Prepared: 12/1/2014 9: 55 am

LAUNDRY & HOUSEKEEPING DI ETARY
LI NEN SERVI CE (SQUARE FEET) (MEALS SERVED) Cost Center Description OTHER ADMI NI STRATI VE OPERATION OF PLANT

		<u>'</u>	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	
			5. 02	7. 00	8. 00	9. 00	10. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2. 00		CAP REL COSTS-BLDG & TTXT						2.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		ADMITTI NG						5. 01
5.02		OTHER ADMINISTRATIVE AND GENERAL	276, 677, 726					5. 02
7.00	1	OPERATION OF PLANT	15, 442, 094	496, 168				7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	1, 431, 821 3, 353, 192	898 3, 015		492, 255		8. 00 9. 00
10. 00		DIETARY	3, 806, 659	29, 016		29, 016	714, 581	10.00
11. 00		CAFETERI A	1, 690, 372	0		0	0	11. 00
13.00	1	NURSING ADMINISTRATION	2, 111, 757	6, 861	0	6, 861	0	13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	7, 038, 843	12, 530		12, 530	0	14. 00
15.00	1	PHARMACY	8, 370, 112	7, 173		7, 173	0	15. 00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	5, 008, 059 2, 553, 026	7, 661 5, 161		7, 661	0	16. 00 17. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRV	2, 555, 020	5, 101	1	5, 161 0	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	2, 785, 941	0	Ö	0	Ö	22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)	385, 569	2, 892	5, 674	2, 892	0	23. 00
23. 01		PHARMACY RESIDENCY PROGRAM	206, 196	0	0	0	0	23. 01
		ENT ROUTINE SERVICE COST CENTERS		10/ 051	7/0/00	10/ 051	007.004	
30.00	1	ADULTS & PEDIATRICS	28, 202, 908	106, 051		106, 051	297, 294	
31. 00 31. 01		INTENSIVE CARE UNIT PEDIATRIC INTENSIVE CARE UNIT	1, 151, 359	0 4, 381		0 4, 381	0 6, 373	31. 00 31. 01
31. 01	1	NEONATAL INTENSIVE CARE UNIT	3, 438, 965	11, 068		11, 068	41, 057	31. 01
31. 03		CARDIO INTENSIVE CARE UNIT	15, 268, 405	39, 548		39, 548	141, 309	
32.00		CORONARY CARE UNIT	5, 612, 039	15, 400		15, 400	27, 811	32. 00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40. 00
43. 00		NURSERY	393, 164	546	0	546	14, 019	43. 00
50. 00		_ARY SERVICE COST CENTERS OPERATING ROOM	26, 590, 432	103, 368	422, 765	103, 368	0	50. 00
51. 00	1	RECOVERY ROOM	20, 390, 432	103, 306	_	0	0	51.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	1, 586, 259	Ö		0	Ö	52. 00
53.00		ANESTHESI OLOGY	326, 803	80	0	80	0	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	8, 553, 313	15, 847	107, 796	15, 847	0	54. 00
54. 01	1	PET SCAN	824, 551	1, 725		1, 725	0	54. 01
56. 00		RADI OI SOTOPE	1, 843, 684	4, 018		4, 018	0	56.00
57. 00 58. 00	05800	CT SCAN	1, 335, 812	1, 987 0		1, 987 0	0	57. 00 58. 00
60. 00	1	LABORATORY	16, 767, 038	17, 041	_	_	0	60.00
65. 00		RESPI RATORY THERAPY	5, 576, 600	5, 745		5, 745	0	65. 00
66. 00		PHYSI CAL THERAPY	4, 360, 475	12, 160	14	12, 160	0	66. 00
67. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00		SPEECH PATHOLOGY	0	12.540	0	0	0	68. 00
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	2, 138, 684 2, 112, 318	13, 548 1, 504		13, 548 1, 504	0	69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	17, 975, 055	1, 304		1, 304	0	71.00
	1	IMPL. DEV. CHARGED TO PATIENTS	19, 614, 899			_	0	
	1	DRUGS CHARGED TO PATIENTS	25, 514, 203	0	0	0	0	73. 00
74.00		RENAL DIALYSIS	2, 212, 327	7, 940		7, 940	0	74. 00
76. 00		CARDIO CATH LAB	4, 210, 236	6, 472		6, 472	0	76. 00
76. 01 76. 02	1	ENDOSCOPY CARDI AC REHAB	5, 817, 813 580, 491	6, 956 0		6, 956 0	0	76. 01 76. 02
70.02		TIENT SERVICE COST CENTERS	360, 491	0	0	0	0	70.02
90. 00		CLINIC	4, 306, 520	20, 432	32, 908	20, 432	0	90.00
91.00		EMERGENCY	6, 780, 972	20, 173			0	91. 00
92.00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05.00		REI MBURSABLE COST CENTERS	0.000 (7.1					
95. 00	1	AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	3, 893, 674 0	462 0		462 0	0 0	95. 00 96. 00
96. 00		AL PURPOSE COST CENTERS	U	U	0	0	0	90.00
105.00		KIDNEY ACQUISITION	1, 713, 914	2, 105	0	2, 105	0	105. 00
		HEART ACQUISITION	786, 151	0		0		106. 00
118. 00	-	SUBTOTALS (SUM OF LINES 1-117)	273, 672, 705	493, 764	2, 145, 118	489, 851	527, 863	118. 00
40		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	62, 324	2, 404		2, 404		190.00
		PHYSICIANS' PRIVATE OFFICES CLOSED PSYCH UNIT	459, 365 0	0	0	0	160, 470 0	194. 00
		MARKETI NG	2, 106, 979	0	1 0	0		194. 00
		SENI OR CIRCLE	79, 218	Ö	o o	Ö	0	194. 02
194. 03	07953	OTHER NONREIMBURSABLE COST CENTERS	297, 135	0	0	0	26, 248	194. 03
200.00	<u> </u>	Cross Foot Adjustments						200. 00

Heal th	Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2013	Worksheet B-1	
					Γο 06/30/2014		
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		AND GENERAL	(SQUARE FEET)	(POUNDS OF			
		(ACCUM. COST)		LAUNDRY)			
		5. 02	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	52, 492, 986	18, 371, 861	1, 736, 72	4, 101, 018	5, 845, 006	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 189726	37. 027501	0. 80961	8. 331084	8. 179627	203. 00
204.00	Cost to be allocated (per Wkst. B,	6, 105, 962	4, 404, 722	61, 01	5 207, 220	1, 118, 479	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 022069	8. 877481	0. 02844	0. 420961	1. 565224	205.00
	11)						

COST CALLOCATION STATISTICAL DASIS Provider ORL 150017 Provider CALLOCATION COST CALLOCATION COST CALLOCATION CALLOCATIO			LUTHERAN HOSPIT				eu of Form CMS-:	
Cost Center Description	COST A	ALLOCATION - STATISTICAL BASIS		Provi der			Worksheet B-1	
Cost Center Description							Date/Time Pre	pared:
CETTE S. MONINGSTANT IN SERVICES RECULS STORMS SERVICES STORMS SERVICES STORMS SERVICES		Cost Center Description	CAFETERIA	NURSLNG	CENTRAL	PHΔRMΔCV		5 am
COUNTRY SERVICE COST CENTERS 1.00 15.00 14.00 15.00 16.00 10.0		cost defiter bescription						
BERSIAL SERVICE COST CENTERS						REQUIS.)		
				7	7		,	
CREAM_SERVICE_COST_CAPILES			11 00			15.00		
2.00 CORDO CAP REL CUSTS -WINELE EQUIP 2.00 CORDO CAP REL CUSTS -WINELE EQUIP 4.00 CORDO CAP REL CUSTS -WINELE EQUI		GENERAL SERVICE COST CENTERS	111.00	10.00	11.00	101.00	10.00	
4.00 ODADO INTERNET IS DEPARTMENT A								1
5.01 0.0540 ADMITTING								1
5.02 0.0500 O.0500							1	
7.00 00700 GERATION OF PLANT 100 001000 CALEFERIA N 100 001000 CALEFERIA N 100 001000 CALEFERIA N 100 001000 CALEFERIA N 11.00 011000 CALEFERIA SERVICES & SUPPLY 11.00 011000 CALEFERIA N 11.00 011								1
9.00 00000 MUSICKEET INS								1
10.00 101000 DIETARY								1
11.00 01100 CAFETERIA 10.0, 752 1.00 01100 CAFETERIA 10.0, 1752 1.00 01100 CENTRAL SERVICES & SUPPLY 5.089 57,472,552 5.697,555 1.30,104 1								1
13.00 01300 IURISI NO ZOMINI STRATION 1,002 57,472,505 56,997,955 1.0 1.0 01300 IURISI NO ZOMINI STRATION 1,002 1.0 0.0 0.0 1.396,104 1.0 0.			160, 752					1
15.00 101000 PHARMACY 17.348		01300 NURSI NG ADMI NI STRATI ON	1, 902	57, 472, 552				1
16.00 16-00 MEDICAL RECORDS & LIBRARY 6,496 0 47,523 0 1,984,598,404 16,00 17,00 1700 01			1	1				1
17.00 01700 SOCIAL SERVICE 3.018				1			l	
21.00 02.00 AR SERVICES-SALARY & FINNES APPRIVED 0 0 0 0 22.00		I I		1		0	l '	1
22.00 02200 ABN SERVICES-OTHER PROM COSTS APPRV 0 0 2.90 0 0 22.00 23.01 02300 PARAMED ED PREAM-CSPECIES 7.74 0 0 0 0 0 23.01 02300 PARAMED ED PREAM-CSPECIES 7.74 0 0 0 0 0 0 23.01 02300 PARAMED ED PREAM-CSPECIES 7.75 0 0 0 0 0 0 0 0 0			1	1		Ö	·	1
1,230	22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	C	o	29	0	0	1
IMPARTIENT ROUTINE SERVICE COST CENTERS		1 1	1	1	· ·			1
30.00 30.00 ADULTIS & PEDIATRICS 32, 628 16, 241, 477 2, 123, 399 0 97, 806, 578 30, 00 31, 00 310, 10 100, 100 10 10 10 10	23. 01		276) <u> </u>	0	O	0	23.01
31.00 0.03100 INTERSIYE CARE UNIT	30. 00		32, 628	16, 241, 477	2, 123, 399	0	97, 806, 578	30.00
31.02 02000 NEONATAL INTENSIVE CARE UNIT 17,3 86 9,915; 102 1,293,731 0 14,166,360 31.02 3				1				1
31.03 (3010) CARDIO I NITENSIVE CARE UNIT		i i		1		_	1	1
32.00 0 30200 CORDINARY CARE UNIT 5, 945 3, 674, 214 516, 409 0 24, 974, 258 32.00 0 0 3000 NURSERY F 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_		
40.00 04000 04000 04000 0 0 0								
MOLILLARY SERVICE COST CENTERS			1			_	1	1
50.00	43.00		433	267, 764	57, 070	0	1, 685, 765	43. 00
51.00 05100 RECOVERY ROOM LABOR ROOM 1.799 1.111, 063 0 0 0 0 6.994, 934 52.00 52.00 05200 DELIVERY ROOM LABOR ROOM 1.799 1.111, 063 0 0 0 0 0 0 0 0 0	FO 00		14 000	7 007 070	/ 720 F74	0	2/1 071 220	1 50 00
52.00 05200 DELLYREY ROOM & LABOR ROOM 1.799 1.111. 063 0 0 6.994, 934 52. 00 53.00 53.00 63.00 ARSTHESI LOGY 46.2 0 2.132 0 42. 141. 130 53. 00 53.00 ARSTHESI LOGY 69.9 335. 040 0 0 5.735. 464 54. 01 0 0 0 0 5.735. 464 54. 01 0 0 0 0 0 0 5.735. 464 54. 01 0 0 0 0 0 0 0 0 0			14, 900					1
54.00 05400 RADI DLOCY-DI AGNOSTIC 8.317 4.502, 763 466, 625 0 90, 599, 823 54.00 156.00 05600 RADI DISTORE 564 353, 944 30, 597 0 28, 920, 949 56.00 157.00 05700 CT SCAN 1, 287 642, 653 74, 616 0 73, 756, 438 57.00 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 RESPI RATIORY THERAPY 9, 113 0 3, 842, 969 0 163, 810, 992 60.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 72, 00 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 18, 85, 76, 858 0 77, 06, 26, 30 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 18, 85, 76, 858 0 77, 06, 26, 30 159.00 07000 RESPI RATIORY THERAPY 74, 00			1, 799	1			l	1
54.01 05401 PET SCAN 69 35, 040 0 0 5, 735, 464 54.00		I I	1	1		0		1
56.00 OSGO RADIO I SOTOPE 564 333, 944 30, 597 0 28, 920, 949 56, 00 58, 00 07, 00 5700 CT SCAN 1, 287 642, 653 74, 616 0 73, 756, 438 57, 00 58, 00 0800 MRI 0 0 0 0 0 0 0 0 0								1
57.00 OSTOO CT SCAN 1,887 642,653 74,616 0 73,756,438 57.00		I I				_		1
58. 00 05800 MR 0 0 0 0 0 0 0 58. 00 0. 00 06000 LABORATORY 9,113 0 3,842,969 0 163,810,992 60. 00 065.00 06500 RESPIRATORY THERAPY 6,996 0 409,068 0 53,068,637 65. 00 066.00 06600 PRYSI CAL THERAPY 4,321 0 115,371 0 17,728,066 66. 00 067.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 08. 00 06900 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 071.00 071000 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 16,696,359 0 98,043,620 71.00 072.00 072000 IMPL. DEV. CHARGED TO PATIENTS 0 0 18,785,922 0 202,783,096 72.00 073.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 18,785,922 0 24,190,648 323,765,854 73.00 074.00 07400 RENAL DIALYSIS 0 0 0 0 47,379 0 076.00 03140 CABDIO CATH LAB 1,888 1,188,201 75,0858 0 77,062,563 76.00 076.01 03050 EMDOSCOPY 5,719 2,890,456 1,108,515 0 49,012,568 76.00 076.02 03051 CARDIAC REHAB 957 0 15,894 0 3,444,797 076.02 0000 0000 CLINIC C 3,606 2,502,494 448,830 0 3,173,904 077.00 09000 CHINEC SERVICES 3,547 0 106,413 0 6,83,008 079.00 09000 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 0						-		1
65.00 05500 RESPIRATORY THERAPY 6,996 0 409,068 0 53,068,637 65.00	58. 00	05800 MRI		1	0	0	0	58. 00
66.00 06600 PMSI CAL THERAPY 0 0 115, 371 0 17, 728, 066 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68.00 06900 069000 SPEECH PATHOLOGY 2,145 0 28,942 0 60,964,769 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 16,696,359 0 98,043,620 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 16,696,359 0 98,043,620 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 18,785,922 0 020,783,096 72.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 24,190,648 323,765,854 73.00 74.00 07400 REVAL DI LALYSI S 0 0 0 47,379 0 9,098,177 74.00 76.00 07400 REVAL DI LALYSI S 0 0 0 47,379 0 9,098,177 74.00 76.00 07400 CARDI LA BREWLE CAST CENTERS 0 0 0 18,885 0 07,062,563 76.00 76.01 07500 CARDI LA BREWLE CAST CENTERS 0 0 0 3,444,797 76.02 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 07500 07500 76.00 07500 07500 07500 07500 07500 07500 07500 07500 76.00 07500				1		_		1
67. 00 06700 05CUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0		I I				-		1
68. 00 66800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 2, 145 0 28, 942 0 60, 964, 769 80, 00 70. 00 07000 ELECTROCENCEPHALOGRAPHY 1, 730 0 401, 802 0 8, 657, 668 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 16, 696, 359 0 98, 043, 620 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 18, 785, 922 0 2022, 783, 096 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 47, 379 0 9, 098, 177 74. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 47, 379 0 9, 098, 177 74. 00 76. 00 03401 CARDIO CATH LAB 1, 88 1, 188, 201 750, 858 0 77, 062, 563 76. 00 76. 01 03050 ENDOSCOPY 5, 719 2, 890, 456 1, 108, 515 0 49, 012, 568 76. 01 76. 02 03051 CARDIA CREHAB 957 0 15, 894 0 3, 444, 797 79. 00 09000 CLINI C 3, 606 2, 502, 494 448, 830 0 3, 173, 904 90. 00 79. 00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 79. 00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 70. 00 09000 KIDNEY ACQUI SITI ON 242 0 0 0 0 0 3, 110, 700 106, 00 70. 00 09000 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 3, 110, 700 106, 00 70. 00 0000 0000 0000 0000 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 0000 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 0000 0000 0000 0000 70. 00 0000 0000 0000 0000 0000 0000 0000 0000 0000 70. 00 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000		I I				-	,.==,.	1
70. 00 070000 070000 07000 07000 070000 070000 070000 070000 070000 0700000 0700000000			-			_		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 16, 696, 359 0 98, 043, 620 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 18, 785, 922 0 202, 783, 096 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 24, 190, 648 323, 765, 854 73. 00 74				1		0		
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 18, 785, 922 0 202, 783, 096 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 47, 379 0 9, 098, 177 74. 00 74.			1, 730	1		0		1
73. 00						0		
76. 00 03140 CARDI O CATH LAB 1,888 1,188,201 750,858 0 77,062,563 76. 00 76. 01 03050 ENDOSCOPY 5,719 2,890,456 1,108,515 0 49,012,568 76. 01 76. 02 03051 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 76. 02 00 00 00 0 0 0 0 0			Č	Ö		-		1
76. 01 03050 CARDI AC REHAB 957 0 15,894 0 49,012,568 76. 01 76. 02 03051 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 0201 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 0201 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 0201 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 0201 CARDI AC REHAB 957 0 03051 CARDI AC REHAB 957 0 031,73,904 90. 00 09. 00 09. 00 0 0 0 0 0 0 0 0 0			C	o		0		1
76. 02 03051 CARDIAC REHAB 957 0 15,894 0 3,444,797 76. 02 0179ATI ENT SERVICE COST CENTERS 90. 00 0900 CLI NI C 3,606 2,502,494 448,830 0 3,173,904 90. 00 91. 00 09100 EMERGENCY 6,490 3,347,388 1,054,953 0 87,850,570 91. 00 0920 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 106,413 0 6,833,008 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_		1
OUTPATI ENT SERVI CE COST CENTERS 3,606 2,502,494 448,830 0 3,173,904 90.00 91.00 90.00 EMERGENCY 6,490 3,347,388 1,054,953 0 87,850,570 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 92.00 00 00 00 00 00 00 00		i i				_		1
90. 00	70.02		757) 0	15, 674	<u> </u>	3, 444, 777	70.02
92. 00	90.00		3, 606	2, 502, 494	448, 830	0	3, 173, 904	90.00
OTHER REI MBURSABLE COST CENTERS 3, 547 0 106, 413 0 6, 833, 008 95. 00		i i	6, 490	3, 347, 388	1, 054, 953	0	87, 850, 570	1
95. 00	92. 00							92.00
96. 00	95. 00		3,547	0	106, 413	0	6, 833, 008	95. 00
105. 00		I I		1	· ·			1
106. 00			_					
118. 00 SUBTOTALS (SUM OF LINES 1-117) 159, 958 57, 472, 552 56, 991, 845 24, 190, 648 1, 984, 598, 649 18. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 190. 00 192				1		0		
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 194.00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194.00 194.01 07951 MARKETI NG 529 0 4,862 0 0 194.01 194.02 07952 SENI OR CI RCLE 58 0 555 0 0 194.02 194.02 07952 195.02 195.02 195.02 195.02 195.03 195.02 195.02 195.02 195.02 196.04 196.02 195.02 195.02 196.05 196.05 196.05 196.06 196.05 196.05 196.07 196.07 196.08 196.08				1	Ĭ	0 24 190 648		
190. 00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 0 190. 00 192. 00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02	110.00		137, 730	31, 412, 332	30, 771, 043	24, 170, 040	1, 704, 370, 047	1110.00
194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	293	0	0	190. 00
194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02			0	이	0	0		
194. 02 07952 SENIOR CIRCLE 58 0 555 0 0 194. 02			C		0	0	1	1
				1		0	l	1
				1		-		

Health Fina	ancial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTE' S)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LI BRARY	
			(DIRECT NRSING	(COSTED		(GROSS CHAR	
			HRS)	REQUIS.)		GES)	
		11.00	13.00	14.00	15. 00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 011, 080	2, 847, 413	9, 006, 30	10, 596, 025	6, 394, 487	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 510451	0. 049544	0. 15801	2 0. 438022	0. 003222	203. 00
204.00	Cost to be allocated (per Wkst. B,	44, 313	288, 825	949, 99	580, 571	426, 831	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 275661	0. 005025	0. 01666	0. 024000	0. 000215	205. 00
	[11]						

	Financial Systems ALLOCATION - STATISTICAL BASIS	LUTHERAN HOSPITA		CCN: 150017 Pe	In Lie	u of Form CMS-: Worksheet B-1	
C031 F	ALLOCATION - STATISTICAL BASIS		i i ovi dei		om 07/01/2013	Date/Time Pre	pared:
			INTERNS &	RESI DENTS		12/1/2014 9:5	5 am
	Cost Center Description	SOCI AL SERVI CE (GROSS CHAR GES)			PARAMED ED PRGM (ASSI GNED TI ME)	PHARMACY RESI DENCY PROGRAM (ASSI GNED TI ME) 23. 01	
	GENERAL SERVICE COST CENTERS	17.00	21100	221 00	20.00	20.0.	
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMITTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00
9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 984, 598, 649					9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
21. 00 22. 00 23. 00 23. 01	02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY) 02301 PHARMACY RESI DENCY PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0	10, 900	10, 900	66, 466 O	10, 000	21. 00 22. 00 23. 00 23. 01
30.00	03000 ADULTS & PEDIATRICS	97, 806, 578	1, 250	1, 250	48, 341	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	
31. 01 31. 02	02080 PEDIATRIC INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	2, 394, 923 14, 166, 369	50 950	50 950	250 1, 125	0	
31. 03	03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705	0	0	4, 725	0	1
32. 00	03200 CORONARY CARE UNIT	24, 974, 258	0	0	2, 375	0	
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	0 1, 685, 765	0	0	0	0	
43.00	ANCI LLARY SERVI CE COST CENTERS	1,065,765	O	U _I	<u> </u>		43.00
50.00	05000 OPERATING ROOM	361, 071, 239	2, 950	2, 950	1, 775	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	6, 994, 934 42, 141, 130	0	0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	90, 599, 823	0	0	0	0	1
54. 01	05401 PET SCAN	5, 735, 464	0	0	0	0	1
56.00	05600 RADI OI SOTOPE	28, 920, 949	0	0	0	0	
57.00	05700 CT SCAN 05800 MRI	73, 756, 438	0	0	0	0	57. 00 58. 00
	06000 LABORATORY	163, 810, 992	0	0	ol Ol	0	
	06500 RESPI RATORY THERAPY	53, 068, 637	100	100	Ö	0	1
66.00	06600 PHYSI CAL THERAPY	17, 728, 066	0	0	0	0	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	O O	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	60, 964, 769	o	0	Ö	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	8, 657, 668	o	0	0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	98, 043, 620 202, 783, 096	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	323, 765, 854	0	0	o	10, 000	1
74. 00	07400 RENAL DIALYSIS	9, 098, 177	0	0	0	0	
76.00	03140 CARDI O CATH LAB	77, 062, 563	400	400	500	0	
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	49, 012, 568 3, 444, 797	0	0	0	0	
70.02	OUTPATIENT SERVICE COST CENTERS	0, 111, 777	<u> </u>	o _l	91		70.02
90.00	09000 CLI NI C	3, 173, 904	4, 700	4, 700	3, 250	0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	87, 850, 570	0	0	2, 925	0	91. 00 92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	6, 833, 008	0	0	0	0	95. 00
96. 00		0	0	0	0	0	
	10500 KIDNEY ACQUISITION	1, 500, 085	0	0	0		105. 00
	10600 HEART ACQUISITION	3, 110, 700	0	0	1, 200		106.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1, 984, 598, 649	10, 400	10, 400	66, 466	10, 000	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	O	0	O	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	500	500	0		192.00
	007950 CLOSED PSYCH UNIT 107951 MARKETING	0	0	0	0		194. 00 194. 01
174.0	1/07 YO I INPURIENT THO	<u> </u>	ΟĮ		υ _l	0	11/4.01

Health Finar	ncial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 07/01/2013 To 06/30/2014		
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE PRGM COSTS	R PARAMED ED PRGM	PHARMACY RESI DENCY	
		(GROSS CHAR	APPRV	APPRV	(ASSI GNED	PROGRAM	
		GES)	(ASSI GNED	(ASSI GNED	TIME)	(ASSI GNED	
			TIME)	TIME)		TIME)	
		17. 00	21. 00	22. 00	23. 00	23. 01	
194. 02 07952	SENIOR CIRCLE	0	0		0	0	194. 02
194. 03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	3, 310, 569	0	3, 314, 51	1 598, 262	248, 770	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 001668	0. 000000	304. 08357	9. 001023	24. 877000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	237, 424	0	61, 48	3 105, 944	5, 338	204. 00
	1	1	1				1

0. 000000

5. 640642

1. 593958

0. 533800 205. 00

Unit cost multiplier (Wkst. B, Part

					o 06/30/2014	Date/Time Pre 12/1/2014 9:5	pared: 5 am
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	43, 880, 713		43, 880, 713	0	43, 880, 713	30.00
31.00	03100 INTENSIVE CARE UNIT	0		(o	0	31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249		1, 710, 249	ol	1, 710, 249	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	5, 225, 994		5, 225, 994		5, 225, 994	1
31. 03	03101 CARDIO INTENSIVE CARE UNIT	22, 599, 399		22, 599, 399	ol	22, 599, 399	
32. 00	03200 CORONARY CARE UNIT	8, 155, 565		8, 155, 565	ol ol	8, 155, 565	32.00
40.00	04000 SUBPROVI DER - I PF	0			ol	0	40.00
43.00	04300 NURSERY	643, 138		643, 138	0	643, 138	43.00
	ANCILLARY SERVICE COST CENTERS				-1		
50.00		40, 090, 848		40, 090, 848	3 0	40, 090, 848	50.00
51. 00		0		(0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 998, 973		1, 998, 973		1, 998, 973	1
53.00	05300 ANESTHESI OLOGY	604, 621		604, 62		604, 621	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	11, 826, 071		11, 826, 07		11, 826, 071	
54. 01	05401 PET SCAN	1, 089, 879		1, 089, 879		1, 089, 879	
56. 00	05600 RADI OI SOTOPE	2, 546, 579		2, 546, 579		2, 546, 579	1
57. 00	05700 CT SCAN	2, 126, 328		2, 126, 328		2, 126, 328	1
58. 00	05800 MRI	2, 120, 020		2, 120, 020		2, 120, 020	58.00
60. 00	06000 LABORATORY	22, 245, 742		22, 245, 742	o o	22, 245, 742	
65. 00	06500 RESPI RATORY THERAPY	7, 313, 522		7, 313, 522		7, 313, 522	1
66. 00	06600 PHYSI CAL THERAPY	5, 898, 319		5, 898, 319		5, 898, 319	
67. 00	06700 OCCUPATI ONAL THERAPY	3, 070, 317	0	3, 070, 31		0, 070, 317	67. 00
68. 00	06800 SPEECH PATHOLOGY		0			0	68. 00
69. 00		3, 495, 048	0	3, 495, 048		3, 495, 048	1
70. 00	07000 ELECTROCARDI OLOGI	2, 708, 768		2, 708, 768		2, 708, 768	1
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 503, 049		24, 503, 049		24, 503, 049	
71.00		27, 296, 369		27, 296, 369		27, 296, 369	
73. 00	07300 DRUGS CHARGED TO PATIENTS	42, 782, 921		42, 782, 92		42, 782, 921	
74. 00		3, 044, 186		3, 044, 186		3, 044, 186	1
76. 00	03140 CARDI O CATH LAB	5, 921, 720		5, 921, 720		5, 921, 720	1
	03050 ENDOSCOPY				1		1
76. 01		7, 927, 673		7, 927, 673		7, 927, 673	1
76. 02	03051 CARDI AC REHAB	721, 954		721, 954	l 0	721, 954	76. 02
00.00	OUTPATIENT SERVICE COST CENTERS	/ 2/1 700	I	/ 2/1 70/		/ 2/1 700	00.00
	09000 CLINIC	6, 361, 780		6, 361, 780		6, 361, 780	1
91.00		10, 055, 002		10, 055, 002		10, 055, 002	1
92. 00		628, 657		628, 657		628, 657	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	4 747 074		4 747 04	ار	4 747 0/4	05.00
	09500 AMBULANCE SERVI CES	4, 747, 964		4, 747, 964		4, 747, 964	1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		() 0	0	96. 00
405.0	SPECIAL PURPOSE COST CENTERS	0.447.400		0.447.40	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0.447.400	105.00
	10500 KIDNEY ACQUISITION	2, 147, 182		2, 147, 182		2, 147, 182	
106. 0	10600 HEART ACQUISITION	964, 332		964, 332		964, 332	
	I SUDINTAL (SOO INSTRUCTIONS)	1 3/1 /6/ 5/5	1 ()	1 471 767 549	\i ()	3/1 /6/ 5/5	12111 (11)

321, 262, 545

320, 633, 888

628, 657

628, 657

0

321, 262, 545 200. 00 628, 657 201. 00 320, 633, 888 202. 00

321, 262, 545

320, 633, 888

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Provider CCN: 150017

						12/1/2014 9:5	5 am
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	84, 850, 577		84, 850, 57	'7		30. 00
31.00	03100 INTENSIVE CARE UNIT	0			0		31.00
	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 394, 923		2, 394, 92	23		31. 01
	02060 NEONATAL INTENSIVE CARE UNIT	14, 166, 369		14, 166, 36			31. 02
	03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705		64, 441, 70			31. 03
	03200 CORONARY CARE UNIT	24, 974, 258		24, 974, 25			32. 00
	04000 SUBPROVI DER - I PF	0		2.,,,,,,	0		40. 00
	04300 NURSERY	1, 685, 765		1, 685, 76	-		43. 00
	NCILLARY SERVICE COST CENTERS	1,000,700		1,000,70	,0		10.00
	05000 OPERATING ROOM	202, 290, 538	158, 780, 701	361, 071, 23	0. 111033	0. 000000	50.00
	05100 RECOVERY ROOM	202, 270, 330	130, 700, 701		0. 000000	0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	6, 939, 038	55, 896			0. 000000	
	05300 ANESTHESI OLOGY	25, 229, 613	16, 911, 517			0. 000000	
	05300 RADI OLOGY-DI AGNOSTI C	35, 671, 817	54, 928, 006			0. 000000	
	D5401 PET SCAN	182, 489	5, 552, 975			0.000000	
	D5600 RADI OI SOTOPE	5, 306, 125	23, 614, 824			0.000000	
	D5700 CT SCAN	30, 286, 909	43, 469, 529			0.000000	
	05800 MRI	0			0.000000	0. 000000	
	06000 LABORATORY	96, 118, 328	67, 692, 664			0. 000000	
	06500 RESPI RATORY THERAPY	50, 488, 396	2, 580, 241			0. 000000	
	06600 PHYSI CAL THERAPY	10, 912, 535	6, 815, 531	17, 728, 06		0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0. 000000	
	06800 SPEECH PATHOLOGY	0	0		0. 000000	0. 000000	
	06900 ELECTROCARDI OLOGY	26, 017, 305	34, 947, 464			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 109, 368	7, 548, 300	8, 657, 66	0. 312875	0. 000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	65, 412, 497	32, 631, 123	98, 043, 62	0. 249920	0.000000	71. 00
72. 00 C	07200 IMPL. DEV. CHARGED TO PATIENTS	130, 175, 126	72, 607, 970	202, 783, 09	0. 134609	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	225, 667, 210	98, 098, 644	323, 765, 85	0. 132142	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	8, 913, 747	184, 430	9, 098, 17	7 0. 334593	0.000000	74.00
76. 00 C	03140 CARDIO CATH LAB	38, 408, 622	38, 653, 941	77, 062, 56	0. 076843	0.000000	76. 00
	03050 ENDOSCOPY	8, 353, 798	40, 658, 770	49, 012, 56	0. 161748	0.000000	76. 01
	03051 CARDI AC REHAB	2, 709, 062	735, 735			0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	343, 767	2, 830, 137	3, 173, 90	2. 004402	0. 000000	90.00
	09100 EMERGENCY	27, 583, 754	60, 266, 816			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 421, 100	10, 534, 901			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	27 12 17 100	10,001,701	12/ /00/ 00	0.0.0022	0.00000	72.00
	09500 AMBULANCE SERVICES	5, 444	6, 827, 564	6, 833, 00	0. 694857	0. 000000	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0, 444	0, 027, 304	1	0.000000	0. 000000	
	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	I	0.00000	0.00000	1 70.00
	10500 KIDNEY ACQUISITION	1, 500, 085	0	1, 500, 08) E		105. 00
	10600 HEART ACQUISITION	3, 110, 700	0				106. 00
200. 00	Subtotal (see instructions)	1, 197, 670, 970	O				200. 00
		1, 197, 670, 970	100, 921, 019	1, 984, 598, 64	7		
201.00	Less Observation Beds	1 107 470 070	704 007 470	1 004 500 /	10		201. 00
202. 00	Total (see instructions)	1, 197, 670, 970	100, 921, 619	1, 984, 598, 64	7		202. 00

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA		In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Pı	Provider CCN:	150017	From 07/01/2013	Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am
		Title XVI	H	Hosni tal	PPS

					12/1/2014 9:5	5 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
<u>[</u>	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT					31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT					31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT					31. 03
32.00	03200 CORONARY CARE UNIT					32. 00
	04000 SUBPROVIDER - IPF					40.00
	04300 NURSERY					43. 00
	ANCI LLARY SERVI CE COST CENTERS					10.00
-	05000 OPERATING ROOM	0. 111033				50. 00
1	05100 RECOVERY ROOM	0. 000000				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 285774				52.00
	05300 ANESTHESI OLOGY	0. 283774				53. 00
		1				
1	05400 RADI OLOGY-DI AGNOSTI C	0. 130531				54.00
1	05401 PET SCAN	0. 190025				54. 01
	05600 RADI OI SOTOPE	0. 088053				56. 00
	05700 CT SCAN	0. 028829				57. 00
1	05800 MRI	0. 000000				58. 00
1	06000 LABORATORY	0. 135801				60. 00
1	06500 RESPI RATORY THERAPY	0. 137813				65. 00
1	06600 PHYSI CAL THERAPY	0. 332711				66. 00
1	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
1	06800 SPEECH PATHOLOGY	0. 000000				68. 00
	06900 ELECTROCARDI OLOGY	0. 057329				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 312875				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 249920				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 134609				72. 00
73.00	07300 DRUGS CHARGED TO PATLENTS	0. 132142				73. 00
74.00	07400 RENAL DIALYSIS	0. 334593				74.00
76. 00	03140 CARDIO CATH LAB	0. 076843				76. 00
76. 01	03050 ENDOSCOPY	0. 161748				76. 01
76. 02	03051 CARDI AC REHAB	0. 209578				76. 02
	OUTPATIENT SERVICE COST CENTERS	<u> </u>				
	09000 CLI NI C	2. 004402				90. 00
91. 00	09100 EMERGENCY	0. 114456				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 048522				92. 00
	OTHER REIMBURSABLE COST CENTERS	,,				
	09500 AMBULANCE SERVICES	0. 694857				95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
	SPECIAL PURPOSE COST CENTERS	0.000000				70.00
	10500 KIDNEY ACQUISITION					105. 00
	10600 HEART ACQUISITION					106. 00
200.00	Subtotal (see instructions)					200. 00
1	1					200.00
201.00	Less Observation Beds					201.00
202. 00	Total (see instructions)					ZUZ. UU

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	1	Period: From 07/01/2013 Fo 06/30/2014		
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	43, 880, 713		43, 880, 713	3 0	43, 880, 713	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0	0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249		1, 710, 249	9 0	1, 710, 249	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	5, 225, 994		5, 225, 994	4 O	5, 225, 994	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	22, 599, 399		22, 599, 399	9 0	22, 599, 399	31. 03
32. 00 03200 CORONARY CARE UNIT	8, 155, 565		8, 155, 56!	5 0	8, 155, 565	32.00
40. 00 04000 SUBPROVI DER - I PF	0			0	0	40.00
43. 00 04300 NURSERY	643, 138		643, 138	3 0	643, 138	43.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am Provider CCN: 150017 Peri od: From 07/01/2013 To 06/30/2014 014 .. Cost Title XIX Hospi tal Charges

		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		•	+ col. 7)	Ratio	Inpati ent	
			_		Rati o	
	6.00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	84, 850, 577		84, 850, 577			30. 00
31. 00 03100 INTENSIVE CARE UNIT	0		0			31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	2, 394, 923		2, 394, 923			31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	14, 166, 369		14, 166, 369			31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705		64, 441, 705			31. 02
	1					
32. 00 03200 CORONARY CARE UNIT	24, 974, 258		24, 974, 258			32.00
40. 00 04000 SUBPROVI DER - PF	0		0			40.00
43. 00 04300 NURSERY	1, 685, 765		1, 685, 765			43. 00
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	202, 290, 538	158, 780, 701	361, 071, 239		0. 000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0. 000000	0.000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 939, 038	55, 896			0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	25, 229, 613	16, 911, 517	42, 141, 130	0. 014348	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	35, 671, 817	54, 928, 006	90, 599, 823	0. 130531	0.000000	54.00
54. 01 05401 PET SCAN	182, 489	5, 552, 975	5, 735, 464	0. 190025	0.000000	54. 01
56. 00 05600 RADI 0I SOTOPE	5, 306, 125	23, 614, 824	28, 920, 949	0. 088053	0.000000	56.00
57. 00 05700 CT SCAN	30, 286, 909	43, 469, 529	73, 756, 438	0. 028829	0.000000	57.00
58. 00 05800 MRI	O	0	C	0.000000	0.000000	58. 00
60. 00 06000 LABORATORY	96, 118, 328	67, 692, 664	163, 810, 992	0. 135801	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	50, 488, 396	2, 580, 241			0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	10, 912, 535	6, 815, 531			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	1		0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	26, 017, 305	34, 947, 464	1		0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 109, 368	7, 548, 300			0. 000000	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	65, 412, 497	32, 631, 123			0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	130, 175, 126	72, 607, 970			0. 000000	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS					0. 000000	73. 00
	225, 667, 210	98, 098, 644				
74. 00 07400 RENAL DI ALYSI S	8, 913, 747	184, 430			0.000000	74.00
76. 00 03140 CARDI 0 CATH LAB	38, 408, 622	38, 653, 941			0.000000	76. 00
76. 01 03050 ENDOSCOPY	8, 353, 798	40, 658, 770			0.000000	76. 01
76. 02 03051 CARDI AC REHAB	2, 709, 062	735, 735	3, 444, 797	0. 209578	0. 000000	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	343, 767	2, 830, 137			0. 000000	90. 00
91. 00 09100 EMERGENCY	27, 583, 754	60, 266, 816		I	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 421, 100	10, 534, 901	12, 956, 001	0. 048522	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS			,			
95. 00 09500 AMBULANCE SERVICES	5, 444	6, 827, 564	6, 833, 008		0.000000	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0.000000	0.000000	96. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	1, 500, 085	0	1, 500, 085			105.00
106.00 10600 HEART ACQUISITION	3, 110, 700	0	3, 110, 700			106. 00
200.00 Subtotal (see instructions)	1, 197, 670, 970	786, 927, 679	1, 984, 598, 649			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	1, 197, 670, 970	786, 927, 679	1, 984, 598, 649			202. 00
	•		•	•		

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15001	From 07/01/2013	Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am
			_

				12/1/2014 9:55 ar	am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					0. 00
31.00 03100 INTENSIVE CARE UNIT					1. 00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT				31	1. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT				31	1. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT				31	1. 03
32. 00 03200 CORONARY CARE UNIT				32	2. 00
40. 00 04000 SUBPROVI DER - 1 PF				40	0. 00
43. 00 04300 NURSERY				43	3.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 000000			50	0. 00
51.00 05100 RECOVERY ROOM	0. 000000			51	1. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52	2. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53	3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	4. 00
54. 01 05401 PET SCAN	0. 000000				4. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000				6. 00
57. 00 05700 CT SCAN	0. 000000			•	7. 00
58. 00 05800 MRI	0. 000000				8. 00
60. 00 06000 LABORATORY	0. 000000				0. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			•	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			1	7. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			1	8. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				0. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				1. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				3. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000				4. 00
76. 00 03140 CARDI O CATH LAB	0. 000000				6. 00
76. 01 03050 ENDOSCOPY	0. 000000				6. 01
76. 02 03051 CARDI AC REHAB	0. 000000				6. 02
OUTPATIENT SERVICE COST CENTERS	0. 000000			/0	0. 02
90. 00 09000 CLINIC	0. 000000			90	0. 00
91. 00 09100 EMERGENCY	0. 000000				1. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				2. 00
OTHER REIMBURSABLE COST CENTERS	0. 000000			72	2.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			05	5. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			l	6. 00
SPECIAL PURPOSE COST CENTERS	0.00000			70	0. 00
105. 00 10500 KIDNEY ACQUISITION				105	5. 00
106. 00 10600 HEART ACQUISITION					6. 00
200.00 Subtotal (see instructions)					0. 00
201. 00 Less Observation Beds				•	1. 00
202.00 Total (see instructions)					2. 00
202.00 10101 (366 111311 0011 0113)	ı I			1202	2.00

Heelth Financial Systems	LUTUEDAN HOCDIT	TAL OF INDIANA		lm lie	of Form CMC	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	LUTHERAN HOSPIT COSTS		CCN: 150017	Period: From 07/01/2013 To 06/30/2014		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost (col. 1 - col 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	•			
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 31.01 PEDIATRIC INTENSIVE CARE UNIT 31.02 NEONATAL INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 40.00 SUBPROVIDER - IPF 43.00 NURSERY 200.00 Total (lines 30-199) Cost Center Description	7,886,138 0 214,791 663,832 2,255,162 823,282 0 54,802 11,898,007 Inpatient Program days	Inpatient Program Capital Cost	214, 79 663, 83 2, 255, 16 823, 28	0 0 0 01 906 12 4, 545 12 28, 006 12 7, 206 0 0 02 1, 969	0. 00 237. 08 146. 06 80. 52 114. 25 0. 00 27. 83	31. 00 31. 01 31. 02 31. 03 32. 00 40. 00
		(col. 5 x col. 6)				
	6.00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 31. 01 PEDIATRIC INTENSIVE CARE UNIT 31. 02 NEONATAL INTENSIVE CARE UNIT 31. 03 CARDIO INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 40. 00 SUBPROVIDER - IPF 43. 00 NURSERY	20, 460 0 0 7, 379 2, 442 0	0 0 0 594, 157 278, 999 0 0				30. 00 31. 00 31. 01 31. 02 31. 03 32. 00 40. 00 43. 00
200.00 Total (lines 30-199)	30, 281	3, 947, 066	1			200. 00

		LUTHERAN HOSPIT				u of Form CMS-2	2552-10
APPOR1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Pre 12/1/2014 9:5	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges		I npati ent	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOLILARY OF BUILDE COOT OF STATE DO	1.00	2.00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.000.100	2/1 071 220	0.00470	7 (4 520 2/2	1 505 040	F0 00
		8, 928, 133					50. 00 51. 00
		0	ļ			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	49, 926				213	52.00
53.00	05300 ANESTHESI OLOGY	33, 459					53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 368, 653		•			
54. 01	05401 PET SCAN	636, 468				•	
56. 00	05600 RADI OI SOTOPE	204, 038				•	
57. 00	05700 CT SCAN	193, 498	73, 756, 438				57. 00
58. 00	05800 MRI	0	0	0.00000		0	58. 00
	06000 LABORATORY	1, 842, 748					60.00
65. 00	06500 RESPI RATORY THERAPY	605, 133					
	06600 PHYSI CAL THERAPY	746, 450	17, 728, 066				
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0.00000		0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0.00000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	861, 843		•			
	07000 ELECTROENCEPHALOGRAPHY	614, 115					
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	728, 206		•		•	
	07200 I MPL. DEV. CHARGED TO PATIENTS	856, 107					
	07300 DRUGS CHARGED TO PATIENTS	1, 319, 449					
74.00	07400 RENAL DIALYSIS	321, 941		•			
76. 00		1, 799, 228					76. 00
76. 01	03050 ENDOSCOPY	954, 383					
76. 02	03051 CARDI AC REHAB	49, 823	3, 444, 797	0. 01446	3 1, 008, 723	14, 589	76. 02
	OUTPATIENT SERVICE COST CENTERS						
$\Omega \Omega$	00000 CLINIC	920 660	2 172 004	0 25056	0 102 560	EU U10	

820, 669

0 25, 328, 872 1, 780, 641, 259

1, 281, 621 112, 981

3, 173, 904 87, 850, 570 12, 956, 001

0. 258568

0. 014589

0.008720

0.000000

50, 048

110, 666 12, 507

0 4, 178, 492 200. 00

193, 560

7, 585, 545 1, 434, 240

0 320, 746, 192

90.00

91.00

92. 00

95.00

96.00

90.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED 200. 00 | Total (lines 50-199)

91. 00 09100 EMERGENCY

Heal th Financial	Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2552-10

Health Financial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS		<u> </u>	Period: From 07/01/2013 Fo 06/30/2014	Worksheet D Part III Date/Time Pre 12/1/2014 9:5	pared: 5 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	435, 119	'	0	435, 119	30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	0	(0	31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	2, 250			2, 250	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	0	10, 126			10, 126	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	0	42, 530	1		42, 530	31. 03
32. 00 03200 CORONARY CARE UNIT	0	21, 377			21, 377	32. 00
40. 00 04000 SUBPROVI DER - PF	0	0	(0	0	40. 00
43. 00 04300 NURSERY	0	0	(0	43.00
200. 00 Total (lines 30-199)	0	511, 402)	511, 402	200.00
Cost Center Description		Per Diem (col.	Inpatient	I npati ent		
	Days	5 ÷ col . 6)	Program Days	Program		
				Pass-Through Cost (col. 7 x		
				cost (cor. / x		
	6, 00	7.00	8. 00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS	52, 490	8. 29	20, 460	169, 613		30.00
31. 00 03100 I NTENSI VE CARE UNI T	02,170	l .		0 .07,0.0		31.00
31. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T	906			0		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	4, 545			0		31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	28, 006	1		11, 216		31. 03
32, 00 03200 CORONARY CARE UNIT	7, 206					32. 00
40. 00 04000 SUBPROVI DER - PF	0	l .		0		40.00
43. 00 04300 NURSERY	1, 969			ol o		43. 00
200.00 Total (lines 30-199)	95, 122		30, 28°	1 188, 082		200. 00
·						

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS P		Peri od: From 07/01/2013	Worksheet D Part IV
TINOUGH COSTS				Date/Time Prepared: 12/1/2014 9:55 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	Non Physician Nursing		h All Other	Total Cost

				1	0 06/30/2014	12/1/2014 9:5	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	9	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			45.033		45.033	
	O5000 OPERATING ROOM	0	0	15, 977	0	15, 977	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	05401 PET SCAN	0	0	0	0	0	54. 01
	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
	05700 CT SCAN	0	0	0	0	0	57. 00
	D5800 MRI D6000 LABORATORY	0	0	0	0	0	58. 00
	D6500 RESPI RATORY THERAPY	0	0	0	0	0	60. 00 65. 00
	06600 PHYSI CAL THERAPY	0	0	0	0	0	
1	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	66. 00 67. 00
	06800 SPEECH PATHOLOGY		0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS		0	248, 770	0	248, 770	l
	07400 RENAL DIALYSIS		0	240,770	0	240,770	74.00
	03140 CARDIO CATH LAB		0	4, 501	0	4, 501	76.00
	03050 ENDOSCOPY		0	1, 551	0	0	76. 01
	03051 CARDI AC REHAB	0	0	0	0	0	76. 02
H-	DUTPATIENT SERVICE COST CENTERS	-1	-	-			
	09000 CLI NI C	0	0	29, 253	0	29, 253	90.00
91.00	09100 EMERGENCY	o	0	1		26, 328	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	6, 234	0	6, 234	92.00
(OTHER REIMBURSABLE COST CENTERS			<u> </u>			
	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
200.00	Total (lines 50-199)	0	0	331, 063	0	331, 063	200. 00

Health Financial Systems	LUTHERAN HOSPIT				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2013 To 06/30/2014	Part IV Date/Time Pre	nared:
				10 00/30/2014	12/1/2014 9:5	5 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCI LLARY SERVI CE COST CENTERS			1	.1		
50. 00 05000 OPERATI NG ROOM	15, 977	361, 071, 239			64, 538, 362	
51. 00 05100 RECOVERY ROOM	0	0	1 0.00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	6, 994, 934		I	29, 897	52.00
53. 00 05300 ANESTHESI OLOGY	0	42, 141, 130			7, 717, 208	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	90, 599, 823		I	12, 580, 666	
54. 01 05401 PET SCAN	0	5, 735, 464			41, 709	54. 01
56. 00 05600 RADI OI SOTOPE	0	28, 920, 949			1, 962, 080	
57. 00 05700 CT SCAN	0	73, 756, 438		I	10, 048, 452	
58. 00 05800 MRI	0	0	0.000000		0	58. 00
60. 00 06000 LABORATORY	0	163, 810, 992		I	33, 256, 676	60.00
65. 00 06500 RESPI RATORY THERAPY	0	53, 068, 637			16, 534, 340	
66. 00 06600 PHYSI CAL THERAPY	0	17, 728, 066			4, 342, 602	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.000000	I	0	
68. 00 06800 SPEECH PATHOLOGY	0	0	0.000000	I	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	60, 964, 769			9, 872, 637	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	8, 657, 668		I	326, 151	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	98, 043, 620		I .	20, 560, 285	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	202, 783, 096	•		39, 776, 376	
73. 00 07300 DRUGS CHARGED TO PATIENTS	248, 770			I .	69, 454, 688	
74. 00 07400 RENAL DI ALYSI S	0	9, 098, 177			4, 996, 200	
76. 00 03140 CARDI O CATH LAB	4, 501	77, 062, 563			11, 363, 079	
76. 01 03050 ENDOSCOPY	0	49, 012, 568			3, 122, 716	
76. 02 03051 CARDI AC REHAB	0	3, 444, 797	0. 000000	0.000000	1, 008, 723	76. 02
OUTPATIENT SERVICE COST CENTERS	20.252	2 172 004	0.00021	7 0 000217	102 560	

29, 253

26, 328 6, 234

3, 173, 904

87, 850, 570 12, 956, 001

0 331, 063 1, 780, 641, 259

0.009217

0.000300

0. 000481

0.000000

0.009217

0.000300

0. 000481

0.000000

193, 560

7, 585, 545 1, 434, 240

90.00

91.00

92.00

95.00

96.00

0 320, 746, 192 200. 00

90.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED 200. 00 | Total (lines 50-199)

91. 00 09100 EMERGENCY

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150017	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared:

					12/1/2014 9:	55 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 840	36, 725, 838	1, 616			50. 00
51.00 05100 RECOVERY ROOM	0	0	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	3, 257, 491	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	13, 160, 609	0			54.00
54. 01 05401 PET SCAN	0	1, 210, 328	0			54. 01
56. 00 05600 RADI 0I SOTOPE	0	6, 432, 293	0			56. 00
57. 00 05700 CT SCAN	0	9, 882, 044	0			57. 00
58. 00 05800 MRI	0	0	0			58. 00
60. 00 06000 LABORATORY	0	5, 712, 533	0			60. 00
65. 00 06500 RESPIRATORY THERAPY	0	520, 592	2 0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	122, 264	. 0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	O	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	9, 232, 650	0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	O	1, 369, 025	0			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	7, 328, 947	· 0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	21, 780, 123	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	53, 341	21, 858, 100	16, 787			73. 00
74.00 07400 RENAL DIALYSIS	o	167, 526	0			74. 00
76.00 03140 CARDIO CATH LAB	659	11, 570, 738	671			76. 00
76. 01 03050 ENDOSCOPY	O	9, 570, 731	0			76. 01
76. 02 03051 CARDI AC REHAB	O	197, 851	0			76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 784	434, 544	4, 005			90.00
91. 00 09100 EMERGENCY	2, 276	10, 982, 563				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	690	1, 997, 510	961			92.00
OTHER REIMBURSABLE COST CENTERS			•	ı.		
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	0	0			96. 00
200.00 Total (lines 50-199)	61, 590	173, 514, 300	27, 335			200. 00

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150017	Peri od: From 07/01/2013	Worksheet D

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111033 36, 725, 838 4, 077, 780 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 285774 0 52 00 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.014348 3, 257, 491 46, 738 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 130531 13, 160, 609 0 1, 717, 867 54.00 1, 210, 328 54.01 05401 PET SCAN 0.190025 0 0 229, 993 54.01 05600 RADI OI SOTOPE 0.088053 0 56.00 6, 432, 293 566, 383 56.00 57.00 05700 CT SCAN 0.028829 9, 882, 044 0 284, 889 57.00 05800 MRI 58.00 0.000000 0 0 58.00 0 06000 LABORATORY 5, 712, 533 775, 768 0 135801 12, 746 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 0.137813 520, 592 0 71, 744 65.00 06600 PHYSI CAL THERAPY 0. 332711 122, 264 0 40, 679 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.057329 9, 232, 650 0 0 529, 299 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 312875 1, 369, 025 0 428, 334 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 249920 7, 328, 947 0 0 1, 831, 650 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72 00 0.134609 21, 780, 123 2, 931, 801 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 132142 21, 858, 100 137, 299 2, 888, 373 73.00 07400 RENAL DIALYSIS 0 74.00 0.334593 167, 526 0 56,053 74.00 03140 CARDIO CATH LAB 0 76.00 0.076843 11, 570, 738 889, 130 76.00 0 0 03050 ENDOSCOPY 76.01 0. 161748 9, 570, 731 0 1, 548, 047 76.01 03051 CARDI AC REHAB 0. 209578 197, 851 0 41, 465 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2.004402 434, 544 871,001 90.00 0 0 91.00 09100 EMERGENCY 0. 114456 10, 982, 563 0 1, 257, 020 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.048522 1, 997, 510 96, 923 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 694857 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 200.00 Subtotal (see instructions) 173, 514, 300 12, 746 137, 299 21, 180, 937 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 173, 514, 300 12, 746 137, 299 21, 180, 937 202. 00

Health Financial Systems	LUTHERAN HOSPI TAL	OF INDIANA	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150017	Peri od: From 07/01/2013	Worksheet D Part V

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54. 01 05401 PET SCAN 54.01 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 0 0 58.00 58.00 06000 LABORATORY 60 00 60 00 1.731 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 0 0 0 0 0 0 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 143 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 03140 CARDIO CATH LAB 76.00 0 76.00 03050 ENDOSCOPY 76.01 76.01 0 76.02 03051 CARDI AC REHAB 0 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 09100 EMERGENCY 0 91.00 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 200.00 200. 00 Subtotal (see instructions) 1,731 18, 143 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 202.00 1,731 18, 143 202.00

Health Financial Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150017	Peri od:	Worksheet D

From 07/01/2013 Part V To 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111033 5, 366, 800 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 285774 52 00 0 3, 387 52 00 0 05300 ANESTHESI OLOGY 53.00 0.014348 0 599, 778 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 130531 2, 111, 953 0 54.00 54.01 05401 PET SCAN 0.190025 0 472, 869 54.01 0 05600 RADI OI SOTOPE 0.088053 56.00 473, 199 0 56.00 57.00 05700 CT SCAN 0.028829 1, 793, 997 0 57.00 05800 MRI 58.00 0.000000 0 58.00 06000 LABORATORY 0 135801 3, 021, 471 60 00 60 00 0 65.00 06500 RESPIRATORY THERAPY 0.137813 158, 505 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 332711 637, 962 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.057329 808, 863 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 312875 306, 531 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 249920 1, 108, 562 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 134609 2, 829, 860 72.00 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 132142 7, 191, 255 0 73.00 07400 RENAL DIALYSIS 9, 386 74.00 74.00 0.334593 0 03140 CARDIO CATH LAB 0 76.00 0.076843 924, 252 0 76.00 03050 ENDOSCOPY Ω 76.01 0. 161748 1, 003, 789 Ω 76.01 03051 CARDI AC REHAB 0. 209578 17, 566 0 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 2.004402 90.00 09000 CLINIC 148, 203 0 0 0 91.00 09100 EMERGENCY 0. 114456 0 3, 452, 946 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.048522 531, 816 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0. 694857 95.00 09500 AMBULANCE SERVICES 95.00 0 514, 952 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 C 0 0 96.00 0 0 200.00 200.00 Subtotal (see instructions) 0 33, 487, 902 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 0 202. 00 202.00 0 33, 487, 902 0

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150017	Peri od: From 07/01/2013	Worksheet D Part V

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 595, 892 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 968 0 52.00 05300 ANESTHESI OLOGY 0 53.00 8,606 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 275, 675 54.00 0 54. 01 05401 PET SCAN 89.857 54.01 05600 RADI OI SOTOPE 0 56.00 41, 667 56.00 57.00 05700 CT SCAN 51, 719 0 57.00 05800 MRI 0 58.00 58.00 0 06000 LABORATORY 410. 319 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 21,844 65.00 66.00 06600 PHYSI CAL THERAPY 212, 257 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 Ol 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 46, 371 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 95, 906 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 277, 052 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 380, 925 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 950, 267 0 73.00 74.00 07400 RENAL DIALYSIS 3, 140 0 74.00 03140 CARDIO CATH LAB 0 76.00 71.022 76.00 03050 ENDOSCOPY 0 76.01 162, 361 76.01 76.02 03051 CARDI AC REHAB 3,681 0 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 297, 058 90.00 0 09100 EMERGENCY 91.00 395, 210 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 25, 805 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 357, 818 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 200.00 0 200. 00 Subtotal (see instructions) 4, 775, 420 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 202.00 4, 775, 420 0 202.00

Health Financial Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150017	Peri od: From 07/01/2013	Worksheet D-1	
			To 06/30/2014	Date/Time Prep 12/1/2014 9:55	pared: 5 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days	00 Inpatient days (including private room days and swing-bed days, excluding newborn)				
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 52,490 Inpatient days (including private room days, excluding swing-bed and newborn days) 52,490					2. 00

	Cost Center Description	113	
	cost center bescription	1. 00	
	PART I - ALL PROVIDER COMPONENTS	11.00	
	I NPATI ENT DAYS		ı
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	52, 490	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	52, 490	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		ı
4.00	Semi-private room days (excluding swing-bed and observation bed days)	51, 738	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		i
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7 00
7. 00	reporting period	۷	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	20, 460	9. 00
	newborn days)		1
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		i
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	υĮ	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)		13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	ő	
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		ı
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		i
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	1
21. 00	Total general inpatient routine service cost (see instructions)	43, 880, 713	21. 00
22. 00	Swing-Ded cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
	5 x line 17)		1
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
04.00	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	٠Į	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	In line 20)	ĭ	23.00
26. 00	Total swing-bed cost (see instructions)	o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	43, 880, 713	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		ı
	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28. 00
	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	43, 880, 713	
27.00	27 minus line 36)	.5, 555, 715	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		ı
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		ı
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	835. 98	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	17, 104, 151	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	17, 104, 151	41.00

33.00	Average per dreii private room cost diriterential (irile 54 x irile 51)	0.00	33.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	43, 880, 713	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	835. 98	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	17, 104, 151	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	17, 104, 151	41.00

IVII U I	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150017	Peri od:	Worksheet D-1	2552
					From 07/01/2013 To 06/30/2014	Date/Time Pre	
			Ti tl	e XVIII	Hospi tal	12/1/2014 9: 5 PPS	5 an
	Cost Center Description	Total Inpatient Cost	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42
. 00	Intensive Care Type Inpatient Hospital Units			0.0	,0 0	0	72
. 00	INTENSIVE CARE UNIT	0	0	0.0	00 0	0	43
. 01	PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249				0	
. 02	NEONATAL INTENSIVE CARE UNIT	5, 225, 994				0	43
. 03	4	22, 599, 399					
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	8, 155, 565	7, 206	1, 131. 7	2, 442	2, 763, 782	44
. 00	SURGICAL INTENSIVE CARE UNIT						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00	10					1. 00	10
00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			ins)		42, 563, 212 68, 385, 629	
	PASS THROUGH COST ADJUSTMENTS	Tr thi ough 10) (300 111311 4011 0	113)		00, 000, 027	''
. 00	Pass through costs applicable to Program in	patient routine	services (from	Wkst. D, sum	of Parts I and	4, 135, 148	50
00		:	(6-	WI+ D -	£ Dt- 11	4 240 002	
. 00	Pass through costs applicable to Program in and IV)	patrent anciliar	y services (Tr	OM WKSt. D, S	sum or Parts II	4, 240, 082	51
. 00	Total Program excludable cost (sum of lines	50 and 51)				8, 375, 230	52
. 00	Total Program inpatient operating cost excl	uding capital re	lated, non-phy	sician anesth	etist, and	60, 010, 399	53
	medical education costs (line 49 minus line	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION					0	ļ.,
00	Program discharges Target amount per discharge					0 0. 00	
. 00	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient opera	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0	1
00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, ι	pdated and co	empounded by the	0. 00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the m	arkat haskat		0.00	60
. 00	1				the amount by	0.00	
	which operating costs (line 53) are less that						-
	amount (line 56), otherwise enter zero (see	instructions)				_	
. 00							62
. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see mstru	ictions)			U	63
. 00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	cost reporti	ng period (See	0	64
	instructions)(title XVIII only)	3		·	3 1 .		
. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65
00	instructions) (title XVIII only)	: (1:	// -l ! /	E) (+: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	II>	0	ļ,,
. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (iine	64 prus rine c	5)(title XVII	i only). For	0	66
. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 c	of the cost re	porting period	0	67
	(line 12 x line 19)	3			. 31		
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repo	rting period	0	68
OΩ	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 ± line	68)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER I					0	1 09
. 00	Skilled nursing facility/other nursing faci		·				70
. 00	Adjusted general inpatient routine service	cost per diem (I					71
. 00	Program routine service cost (line 9 x line		Z11 - 4 : · · ·	05)			72
. 00	Medically necessary private room cost applicated Program gaporal impatient routing sor						73
. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient		,		Part II column		75
. 50	26, line 45)	. Jan 110 Jei VI Ce	. 55513 (11011111	o. Roncot D, F	a. c ii, corumii		′`
. 00	Per diem capital-related costs (line 75 ÷ l						76
. 00	Program capital -related costs (line 9 x line						77
. 00	· · · · · · · · · · · · · · · · · · ·						78
. 00	Total Program routine service costs for com				us line 79)		80
. 00	Inpatient routine service cost per diem lim			(o /o mili	,		81
	Inpatient routine service cost limitation ()				82
. 00	Reasonable inpatient routine service costs	•	ıs)				83
. 00	Program inpatient ancillary services (see in		>				84
. 00	Utilization review - physician compensation Total Program inpatient operating costs (su						85
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS		ii ougii oo)				1 00
00	Total observation bed days (see instruction					752	87
. 00	,	· ·					
00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (so	•				835. 98 628, 657	

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1		
				From 07/01/2013 To 06/30/2014			
		Ti tl	e XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1. 00	2. 00	3.00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	7, 886, 138	43, 880, 713	0. 17971	8 628, 657	112, 981	90.00	
91.00 Nursing School cost	0	43, 880, 713	0.00000	0 628, 657	0	91.00	
92.00 Allied health cost	435, 119	43, 880, 713	0. 00991	628, 657	6, 234	92.00	
93.00 All other Medical Education	0	43, 880, 713	0. 00000	0 628, 657	0	93. 00	

Health Financial Systems LUTHERAN HOSPITAL	_ OF INDIANA		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
			From 07/01/2013 To 06/30/2014	Date/Time Pre	nared:
			10 00/30/2014	12/1/2014 9:5	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			28, 759, 562		30. 00
31. 00 03100 INTENSIVE CARE UNIT			0		31. 00
31. 01 02080 PEDI ATRI C I NTENSI VE CARE UNI T			0		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT 31. 03 03101 CARDIO INTENSIVE CARE UNIT			23, 135, 978		31. 02 31. 03
31. 03 03101 CARDIO INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT			8, 716, 117		31.03
40. 00 04000 SUBPROVI DER - 1 PF			0, 710, 117		40.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 11103	3 64, 538, 362	7, 165, 888	50. 00
51.00 05100 RECOVERY ROOM		0.00000	0	0	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 28577		8, 544	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 01434			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13053			
54. 01 05401 PET SCAN 56. 00 05600 RADI 0I SOTOPE		0. 19002 0. 08805			1
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN		0. 02882		172, 767 289, 687	57.00
58. 00 05800 MRI		0.00000		289,087	58.00
60. 00 06000 LABORATORY		0. 13580		4, 516, 290	
65. 00 06500 RESPIRATORY THERAPY		0. 13781			1
66. 00 06600 PHYSI CAL THERAPY		0. 33271	1 4, 342, 602	1, 444, 831	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 05732		565, 988	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 31287		102, 044	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 24992		5, 138, 426	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 13460 0. 13214		5, 354, 258	
73. 00 07300 DROGS CHARGED TO PATTENTS 74. 00 07400 RENAL DIALYSIS		0. 13214			
76. 00 03140 CARDI 0 CATH LAB		0. 07684			1
76. 01 03050 ENDOSCOPY		0. 16174			1
76. 02 03051 CARDI AC REHAB		0. 20957			1
OLITANT SERVICE COST CENTERS		•			1

7, 585, 545

1, 434, 240

320, 746, 192

320, 746, 192

193, 560

387, 972

868, 211

69, 592

Ω

42, 563, 212 200. 00

90.00

91.00

92.00

95.00

96. 00

201. 00

202. 00

2. 004402

0. 114456

0.048522

0.000000

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net Charges (line 200 minus line 201)

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

09000 CLI NI C

09100 EMERGENCY

90.00

91.00

92.00

95.00

200.00

201.00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Pre	
			10 00/30/2014	12/1/2014 9:5	5 am
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	5 044 570		
30. 00 03000 ADULTS & PEDI ATRI CS			5, 214, 570		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT			285, 726		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT			2, 029, 172		31. 02
31. 03 03101 CARDLO INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT			5, 140, 621		31. 03
32. 00 03200 CORONARY CARE UNI T 40. 00 04000 SUBPROVI DER - PF			1, 522, 103		40.00
43. 00 04300 NURSERY			119, 636		43.00
ANCI LLARY SERVI CE COST CENTERS			119,030		43.00
50. 00 05000 OPERATING ROOM		0. 11103	10, 662, 009	1, 183, 835	50.00
51. 00 05100 RECOVERY ROOM		0.00000		1, 103, 033	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 28577		107, 075	
53. 00 05300 ANESTHESI OLOGY		0. 01434		19, 625	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13053		328, 676	
54. 01 05401 PET SCAN		0. 19002		1, 592	
56. 00 05600 RADI 0I SOTOPE		0. 08805		22, 034	
57.00 05700 CT SCAN		0. 02882		57, 859	57.00
58. 00 05800 MRI		0.00000	00	0	58.00
60. 00 06000 LABORATORY		0. 13580	6, 948, 981	943, 679	60.00
65. 00 06500 RESPIRATORY THERAPY		0. 13781	13 4, 432, 822	610, 900	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33271	561, 905	186, 952	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67.00
68.00 06800 SPEECH PATHOLOGY		0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 05732		82, 156	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 31287		33, 499	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 24992		967, 122	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 13460		651, 091	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 13214		2, 361, 273	
74. 00 07400 RENAL DI ALYSI S		0. 33459		151, 596	
76. 00 03140 CARDIO CATH LAB		0. 07684		114, 360	
76. 01 03050 ENDOSCOPY		0. 16174			
76. 02 03051 CARDI AC REHAB		0. 20957	78 127, 769	26, 778	76. 02
OUTPATIENT SERVICE COST CENTERS		2 00440	28 493	57 111	1 00 0
			1/1 /N 493		

2. 004402

0. 114456

0.048522

0.000000

28, 493

85, 118

1, 668, 459

61, 601, 363

61, 601, 363

57, 111

190, 965

4, 130

0

8, 183, 576 200. 00

90. 00 91. 00

92.00

95.00

96. 00

201. 00

202. 00

90.00

91.00

92.00

95.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net Charges (line 200 minus line 201)

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

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

	Financial Systems ATION OF ORGAN ACQUISITION COSTS AND CHARGES	FOR HOSPITALS			CCN: 150017	Peri od:	wof Form CMS-2 Worksheet D-4	
WHI CH	ARE CERTIFIED TRANSPLANT CENTERS		Со	mponent	CCN:	From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
				Ki	dney	Hospi tal	PPS	
	Cost Center Description	Worksheet D-1	Inpat		Per Diem Cost		Cost (col. 2 x	
		Line Numbers	Routine		(from Wkst.	Acqui si ti on	col. 3)	
		0	Char		D-1, Part II		4.00	
	DART I COMPUTATION OF ORCAN ACQUISITION CO	0 OCTS (INDATIENT	1. (2.00	3. 00	4. 00	
	PART I - COMPUTATION OF ORGAN ACQUISITION CO Computation of Inpatient Routine Service Co					CES)		
1.00	ADULTS & PEDI ATRI CS	38.00		45, 172	835. 9	98 25	20, 900	1.00
2.00	INTENSIVE CARE UNIT	43. 00	1	43, 172	0. 0		20, 700	2.00
2. 01	PEDIATRIC INTENSIVE CARE UNIT	43. 01	1	0	1, 887. <i>6</i>		Ö	2. 01
2. 02	NEONATAL INTENSIVE CARE UNIT	43. 02	1	0	1, 149. 8		Ö	2. 02
2. 03	CARDIO INTENSIVE CARE UNIT	43. 03	1	0	806. 9		0	2. 03
3.00	CORONARY CARE UNIT	44. 00		0	1, 131. 7	77 0	0	3. 00
4.00	BURN INTENSIVE CARE UNIT	45. 00		0	0.0	00	0	4. 00
5.00	SURGICAL INTENSIVE CARE UNIT	46. 00		0	0.0	00	0	5. 00
6.00	OTHER SPECIAL CARE (SPECIFY)	47. 00		0	0.0		0	6. 00
7.00	TOTAL (sum of lines 1-6)			45, 172		25	20, 900	7. 00
	Cost Center Description		Worksh		Ratio of	0rgan	0rgan	
			Line Nu	umbers	Cost/Charges		Acquisition Ancillary	
					(from Wkst. (C) Ancillary Charges	Costs	
			0		1.00	2. 00	3. 00	
	Computation of Ancillary Service Cost Applic	able to Organ A			1.00	2.00	3.00	
8. 00	OPERATI NG ROOM	ioner o de di gani i		50.00	0. 11103	1, 199, 092	133, 139	8.00
9.00	RECOVERY ROOM			51.00	0.00000		0	9. 00
10.00	DELIVERY ROOM & LABOR ROOM			52.00	0. 28577	74 0	0	10.00
11.00	ANESTHESI OLOGY			53.00	0. 01434	104, 025	1, 493	11. 00
12.00	RADI OLOGY-DI AGNOSTI C			54.00	0. 13053		32, 039	1
12. 01	PET SCAN			54. 01	0. 19002		0	12. 01
13.00	RADI OLOGY-THERAPEUTI C			55.00	0.00000		0	13.00
14.00	RADI OI SOTOPE			56.00	0. 08805		79, 924	14.00
15. 00 16. 00	CT SCAN MRI			57. 00 58. 00	0. 02882		17, 799 0	15. 00 16. 00
17. 00	CARDI AC CATHETERI ZATI ON			59.00	0. 00000 0. 00000		0	17. 00
18. 00	LABORATORY			60.00	0. 13580		181, 184	18. 00
19. 00	PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00	0. 00000		0	19. 00
20. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS			62. 00	0. 00000		Ö	20.00
21.00	BLOOD STORING, PROCESSING & TRANS.			63.00	0.00000		0	21.00
22. 00	INTRAVENOUS THERAPY			64.00	0.00000	00	0	22. 00
23. 00	RESPI RATORY THERAPY			65.00	0. 13781	134, 290	18, 507	23. 00
24. 00	PHYSI CAL THERAPY			66. 00	0. 33271		0	24. 00
25. 00	OCCUPATI ONAL THERAPY			67.00	0. 00000		0	25. 00
26. 00	SPEECH PATHOLOGY			68. 00	0.00000		0	26. 00
27. 00	ELECTROCARDI OLOGY			69.00	0. 05732		16, 790	1
	ELECTROENCEPHALOGRAPHY			70.00	0. 31287		72 701	
	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS			71. 00 72. 00	0. 24992 0. 13460		73, 791 842	
31. 00	DRUGS CHARGED TO PATIENTS			73.00	0. 13214		48, 885	1
32. 00	RENAL DIALYSIS			74. 00			0	32.00
33. 00	ASC (NON-DISTINCT PART)			75. 00	0. 00000		Ö	33.00
34. 00	CARDIO CATH LAB			76. 00	0. 07684		0	34. 00
34. 01	ENDOSCOPY			76. 01	0. 16174		5, 513	
34. 02	CARDI AC REHAB			76. 02	0. 20957		0	1
35.00	RURAL HEALTH CLINIC			88. 00	0. 00000	00	0	35. 00
36. 00	FEDERALLY QUALIFIED HEALTH CENTER			89. 00	0. 00000		0	36. 00
37. 00	CLINIC			90.00	2. 00440		156, 526	
38. 00	EMERGENCY			91.00	0. 11445		201	38. 00
39. 00	OBSERVATION BEDS (NON-DISTINCT PART			92.00	0. 04852	25, 555	1, 240	
40.00	OTHER OUTPATIENT SERVICE COST CENTER TOTAL (sum of lines 8-40)					5, 645, 936	767, 873	40.00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

	TAL OF INDIANA			eu of Form CMS-2	
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS	Provider Componen		Period: From 07/01/2013 Fo 06/30/2014	Worksheet D-4 Date/Time Pre	pared:
	K	i dney	Hospi tal	12/1/2014 9: 5 PPS	o alli
Cost Center Description	Worksheet D-2, Part I Line	Average Cost Per Day (from	0rgan	Organ Acqui si ti on	
	Numbers	Wkst. D-2, Part I, col.		Costs (col. 1 x col. 2)	
	0	4) 1.00	2. 00	3. 00	
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER T					
Computation of the Cost of Inpatient Services of Interns					1
42. 00 ADULTS & PEDIATRICS	2.00				
43. 00 INTENSIVE CARE UNIT	3.00	•			1
43. 01 PEDIATRIC INTENSIVE CARE UNIT	3. 0	•		1	
43. 02 NEONATAL INTENSIVE CARE UNIT	3. 02	•			
43. 03 CARDIO INTENSIVE CARE UNIT 44. 00 CORONARY CARE UNIT	3. 03	•		0	
45. 00 BURN INTENSIVE CARE UNIT	5.00	•			
46. 00 SURGI CAL INTENSI VE CARE UNI T	6. 00	1		0	
47. 00 OTHER SPECIAL CARE (SPECIFY)	7. 00			o o	
48.00 TOTAL (sum of lines 42 through 47)			25	0	
Cost Center Description	Worksheet D-2,	Organ Charges	Ratio of Cost	0rgan	
	Part I Line Numbers	(see instructions)	To Charges from Wkst.	Acquisition Costs (col. 1	
			D-2, Part I,	x col. 2)	
		1.00	col . 4	0.00	
Computation of the Cost of Outpatient Services of Interns	ond Dooi donts I	1.00	2. 00	3.00	
49.00 RURAL HEALTH CLINIC	21.00		0. 000000		49. 00
50. 00 FEDERALLY QUALIFIED HEALTH CENTER	22. 00			0	
51. 00 CLINIC	23. 00	•			
52. 00 EMERGENCY	24. 00	•		0	1
53.00 OBSERVATION BEDS (NON-DISTINCT PART	25. 00	25, 55	0. 000000	0	53.00
54.00 OTHER OUTPATIENT SERVICE COST CENTER	26. 00		0. 000000	0	54. 00
55.00 TOTAL (sum of lines 49 through 52)		105, 40		0	55. 00
	I Co	ost	Cha	rges	
Cost Contor Doscription					
Cost Center Description	Part A	Part B	Part A	Part B	
Cost Center Description PART III - SUMMARY OF COSTS AND CHARGES					
·	Part A	Part B 2.00	Part A	Part B 4.00	56. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient)	Part A 1.00	Part B 2.00	Part A 3.00	Part B 4.00	57. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient)	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions)	Part A 1.00	Part B 2.00	Part A 3.00 5,691,108	Part B 4.00	57. 00 58. 00 59. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions)	Part A 1.00 788, 773	Part B 2.00	Part A 3.00 5,691,108 0 0 2,451,721	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60)	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions)	Part A 1.00 788, 773	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Fr.00 F	Part A 1.00 788, 773	Part B 2.00	Part A 3. 00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958	Part B 2.00	Part A 3. 00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958 2, 248, 818	Part B 2.00	Part A 3. 00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold	Part A 1.00 788, 773 ((2, 147, 18) (2, 935, 955 2, 248, 815 100, 676	Part B 2.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958 2, 248, 818	Part B 2.00 3 3 4 3 0.76595	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 11 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00	Part A 3.00 5,691,108 0 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions)	Part A 1.00 788, 773 ((2, 147, 18) (2, 935, 955 2, 248, 815 100, 676	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 80.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Total (sum of lines 56 thru 60) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of physicians' services in a teaching hospital (see intructions) Cost of p	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00	Part B 4.00 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Excised in Provider (1)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveric 2.00	Part B 4.00 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospitals (2)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 5.00 Li vi ng Rel ater 1.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Non-Transplant Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 5.60 Li vi ng Rel atector 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) Total (sum of lines 56 thru 60) Ratio of Medicare Usable Organs (see instructions) 63. 00 Redicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 3 0.76595 5 6 6 6 6 6 6 6 6 6 7 1.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 19 0 0 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching hospital (see intructions) Total (sum of lines 56 thru 60) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Acquisition of Medicare Usable Organs (see instructions) Acquisition of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) Medicare Cost/Charges (see instructions) Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS Organs Excised in Provider (1) Organs Purchased from Other Transplant Hospitals (2) Organs Purchased from OPOS Total (sum of lines 70 thru 73)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 6 1.00 1:00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 15 3 34	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 Li vi ng Rel ater 1.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 15 3 34	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 08. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 71. 00 Organs Purchased from OPOs 72. 00 Organs Purchased from OPOs 73. 00 Organs Transplanted 76. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 3 19 0 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to OPOs	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from Other Transplant Hospitals 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Sent Outside the U.S. (no revenue received)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 6 0.10 1:00 1:00	Part A 3.00 5,691,108 0 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 15 3 4 15 0 0 0 19 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to OPOs 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold Outside the U.S. 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Used for Research	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 6.00 Li vi ng Rel ater 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 8 34 15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from Other Transplant Hospitals 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Sent Outside the U.S. (no revenue received)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 6.00 Li vi ng Rel ater 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 3 19 0 0 15 3 34 5 0 0 0 17 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 80. 00 81. 00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

Heal th	Financial Systems	_UTHERAN HOSPIT	TAL OF	I NDI ANA			In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF ORGAN ACQUISITION COSTS AND CHARGES ARE CERTIFIED TRANSPLANT CENTERS	FOR HOSPITALS		Provider Component	CCN: 150017 t CCN:	Peri From To	od: n 07/01/2013 06/30/2014		pared:
				Ц	leart		Hospi tal	12/1/2014 9: 5 PPS	<u>5 am</u>
	Cost Center Description	Worksheet D-1	Lnr		Per Diem Cos			Cost (col. 2 x	
	Cost center bescription	Line Numbers		ne Organ			cquisition	col. 3)	
				arges	D-1, Part II				
		0		1. 00	2.00		3. 00	4. 00	
	PART I - COMPUTATION OF ORGAN ACQUISITION COS					(CES			
	Computation of Inpatient Routine Service Cos								
1. 00	ADULTS & PEDI ATRI CS	38. 00	1	0			0	0	1
2.00	INTENSIVE CARE UNIT	43. 00	1	0			0	0	
2. 01	PEDIATRIC INTENSIVE CARE UNIT	43. 01	1	0	.,		0	0	
2. 02	NEONATAL INTENSIVE CARE UNIT	43. 02	1	0			0	0	
2.03	CARDIO INTENSIVE CARE UNIT	43. 03	1	0			0	0	
3. 00 4. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	44. 00 45. 00	1	0			0	0	
5. 00	SURGICAL INTENSIVE CARE UNIT	46. 00	1	0			ol	0	
6. 00	OTHER SPECIAL CARE (SPECIFY)	47. 00		0			Ö	0	
7. 00	TOTAL (sum of lines 1-6)	17.00	1	0	1		o	0	
7.00	Cost Center Description		Work	sheet C	Ratio of		0rgan	Organ	7.00
	'		Li ne	Numbers	Cost/Charges	s A	cqui si ti on	Acqui si ti on	
					(from Wkst. (C)	Ancillary	Ancillary	
							Charges	Costs	
			<u> </u>	0	1.00		2. 00	3. 00	
0.00	Computation of Ancillary Service Cost Applica	able to Organ A	Acqui si		0 1110	22	ما	0	0 00
8.00	OPERATING ROOM			50.00	1		0	0	
9. 00 10. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM			51. 00 52. 00	1		0	0	
11. 00	ANESTHESI OLOGY			53.00	1		ol	0	
12. 00	RADI OLOGY-DI AGNOSTI C			54. 00	1		Ö	0	1
12. 01	PET SCAN			54. 01	1		ő	0	
13. 00	RADI OLOGY-THERAPEUTI C			55. 00	1		o	0	13. 00
14.00	RADI OI SOTOPE			56.00	0. 0880	53	o	0	14. 00
15.00	CT SCAN			57.00	0. 02882	29	0	0	15. 00
16.00	MRI			58. 00	0. 00000	00	0	0	16. 00
17. 00	CARDI AC CATHETERI ZATI ON			59. 00	1		0	0	17. 00
18. 00	LABORATORY			60.00	1		0	0	
19.00	PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00	1		0	0	
20.00	WHOLE BLOOD & PACKED RED BLOOD CELLS			62.00	1		0	0	
21. 00 22. 00	BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY			63. 00 64. 00	1		0	0	21. 00
23. 00	RESPIRATORY THERAPY			65. 00	1		ol	0	23. 00
24. 00	PHYSI CAL THERAPY			66. 00	1		ő	0	24. 00
25. 00	OCCUPATI ONAL THERAPY			67. 00	1		o	0	1
26.00	SPEECH PATHOLOGY			68. 00	1		o	0	26. 00
27.00	ELECTROCARDI OLOGY			69.00	0. 0573	29	o	0	27. 00
28.00	ELECTROENCEPHALOGRAPHY			70.00	0. 3128	75	0	0	28. 00
29. 00	MEDICAL SUPPLIES CHARGED TO PATIENT			71. 00	0. 2499:	20	0	0	29. 00
	IMPL. DEV. CHARGED TO PATIENTS			72. 00	1		0	0	1
31. 00	DRUGS CHARGED TO PATIENTS			73. 00			0	0	
32.00	RENAL DIALYSIS			74.00	1		0	0	
33. 00	ASC (NON-DISTINCT PART)		-	75.00	1		0	0	
34.00	CARDIO CATH LAB ENDOSCOPY			76. 00	1		0	0	
34. 01 34. 02	CARDI AC REHAB		1	76. 01 76. 02	1		0	0	
34. 02 35. 00	RURAL HEALTH CLINIC			76. 02 88. 00	1		ol Ol	0	
	FEDERALLY QUALIFIED HEALTH CENTER			89.00	1		ol	0	1
	CLINIC			90. 00	1		ő	0	1
38. 00	EMERGENCY			91. 00	1		o	0	1
39.00	OBSERVATION BEDS (NON-DISTINCT PART		1	92.00	1		o	0	1
	OTHER OUTPATIENT SERVICE COST CENTER								40. 00
41 00	TOTAL (sum of lines 8-40)		1		I	- 1	0	0	41.00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

	UTHERAN HOSPITAL O				u of Form CMS-2	
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES WHICH ARE CERTIFIED TRANSPLANT CENTERS	FOR HOSPITALS	Provider Component	1	Period: From 07/01/2013 To 06/30/2014	Worksheet D-4 Date/Time Pre	pared:
		Н	eart	Hospi tal	12/1/2014 9: 5 PPS	o alli
Cost Center Description	Par	ssheet D-2, rt I Line Numbers	Average Cost Per Day (from Wkst. D-2, Part I, col.	0rgan	Organ Acquisition Costs (col. 1 x col. 2)	
			4)			
		0	1.00	2. 00	3. 00	
PART II - COMPUTATION OF ORGAN ACQUISITION CO						
Computation of the Cost of Inpatient Services	of Interns and Re					
42. 00 ADULTS & PEDIATRICS		2.00	0.00		0	
43. 00 INTENSIVE CARE UNIT		3.00	0. 00			
43. 01 PEDIATRIC INTENSIVE CARE UNIT		3. 01	0.00		0	43. 01
43. 02 NEONATAL INTENSIVE CARE UNIT		3. 02	0.00		0	43. 02
43. 03 CARDIO INTENSIVE CARE UNIT		3. 03	0.00		0	43. 03
44. 00 CORONARY CARE UNIT		4. 00	0.00		0	44.00
45. 00 BURN INTENSIVE CARE UNIT		5. 00	0.00		0	45. 00
46. 00 SURGICAL INTENSIVE CARE UNIT		6.00	0.00		0	46.00
47. 00 OTHER SPECIAL CARE (SPECIFY)		7. 00	0.00	0	0	47. 00 48. 00
48.00 TOTAL (sum of lines 42 through 47) Cost Center Description	Mork	choot D 2	Organ Charges	Ratio of Cost	Organ	48.00
COST CENTER DESCRIPTION	Par	rt I Line Numbers	(see instructions)	To Charges from Wkst. D-2, Part I,	Acquisition Costs (col. 1 x col. 2)	
		0	1. 00	col . 4	2.00	
Computation of the Cost of Outpatient Service	oc of Intorns and D	O Dosidonts N		2.00	3. 00	
49. 00 RURAL HEALTH CLINIC	es of fifteeris and R	21.00	ot ili Approved	0. 000000		49. 00
50. 00 FEDERALLY QUALIFIED HEALTH CENTER		22. 00			0	50.00
51. 00 CLINIC		23. 00	Ò		Ö	51.00
52. 00 EMERGENCY		24. 00	Ò		Ö	52. 00
53. 00 OBSERVATION BEDS (NON-DISTINCT PART		25. 00	ì		Ö	53. 00
54. 00 OTHER OUTPATIENT SERVICE COST CENTER		26. 00	`	0.00000	Ö	54. 00
55.00 TOTAL (sum of lines 49 through 52)		20.00	ì		0	55. 00
				4		00.00
		Co	st	Chai	raes	
Cost Center Description	_	Co Part A	st Part B	Part A	rges Part B	
Cost Center Description						
PART III - SUMMARY OF COSTS AND CHARGES		Part A	Part B	Part A	Part B	
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I		Part A	Part B	Part A	Part B	56. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient)		Part A 1.00	Part B	Part A 3.00	Part B	57. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient) 1 Interns and Residents (outpatient)		Part A 1.00 0 0	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions)		Part A 1.00	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00 59. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he		Part A 1.00 0 0	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 For unit and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching heintructions)		Part A 1.00 0 0 0 964,332 0	Part B	Part A 3.00 0 0 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) Total (sum of lines 56 thru 60)		Part A 1.00 0 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions)		Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions)	ospi tal (see	Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal	ospi tal (see	Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 70 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62)	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions)	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) Revenue for Organs Sold	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 1nterns and Residents (outpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66)	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 2 7 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 0 783,058 0 783,058	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see Cost Center Description	ospital (see ole Organs	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 1 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Organs Excised in Provider (1)	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 1 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 57. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospic	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 57. 00 Interns and Residents (inpatient) Interns and Residents (outpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from Non-Transplant Hospital 73. 00 Organs Purchased from OPOS Total (sum of lines 70 thru 73)	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1: 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00
PART III - SUMMARY OF COSTS AND CHARGES 75.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 1 Interns and Residents (outpatient) 1 Direct Organ Acquisition (see instructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost Ogans (see instructions) 1 Cost Ogans (see instructions) 1 Cost Office (see instructions) 1 Cost Ogans (see instructions) 1 Cost Ogans Sold 1 Cost Ogans Sold 1 Cost Ogans Furnished Part B 1 Cost Center Description	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Fr.	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1 12	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Part III - Summary of Costs and Charges Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching he intructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) Organs Transplanted 76. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1 12	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching he intructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 0 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1 12	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching he intructions) 61. 00 Total (sum of lines 56 thru 60) 70 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Transplanted 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1 12	Part B 4.00 0 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 78. 00 Organs Sold to Military or VA Hospitals 79. 00 Organs Sold to Military or VA Hospitals 0. Organs Sold Outside the U.S.	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1 12	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 78. 00 79. 00 80. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Fart III - SUMMARY OF COSTS AND CHARGES Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching heintructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Action of Medicare Usable Organs to Total Usal (line 63 + line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Revenue for Organs Sold Roudicare Usable Organs Inne 66) Organs Furnished Part B Medicare Cost/Charges (see instructions) Revenue for Organs Sold Total (line 65 minus line 66) Organs Furnished Part B Medicare Cost/Charges (see instructions) Total (sum of lines from Other Transplant Hospital) Organs Purchased from Other Transplant Hospital Organs Purchased from OPOs Total (sum of lines 70 thru 73) Total (sum of lines 70 thru 73) Organs Sold to Other Hospitals Organs Sold to Other Hospitals Organs Sold to Transplant Hospitals Organs Sold to Transplant Hospitals Organs Sold to Military or VA Hospitals Organs Sold Outside the U.S. Organs Sold Outside the U.S. Organs Sold Outside the U.S. (no revenue received)	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 70. 00 71. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 77. 00 78. 00 79. 00 80. 00 81. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. (no revenue recomposition or the search or the	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1: 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 0 1,174,586 0 1,174,586 0 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 70 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospital 73.00 Organs Purchased from Mon-Transplant Hospital 73.00 Organs Transplanted 76.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Transplant Hospitals 78.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Military or VA Hospitals 80.00 Organs Sold Outside the U.S. 81.00 Organs Sent Outside the U.S. (no revenue reco	ospital (see ole Organs nstructions) tals (2) s	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 80. 00 81. 00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Pre 12/1/2014 9:5	pared: 5 am
		Ti tl	e XVIII	Hospi tal	PPS	
			before 1/1	on/after 1/1	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS	0	1. 00	1. 01	2. 00	
1.00	DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges		12, 653, 05	i3		1. 01
4 00	occurring prior to October 1, 2013 (see instructions)					
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		39, 408, 52	!5		1. 02
1. 03	DRG for Federal specific operating payment for Model 4			0		1. 03
	BPCI (see instructions)					
2.00	Outlier payments for discharges. (see instructions)		3, 207, 04	8		2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0		2. 02
3.00	Managed Care Simulated Payments		29, 440, 32	23		3. 00
4. 00	Bed days available divided by number of days in the cost		383. 9			4. 00
	reporting period (see instructions)					
	Indirect Medical Education Adjustment			_1		
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before		10. 1	3		5. 00
	12/31/1996. (see instructions)					
6.00	FTE count for allopathic and osteopathic programs which		0.0	00		6. 00
	meet the criteria for an add-on to the cap for new					
7.00	programs in accordance with 42 CFR 413.79(e)			20		7 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.0	00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as		0.0	00		7. 01
	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
	cost report straddles July 1, 2011 then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated		0.0	00		8. 00
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12,					
	1998, page 26340 and Vol. 67 Federal Register, page 50069,					
0.01	August 1, 2002.			20		0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report		0.0	10		8. 01
	straddles July 1, 2011, see instructions.					
8.02	The amount of increase if the hospital was awarded FTE cap		0.0	00		8. 02
	slots from a closed teaching hospital under section 5506					
9. 00	of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		10. 1	2		9. 00
7.00	lines (8, 8,01 and 8,02) (see instructions)		10. 1	3		7.00
10.00	FTE count for allopathic and osteopathic programs in the		8. 1	4		10. 00
	current year from your records					
11. 00 12. 00	FTE count for residents in dental and podiatric programs.		0. 0 8. 1			11. 00 12. 00
13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		9. 5			13.00
14. 00	' '		9. 3			14. 00
	year ended on or after September 30, 1997, otherwise enter					
	zero.					
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program		9. C 0. C			15. 00 16. 00
17. 00	Adjusment for residents displaced by program or hospital		0.0			17. 00
	closure					17.00
18. 00	Adjusted rolling average FTE count		9. 0			18. 00
19. 00	Current year resident to bed ratio (line 18 divided by		0. 02349	93		19. 00
20. 00	line 4). Prior year resident to bed ratio (see instructions)		0. 02453	30		20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0. 02349			21. 00
22. 00	IME payment adjustment (see instructions)		1, 039, 63			22. 00
	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of t				
23. 00	Number of additional allopathic and osteopathic IME FTE		0.0	00		23. 00
24. 00	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)		-1.9	00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter		0.0			25. 00
	the lower of line 23 or line 24 (see instructions)					
26. 00	Resident to bed ratio (divide line 25 by line 4)		0. 00000			26. 00
27. 00	IME payments adjustment factor. (see instructions)		0.00000			27. 00
28. 00 29. 00	IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28)		1, 039, 63	0		28. 00 29. 00
£ 7. UU	Di sproporti onate Share Adjustment		1, 037, 03			27.00
30. 00	Percentage of SSI recipient patient days to Medicare Part		3. 7	4		30.00
	A patient days (see instructions)					
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31		17. 8 21. <i>6</i>			31. 00 32. 00
JZ. UU	Jouin of Titles to alla St		J ∠1. C	· · (l	J JZ. UU

86.077

69, 837, 719

4, 777, 664

281.088

120, 052

78,034

60.00

61.00

62.00

63.00

64.00

65.00

instructions)

58)

Primary payer payments

Total amount payable for program

beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries

Allowable bad debts (see instructions)

Adjusted reimbursable bad debts (see

Coinsurance billed to program beneficiaries

60.00

61.00

62.00

63.00

64.00

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150017

						12/1/2014 9:5	55 am
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
				October 1		October 1	
		0		1.00	1. 01	2.00	
66. 00	Allowable bad debts for dual eligible	0		0		2.00	66. 00
67. 00	beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines			64, 857, 001			67. 00
68. 00	62 and 63) Credits received from manufacturers for			15, 200			68. 00
	replaced devices applicable to MS-DRG (see instructions)						
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96) (For SCH see			0			69. 00
70. 00	instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70. 00
70. 50	(SPECIFY) RURAL DEMONSTRATION PROJECT			0			70. 50
70. 92	Bundled Model 1 discount amount			٥			70. 92
	1						
70. 93	HVBP incentive payment (see instructions)			-44, 949			70. 93
70. 94	Hospital readmissions reduction adjustment (see instructions)			-69, 815			70. 94
70. 95	Recovery of accelerated depreciation			0			70. 95
70. 96	Low volume adjustment for federal fiscal		0	0			70. 96
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	prior to 10/1)						
70. 97	Low volume adjustment for federal fiscal		0				70. 97
70. 97			U	0			70.97
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			0			70. 98
71.00	Amount due provider (line 67 minus lines 68			64, 727, 037			71.00
	plus/minus lines 69 & 70)			.,,,			
71. 01	Sequestration adjustment (see instructions)			1, 294, 541			71. 01
	, , , , , , , , , , , , , , , , , , , ,						72.00
72. 00	Interim payments			62, 802, 157			
73. 00	Tentative settlement (for contractor use			0			73. 00
	onl y)						
74.00	Balance due provider (Program) line 71 minus			630, 339			74.00
	lines 71.01, 72 and 73						
75.00	Protested amounts (nonallowable cost report			3, 738, 092			75. 00
	items) in accordance with CMS Pub. 15-2,			, ,			
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR			l	l .	l .	1
90. 00	Operating outlier amount from Worksheet E,			0	I		90.00
90.00				U			90.00
	Part A line 2 (see instructions)						
91. 00	Capital outlier from Worksheet L, Part I,			0			91. 00
	line 2						
92.00	Operating outlier reconciliation adjustment			0			92.00
	amount (see instructions)						
93.00	Capital outlier reconciliation adjustment			1 0			93. 00
70.00	amount (see instructions)			Ĭ			70.00
94. 00	The rate used to calculate the time value of			0.00			94.00
74. 00] 0.00			74.00
05.05	money (see instructions)			_			05.00
95. 00	Time value of money for operating expenses			0			95. 00
	(see instructions)						1
96. 00	Time value of money for capital related			0			96. 00
	expenses (see instructions)						1
	·						

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der (CCN: 150017	From 07/01/2013	Worksheet E Part B Date/Time Prepared: 12/1/2014 9:55 am
				550

			10 00/30/2014	12/1/2014 9:5	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			19, 874	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		21, 153, 602	2. 00
3.00	PPS payments			23, 579, 591	3. 00
4.00	Outlier payment (see instructions)			134, 994	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 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 Worksheet D, Pa	rt IV, column 13, line	e 200	27, 335	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			19, 874	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12. 00	Ancillary service charges			150, 045	
13. 00	Organ acquisition charges (from Worksheet D-4, Part III, line 6	9, col. 4)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			150, 045	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for page 1			0	
16. 00	Amounts that would have been realized from patients liable for	payment for services o	on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	17.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	if lime 10 evenede li	no 11) (ooo	150, 045	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds II	ne II) (See	130, 171	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	no 10) (soo	0	20. 00
20.00	instructions)	II IIIle II exceeds II	11e 10) (See	0	20.00
21. 00					21. 00
22. 00	Interns and residents (see instructions)	riisti deti olis)		19, 874 0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			23, 741, 920	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions))	4, 605, 520	26. 00
27. 00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the			19, 156, 274	
	see instructions)				
28. 00	Direct graduate medical education payments (from Worksheet E-4,	line 50)		93, 085	28. 00
29. 00	ESRD direct medical education costs (from Worksheet E-4, line 3	6)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			19, 249, 359	30. 00
31. 00	Primary payer payments			5, 988	
32. 00	Subtotal (line 30 minus line 31)			19, 243, 371	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)			
33. 00	Composite rate ESRD (from Worksheet I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			67, 261	
35. 00	Adjusted reimbursable bad debts (see instructions)			43, 720	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	
37. 00	Subtotal (see instructions)			19, 287, 091	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	d daylaga (aga i natny	n+: ono)	0	
39. 98	Partial or full credits received from manufacturers for replace	a devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			10 207 001	39. 99
40.00	Subtotal (see instructions)			19, 287, 091	40.00
40. 01	Sequestration adjustment (see instructions)			385, 742	
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			19, 051, 989 0	1
43.00	Balance due provider/program (see instructions)			-150, 640	
44. 00	Protested amounts (nonallowable cost report items) in accordance	a with CMS Dub 15_2	chanter 1	- 130, 040	
44.00	§115. 2	C WI III GWG FUD. 19-2,	спарты Т,		44.00
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			ő	
92. 00	The rate used to calculate the Time Value of Money			-	92. 00
93. 00	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)			0	
				•	•

| Peri od: | Worksheet E-1 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared: | 12/1/2014 9:55 am Health Financial Systems LUTHE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150017

					12/1/2014 9: 5	5 am
			e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		62, 464, 057		19, 051, 989	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	07/01/2013	60, 800		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	02/11/2014	704, 100		0	3. 02
3. 03		0271172011	0		o o	3. 03
3. 04			Ö		l ő	3. 04
3. 05			ĺ		l ő	3. 05
0.00	Provider to Program				J	0.00
3.50	ADJUSTMENTS TO PROGRAM	06/30/2014	426, 800		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		338, 100		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		62, 802, 157		19, 051, 989	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
Г 00	TO BE COMPLETED BY CONTRACTOR	I		1		г оо
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
5. 02	TEMMINE TO THORISEN		Ö		l ol	5. 02
5. 03			0		l ol	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		o	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	SETTLEMENT TO PROVIDER		630, 339		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		150, 640	6. 02
7.00	Total Medicare program liability (see instructions)		63, 432, 496		18, 901, 349	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	INGINE OF COTTE ACTO	I		I	ı	0.00

Heal th	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10	
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150017	Peri od:	Worksheet E-1		
			From 07/01/2013 To 06/30/2014	Part II		
	Date/Time Pre 12/1/2014 9:5					
	Title XVIII Hospital					
			noopi tui	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14					
2.00						
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			18, 262	3. 00	
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		92, 401	4.00	
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			1, 984, 598, 649	5. 00	
6.00	Total hospital charity care charges from Wkst S-10, column 3 l	ine 20		8, 063, 005	6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HIT technology	Worksheet S-2,	0	7. 00	
	Part I line 168					
8.00	Calculation of the HIT incentive payment (see instructions)			1, 442, 766	8. 00	
9.00	Sequestration adjustment amount (see instructions)			28, 855	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1, 413, 911	10. 00	
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)			1, 336, 152		
	Other Adjustment (specify)			0	31. 00	
22 00	Dalamas dua maggidam (lima O (am lima 10) minus lima 20 and li	no 21) (coo i notruction	- N	77 750	22 00	

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

1, 336, 152 30. 00 0 31. 00 77, 759 32. 00

Heal th	Financial Systems LUTHERAN HOSPITAL O	F INDIANA		In lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS			Peri od: From 07/01/2013 To 06/30/2014	Worksheet E-4 Date/Time Prep 12/1/2014 9:55	pared:
-		Ti tl	e XVIII	Hospi tal	PPS	J alli
				•		
					1. 00	
4 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT				0.05	4 00
1. 00	Unweighted resident FTE count for allopathic and osteopathic prending on or before December 31, 1996.	ograms for	cost reporti	ng perioas	8. 95	1. 00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR	413 79(e)(1) (see instr	uctions)	0. 00	2. 00
3. 00	Amount of reduction to Direct GME cap under section 422 of MMA		., (55551	401.01.0)	0.00	
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance w	ith 42 CFR	§413.79 (m).	(see	0. 00	3. 01
4 00	instructions for cost reporting periods straddling 7/1/2011)				0.00	4 00
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	steopatni c	programs due	to a Medicare	0. 00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instru	uctions for	cost reporti	na periods	0. 00	4. 01
	straddl i ng 7/1/2011)	.01.00 .0.	000t . opo. t.	ing point due	0.00	
4.02	ACA Section 5506 number of additional direct GME FTE cap slots	(see inst	ructions for	cost reporting	0.00	4. 02
	peri ods straddling 7/1/2011)				0.05	
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus	or minus	line 4 plus l	ines 4.01 and	8. 95	5. 00
6. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic pr	roorams for	the current	vear from vour	8. 14	6. 00
0.00	records (see instructions)	ogranis roi	the current	year from your	0. 14	0.00
7. 00	Enter the lesser of line 5 or line 6				8. 14	7. 00
			Primary Care		Total	
	lw		1.00	2. 00	3. 00	0.00
8. 00	Weighted FTE count for physicians in an allopathic and osteopat program for the current year.	hi c	8. 1	4 0.00	8. 14	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwis	se	8. 1	4 0.00	8. 14	9. 00
	multiply line 8 times the result of line 5 divided by the amour					
	6.					
10.00	Weighted dental and podiatric resident FTE count for the currer	nt year		0.00		10. 00
11.00	Total weighted FTE count	V005 (000	8. 1			11.00
12. 00	Total weighted resident FTE count for the prior cost reporting instructions)	year (see	8. 9	0.00		12. 00
13. 00	Total weighted resident FTE count for the penultimate cost repo	orti ng	8. 9	0.00		13. 00
	year (see instructions)	Ü				
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided b	y 3).	8. <i>6</i>			14. 00
15.00	Adjustment for residents in initial years of new programs		0.0			15. 00
16. 00 17. 00	Adjustment for residents displaced by program or hospital closu Adjusted rolling average FTE count	ire	0. 0 8. 6			16. 00 17. 00
18. 00	Per resident amount		93, 854. 3			18.00
19. 00	Approved amount for resident costs		814, 65	· ·	814, 656	
			·			
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FTE	resi dent	cap slots rec	eived under 42	0. 00	20. 00
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruct	ione)			0.00	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instruc					22. 00
23. 00	Enter the locally adjustment national average per resident amou		structions)			23. 00
	Multiply line 22 time line 23				0	24. 00
25. 00	Total direct GME amount (sum of lines 19 and 24)		l	.1	814, 656	25. 00
			Inpatient Par	t Managed care		
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
26. 00	Inpatient Days (see instructions)		30, 28	18, 262		26. 00
27. 00	Total Inpatient Days (see instructions)		92, 40			27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 32771			28. 00
29. 00 30. 00	Program direct GME amount Reduction for direct GME payments for Medicare Advantage		266, 97	161, 008 22, 750		29. 00 30. 00
	Net Program direct GME amount			22, 750	405, 231	
	, ,		•			

	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10
DI REC	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 150017	Peri od:	Worksheet E-4	
MEDI CA	AL EDUCATION COSTS		From 07/01/2013 To 06/30/2014		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	`		CAL	
32. 00	1	t. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)				
33. 00			74 and 94)	9, 098, 177	ı
34. 00	3	e 32 ÷ line 33)		0. 000000	1
	Medicare outpatient ESRD charges (see instructions)	0.4 1' 05)		0	
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII Part A Reasonable Cost	UNLY			
37. 00				68, 385, 629	27.00
38.00	·			2, 774, 080	
	Cost of physicians' services in a teaching hospital (see instr	ructions)		2, 774, 080	1
	Primary payer payments (see instructions)	uctions)		86, 077	1
	Total Part A reasonable cost (sum of lines 37 through 39 minus	line 40)		71, 073, 632	
41.00	Part B Reasonable Cost	11116 40)		71,073,032	41.00
42. 00				21, 200, 811	42.00
43. 00	·			5, 988	
	Total Part B reasonable cost (line 42 minus line 43)			21, 194, 823	
	Total reasonable cost (sum of lines 41 and 44)			92, 268, 455	1
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	41 ÷ line 45)		0. 770292	46. 00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line	44 ÷ line 45)		0. 229708	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	ТВ			
	Total program GME payment (line 31)			405, 231	48. 00
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		312, 146	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		93, 085	50.00

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

Provi der CCN: 150017

| Peri od: | From 07/01/2013 | To 06/30/2014 | Worksheet G | Date/Time Prepared: | 12/1/2014 9:55 am

					12/1/2014 9:5	5 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund	0.00	4 00	
	CHIPDENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	-10, 013, 009			0	1.00
2. 00	Temporary investments	-10,013,009			0	2.00
3. 00	Notes receivable				0	3.00
4. 00	Accounts recei vabl e	99, 647, 317	1	, i	0	4. 00
5. 00	Other receivable	0		o o	Ō	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-20, 492, 586		0	0	6. 00
7.00	Inventory	12, 596, 484	. (0	0	7. 00
8.00	Prepai d expenses	2, 756, 010)	0	0	8. 00
9.00	Other current assets	2, 475, 545	6	0	0	9. 00
10.00	Due from other funds	0) (0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	86, 969, 761		0	0	11. 00
	FI XED ASSETS				_	
12.00	Land	14, 006, 167	1			12.00
13.00	Land improvements	3, 905, 311	1	-	0	13.00
14.00	Accumulated depreciation	-1, 052, 509	1		0	14.00
15. 00	Buildings	234, 764, 800	1	-	0	15. 00 16. 00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-31, 205, 041 19, 997, 319	1	-	0	17. 00
18. 00	Accumulated depreciation	-4, 556, 926		-	0	18.00
19. 00	Fi xed equipment	4, 036, 185	1	-	0	19.00
20. 00	Accumulated depreciation	-2, 238, 849	1		0	20.00
21. 00	Automobiles and trucks	1, 058, 149	1		0	21.00
22. 00	Accumulated depreciation	-816, 872	1	-	0	22.00
23. 00	Major movable equipment	62, 749, 391	1	-	0	23. 00
24. 00	Accumulated depreciation	-40, 796, 887		-	0	24.00
25. 00	Mi nor equipment depreciable	30, 903, 349	1	-	Ö	25. 00
26. 00	Accumulated depreciation	-22, 530, 173		-	ő	26.00
27. 00	HIT designated Assets	0		0	Ō	27. 00
28. 00	Accumulated depreciation	0		0	Ō	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		o o	Ō	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	268, 223, 414		0	0	30.00
	OTHER ASSETS		•			
31.00	Investments	0) (0	0	31. 00
32.00	Deposits on Leases	0) (0	0	32. 00
33.00	Due from owners/officers	0) (0	0	33. 00
34.00	Other assets	9, 879, 985	i (0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	9, 879, 985	5	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	365, 073, 160)	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	11, 002, 626	1	-		37. 00
38. 00	Salaries, wages, and fees payable	11, 165, 777	1	-	0	38. 00
39. 00	Payroll taxes payable	1, 204, 556	1	0	0	39. 00
40. 00	Notes and Loans payable (short term)	16, 668		0	0	40.00
41.00	Deferred income	0)	0	0	41.00
42.00	Accel erated payments	0)			42.00
43.00	Due to other funds	-601, 984, 426	1	0	0	43.00
44.00	Other current liabilities	6, 632, 076	1	1		
45. 00	Total current liabilities (sum of lines 37 thru 44)	-571, 962, 723		0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable				0	46. 00
47. 00	Notes payable	1		, i		47.00
48. 00	Unsecured Loans	-4			0	48. 00
49. 00	Other long term liabilities				0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	_4		-		50.00
51. 00	Total liabilites (sum of lines 45 and 50)	-571, 962, 727		o o		51.00
01.00	CAPITAL ACCOUNTS	0,1,,02,,2		,		0 00
52.00	General fund balance	937, 035, 887	'			52. 00
53. 00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			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	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion		1			
59. 00	Total fund balances (sum of lines 52 thru 58)	937, 035, 887		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	365, 073, 160) (0	0	60. 00
	[59]		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 LUTHERAN HOSPITAL OF INDIANA Peri od: From 07/01/2013 Provider CCN: 150017

					To	06/30/2014		epared: 55 am
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0 0 0 0	783, 211, 215 153, 824, 682 937, 035, 897 0 937, 035, 897		0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
	sheet (line 11 minus line 18)	5						17.00
		Endowment Fund	PI ant	Funa				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0		0 0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 0 0 0 0		0			12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150017 Peri od: Worksheet G-2 From 07/01/2013 Parts I & II 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 86, 536, 342 86, 536, 342 1.00 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 0 0 5.00 Swing bed - NF 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 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) 86, 536, 342 86, 536, 342 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 0 11.01 PEDIATRIC INTENSIVE CARE UNIT 2, 394, 923 2, 394, 923 11.01 NEONATAL INTENSIVE CARE UNIT 11.02 14, 166, 369 14, 166, 369 11 02 64, 441, 705 11.03 CARDIO INTENSIVE CARE UNIT 64, 441, 705 11.03 12.00 CORONARY CARE UNIT 24, 974, 258 24, 974, 258 12.00 13.00 BURN INTENSIVE CARE UNIT 13.00 14.00 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 105, 977, 255 105, 977, 255 16.00 Total intensive care type inpatient hospital services (sum of lines 16.00 11-15) 192. 513, 597 17.00 Total inpatient routine care services (sum of lines 10 and 16) 192, 513, 597 17.00 18.00 Ancillary services 974, 703, 308 706, 468, 261 1, 681, 171, 569 18.00 19.00 Outpatient services 30, 354, 065 80, 459, 418 110, 813, 483 19.00 RURAL HEALTH CLINIC 20.00 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 Λ 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 C 23.00 24.00 CMHC 24.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 25, 00 26.00 HOSPI CE 26.00 27.00 OTHER (SPECIFY) 27.00 28 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 1, 197, 570, 970 786, 927, 679 1, 984, 498, 649 28 00 line 1) PART II - OPERATING EXPENSES 29.00 29.00 Operating expenses (per Wkst. A, column 3, line 200) 372, 465, 795 30.00 ADD (SPECIFY) 0 30.00 0 31.00 31.00 0 32.00 32.00 33.00 0 33.00 0 34.00 34.00 0 35.00 35.00 36.00 Total additions (sum of lines 30-35) 36.00 37.00 DEDUCT (SPECIFY) 37.00 0 38.00 38.00 39.00 39.00 40.00 40.00

0

372, 465, 795

41.00

42.00

43.00

41.00

42.00

Total deductions (sum of lines 37-41)

to Wkst. G-3, line 4)

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer

Heal th	Financial Systems LUTHERAN HOSPITAL C		In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 150017	Peri od:	Worksheet G-3	
			From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1, 984, 498, 649	1, 00
2. 00	Less contractual allowances and discounts on patients' accounts			1, 467, 008, 280	
3. 00	Net patient revenues (line 1 minus line 2)	,		517, 490, 369	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		372, 465, 795	
5. 00	Net income from service to patients (line 3 minus line 4)	-,		145, 024, 574	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other that	an patients		0	
17. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				17. 00
18. 00					18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER REVENUE			8, 800, 108	
	Total other income (sum of lines 6-24)			8, 800, 108	
	Total (line 5 plus line 25)			153, 824, 682	
	OTHER EXPENSES (SPECIFY)			0	
28 00	Total other expenses (sum of line 27 and subscripts)			Λ	28 00

28.00

153, 824, 682 29. 00

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)

:ALCIII	Financial Systems LUTHERAN HOSPITAL ATION OF CAPITAL PAYMENT	Provi der CCN: 150017	Peri od:	u of Form CMS-2 Worksheet L	2002		
JALOUI	ATTON OF CALLIAL PAINENT	Trovider con. 130017	From 07/01/2013 To 06/30/2014	Parts I-III Date/Time Pre 12/1/2014 9:5			
		Title XVIII	Hospi tal	PPS			
				4 00			
	PART I - FULLY PROSPECTIVE METHOD			1. 00			
	CAPITAL FEDERAL AMOUNT						
. 00	Capital DRG other than outlier			4, 126, 700	1.0		
. 01	Model 4 BPCI Capital DRG other than outlier			0	1. C		
2. 00	Capital DRG outlier payments			690, 393	2. 0		
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0		
3. 00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	253. 15	3.0		
. 00	· · · · · · · · · · · · · · · · · · ·						
. 00	Indirect medical education percentage (see instructions)			1. 01 41, 680	5. C		
. 00							
. 00	Percentage of SSI recipient patient days to Medicare Part A p. 30) (see instructions)	atient days (Worksheet E	, part A line	3. 74	7. (
. 00	Percentage of Medicaid patient days to total days (see instru	ctions)		17. 87	8. 0		
. 00	Sum of lines 7 and 8	Ct1 0113)		21. 61	9. (
0. 00	Allowable disproportionate share percentage (see instructions)		4. 48			
1. 00	Disproportionate share adjustment (line 10 times the sum of I			184, 876			
2. 00				5, 043, 649	12.		
				1. 00			
	PART II - PAYMENT UNDER REASONABLE COST						
. 00	Program inpatient routine capital cost (see instructions)			0	1. (
. 00	Program inpatient ancillary capital cost (see instructions)			0	2.		
. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.		
. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 5.		
. 00	Total Tripatrent program capital cost (Trie 3 x Trie 4)				ا ن		
			,	_			
				1. 00			
	PART III - COMPUTATION OF EXCEPTION PAYMENTS						
	Program inpatient capital costs (see instructions)			0			
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	2.		
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2)	es (see instructions)		0 0	2. 3.		
.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	es (see instructions)		0 0 0 0.00	2. 3. 4.		
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0 0 0 0.00	2. 3. 4. 5.		
. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	structions)	line 6)	0 0 0 0.00 0	2. 3. 4. 5. 6.		
00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	structions)	line 6)	0 0 0 0.00 0.00	2. 3. 4. 5. 6. 7.		
00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	structions) circumstances (line 2 x	line 6)	0 0 0 0.00 0 0.00	2. 3. 4. 5. 6. 7. 8.		
00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	structions) circumstances (line 2 x cable)	,	0 0 0 0.00 0.00	2. 3. 4. 5. 6. 7. 8.		
.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applications) Current year comparison of capital minimum payment level to concarryover of accumulated capital minimum payment level over concarryover.	structions) circumstances (line 2 x cable) apital payments (line 8	less line 9)	0 0 0 0.00 0 0.00 0	5.		
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri	less line 9) or year	0 0 0 0.00 0 0.00 0 0	2. (3. (4. (5. (6. (7. (8. (9. (10. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin	less line 9) or year e 11)	0 0 0 0.00 0.00 0 0 0	2. (3. (4. (5. (6. (7. (8. (9. (10. (11. (
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.		
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over c	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line	less line 9) or year e 11)	0 0 0 0.00 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.		
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over c (if line 12 is negative, enter the amount on this line)	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line apital payment for the f	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.		
	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over c	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line apital payment for the f	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.		

Health Financia	al Syst	ems	LUTHERAN HOSPITAL O	F INDIANA			In Lie	u of Form	CMS-2	2552-10
This report is	requi r	red by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	ire to report can i	resul t	in all	interim	FORM APPR	OVED	
payments made :	since 1	the beginning of the co	st reporting period being o	leemed overpayments	s (42	USC 1395	g).	OMB NO. O	938-0	0050
HOSPITAL AND H	OSPI TAL	HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN: 150						
AND SETTLEMENT	SUMMAF	RY								
						To 06/	30/2014			
								12/1/2014	1: 22	2 pm
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	12/1/20	14 Tim	e: 1	: 22 pm
2. [] Manually submitted cost report 3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [F] Medicare Utilization. Enter "F" for full or "L" for low. Contractor 5. [1] Cost Report Status 6. Date Received: 10. NPR Date:										
					ler res	submitted	this co	ost report		
	4. [F] Medicare Utilization.	Enter "F" for full or "L"	for low.						
Contractor	5. [1	1Cost Report Status	6. Date Received:		10. NF	R Date:				
use only										4
	(2)	Settled without Audit	8. [N] Initial Report for	this Provider CCN	12. [0]If li	ne 5, co	lumn 1 is	4: E	nter
		Settled with Audit	9. N Final Report for the	nis Provider CCN				es reopene		
	(-)	Reopened								

PART II - CERTIFICATION

(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 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 the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN HOSPITAL OF INDIANA (150017) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
Date	

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	630, 339	-150, 640	77, 759	0	1.00
2.00 Subprovi der - IPF	0	0	0		0	2.00
3.00 Subprovi der - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5. 00
6.00 Swing bed - NF	0				0	6.00
200. 00 Total	0	630, 339	-150, 640	77, 759	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150017 Peri od: Worksheet S-2 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7950 WEST JEFFERSON BLVD 1.00 PO Box: 1.00 State: IN 2.00 City: FT WAYNE Zip Code: 46804 County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 LUTHERAN HOSPITAL OF 150017 23060 1 07/01/1966 Ν 0 3.00 NDI ANA Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2013 06/30/2014 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for ves or "N" for no In-State In-State Out-of Out-of Medicai d Other Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2. 00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 6, 455 2,066 216 63 8,064 24 00 in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state 0 0 0 0 0 25.00 Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27.00 enter the effective date of the geographic reclassification in column 2.

If this is a sole community hospital (SCH), enter the number of periods SCH status in

35.00

effect in the cost reporting period.

1.00 2.00	OSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	F	Period: From 07/01 To 06/30 Beginni	/2014	Workshe Part I Date/Ti 12/1/20 Endi	me Pre	epared:
0. Oil Fith is a Medicare dependent hospital (DMH), enter the number of periods MDH status in refrect in the cost reporting period. 1. Oil Fith is as Medicare dependent hospital (DMH), enter the number of periods MDH status. 1. Oil Fith is as Medicare dependent hospital states of MDH status. Subscript line 38 for number of periods. In the cost reporting period of the periods o										
7.00 If this is a Medicare dependent hospital (M6H), enter the number of periods MBH status in effect in the cost reporting period. 8.00 Enter applicable beginning and ending dates of MBH status. Subscript line 38 for number of periods in excess of view and enter subsequent dates. 9.00 Dees this Facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 1 "Y" for yes or "N" for no. Does the facility meet the all-eage regularements in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 1 "Y" for yes or "N" for no. Does the facility meet the all-eage regularements in accordance with 42 CIR \$412.1010 (2) (2) (1) 7 inter in column 2 "Y" for yes or "N" for no. (See Instructions) 9.00 Prospective Payment System (PPS) -Capital Deplied to the subscript of	6. 00			Subscript line	36 for number					36. 0
1.00 Cheen and period bids period in excess of fore and enter subsequent dates of MRH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates. Y/N	. 00			umber of period	ds MDH status		0			37. 0
of periods in excess of one and enter subsequent dates. Y/N				Cubaarint lina	20 for number					20.0
9.00 Does this facility qualify for the Inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CRR \$412.1016()(2)(11)? Inter in column 1 'Y' for yes or 'N' for no. Does the facility medical the mile age requirements in accordance with 42 CRR \$412.1016()(2)(11)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility medical the mile age requirements in accordance with 42 CRR \$412.1016()(2)(11)? Enter in column 2 "Y' for yes or 'N' for no. (See Instructions) Prospective Payment System (PPS)-Capital and the Accordance with 42 CRR Section \$412.200? (see Instructions) Prospective Payment System (PPS)-Capital in the Accordance with 42 CRR Section \$412.200? (see Instructions) Prospective Payment System (PPS)-Capital with 42 CRR Section \$412.200? (see Instructions) Prospective Payment System (PPS)-Capital with 42 CRR Section \$412.200? (see Instructions) Prospective Payment System (PPS)-Capital with 42 CRR Section \$412.200? (see Instructions) Prospective Payment System (PPS)-Capital With 42 CRR Section \$412.200? (see Instructions) Prospective Payment System (PPS)-Capital Payment for disproportionate share in accordance with 42 CRR Section \$412.200? (see Instructions) Prospective Payment System (PPS)-Capital Payment for disproportionate share in accordance with 42 CRR Section \$412.200? (see Instructions) Prospective Payment System (PPS)-Capital Pa	8.00			Subscript line	38 FOR number					38. 0
9.00 Does this facility quality for the inpatient hospital payment adjustment for low volume hospitals in accordance with 4.2 CRF 8412.010(b) (2)(ii)? Enter in column 1 "Y for no. See instructions) Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 4.2 Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (See Instructions) Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for disproportionate share in accordance with 4.2 CRF 8412.300 (PPS) capital payment for payment fo										
Prespective Payment System (PPS)-Capital 5.00 Does this Facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.300? (see instructions) 6.00 Is this Facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.300? (see instructions) 7.00 Is this racility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no. 8.00 Is the facility electing full rederal capital payment? Enter "Y for yes or "N" for no. 9.01 Is the facility electing full rederal capital payment? Enter "Y" for yes or "N" for no. 1.20 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no. 1.20 Is the facility electing full rederal capital payment? Enter "Y" for yes or "N" for no. 1.20 Is this a hospital involved in training residents in approved GME programs rained at this facility? Enter "Y" for yes or "N" for no in column 1. I'r column 1 is "Y" did residents start training in the first month or this cost reporting period? Enter "Y" for yes or "N" for no in column 2. I'r column 2 is "Y" complete Worksheet E-4. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 2 is "Y" for yes or "N" for no in column 3. I'r column 3 is "Y" for yes or "N" for no in column 3. I'r column 4. See instructions) 1.00 Id your hospital receive FFE slots under ACA section 55037 Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 In the fee average number of unwelghted primary care FIEs from the hospital"s 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the average number of unwelghted pr	9. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req)? Ente Jui remen	er in column 1 nts in accordar	"Y" for yes nce with 42	_				39. 0
Prospective Payment System (PPS)-Capital										1
with 42 CFR Section \$412,3207 (see instructions) 0		Prospective Payment System (PPS)-Capital					1.00	7 2.00	3.00	
Statis facility eligible for additional payment exception for extraordinary circumstances oursunt to 42 CFR \$412.346(F)? If yes, complete Worksheet I, Part III and L-I, Parts I through III.	5. 00		it for (di sproporti onat	te share in ac	cordance	N	Y	N	45. 0
8.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	6. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Work			,		N	N	N	46. 0
Sthis a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. Or "N" for no. Till films 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "N", complete Worksheet E4. If column 2 is "N", complete Worksheet D4. If column 2 is "N", complete Worksheet D4. If column 2 is "N", complete Worksheet D4. If column 2 is "N", complete Worksheet D4. If column 2 is "N", complete Worksheet D4. If column 2 is "N", complete Worksheet D4. If column 2 is "N, column 2 is "N, column 2 is "N, column 2 is "N, column 2		Is the facility electing full federal capital payment							1	47. C 48. C
1.00 If	5. 00	Is this a hospital involved in training residents in	approve	ed GME programs	s? Enter "Y"	for yes	Y			56.0
GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "N", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III, & IV and D-2, Part II, if applicable. 3.00 If fline 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5. 9.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-5. 9.00 Are coulcialming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) 1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care enter the average number of unweighted primary care enter the average number of unweighted primary care enter cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the current year total unweighted primary care endor general surgery residents, which is used for determining compilance with the 75% test. (see instructions) 1.04 Enter the difference between the baseline primary and/or general surgery residents, which is used for determining compilance with the 75% test. (see instructions) 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs that are nonprimary care entered by a primary	7. 00		eriod o	durina which re	esidents in ap	proved	N			57.0
2.00 Are costs claimed on line 100 of Worksheet Â? If yes, complete Worksheet D-2, Part I. 2.00 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) 1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.00 Enter the average number of unweighted primary care FTEs from the hospital is 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding 08/GVN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current year the difference between the baseline primary and/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs and the current year's primary care anal/or general surgery FTEs that are nonprimary care or general surgery. (see instructions) 1.06 Enter the difference between the baseline primary and/or general surgery. (see instructions) 1.00 Fine FTEs in line 61.05, specify each new program proved the section of the FTE count proved the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of th		GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y"N", complete Worksheet D, Part III & IV and D-2, Par If line 56 is yes, did this facility elect cost reimb	yes on the second of the secon	r "N" for no ir his cost report plete Worksheet if applicable. nt for physicia	n column 1. If ting period? t E-4. If colu	column 1 Enter "Y" mn 2 is	N			58. (
provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) V/N IME Direct GME IME Direct GME		Are costs claimed on line 100 of Worksheet A? If yes	, compl	lete Worksheet						59. (
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 1.06 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted Direct GME FTE Count Coun	0. 00						Y			60.0
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Enter the current year total unweighted primary care FTE count (excluding OB/GPN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs that are nonprimary care or general surgery. (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 1.07 Program Name Program Code Unweighted IME FTE Count Direct GME FTE Count Specialty, if any, and the number of FTE residents 1.00 2.00 3.00 4.00 0.00 0.00	I. 01	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.0	O				61. (
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.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) .06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents	. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	d				61. (
.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME FTE Count 1.00 2.00 3.00 4.00 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents	. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.0	o				61.
Program Name Program Code Unweighted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 .10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents	. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary		0.00	0.0	o				61. (
.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents		g.: (Pr		0	FTE Co	ount	Direct (Cou	GME FTE	-
column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE	. 10	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the		1.00	2.00	3.00				61.

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150017 Peri od: Worksheet S-2 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am Program Code Unweighted IME Program Name Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Non-Provider Settings 63.00 Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) N 63.00 Unwei ghted Unwei ghted Ratio (col. 1/ FTEs in FTES (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident 0. 00 0. 00 0.000000 66.00

FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

	instructions) Enter "Y" for yes or "N" for no in the applicable column.			
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter	N	N	93. 00
	"Y" for yes or "N" for no in the applicable column.			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00
	applicable column.			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N	N	96. 00
	applicable column.			
97. 00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0. 00	97. 00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105. 00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment			106. 00
	for outpatient services? (see instructions)			

Health Financial Systems LUTHERAN HOSPIT. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150017	Period: From 07/01 To 06/30	/2013	w of For Workshoper Part I Date/Ti 12/1/20	et S-: me Pro	2 epared:
			1. 00	`	XI		4
107.00 Column 1: If this facility qualifies as a CAH, is it eligil for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on We 25 and the program would be cost reimbursed. If yes complete Column 2: If this facility is a CAH, do I&Rs in an approved train in the CAH's excluded IPF and/or IRF unit? Enter "Y' column 2. (see instructions)	o in column 1. Orksheet B, Pa e Worksheet D- d medical educa " for yes or "I	(see rt I, column 2, Part II. ation program N" for no in		J	2.(<u>JU</u>	107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				a b	Docni r	atony	108.00
	Physi cal 1.00	Occupationa 2.00	3. 00		Respir 4.		+
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.							109.00
				1. 00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of enter the method used (A, B, or E only) in column 2. If column the either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital providers 15-1. \$2208.1.	umn 2 is "E", e for long term	enter in colu care (includ	mn 3 les	N		0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insulan			"N" for	N N			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i			1			118. 00
		Premiums	Losse	es	Insur	ance	
		1. 00	2.00)	3. (00	
118.01 List amounts of malpractice premiums and paid losses:		617, 3	74 18	39, 118			0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.			1. 00 N)	2. (00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies the Hold Harmless provision in ACA §3121 and applicable amendments.	n column 1 "Y" ualifies for tl	for yes or he Outpatient			N	I	119. 00 120. 00
Enter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y				121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	for yes and "N"	for no. If	Y				125. 00
			14 (05 (2008			126. 00
yes, enter certification date(s) (mm/dd/yyyy) below.		fication date					
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2	2. ter the certifi 2.	ication date	02/16/1				
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ender in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, ender in column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, ender in column 1 and termination date, if applicable, in column 1	 ter the certifi ter the certifi . 	ication date	02/16/1				128. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, entocolumn 1 and termination date, if applicable, in column 2.130.00 If this is a Medicare certified pancreas transplant center,	2. ter the certifi 2. ter the certifi 2. er the certifi enter the certifi	ication date ication date cation date i	02/16/1				128. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.	2. ter the certifi 2. ter the certifi 2. er the certifi enter the certifi tumn 2. r, enter the certifi	ication date ication date cation date i tification	02/16/1				128. 00 129. 00 130. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, encolumn 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 101	2. ter the certification the certification the certification the certification the certification the certification the certification the certification the certification that the certi	ication date ication date cation date itification date itification	02/16/1				128. 00 129. 00 130. 00 131. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified lung transplant center, enticolumn 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, and termination date, if applicable, and termination date, if applicable, and termination date, if applicable, and termination date, and termination date, and termination date, and termination date, and termination date, and termination date, and termination date, and termination date, and termination date, and termination date, and termination date, and termination date, and termination	2. ter the certifi 2. ter the certifi 2. er the certifi enter the certifi umn 2. r, enter the certifi 1umn 2. ter the certifi 2. ter the certifi 2.	ication date ication date cation date itification ertification date ication date	02/16/1				127. 00 128. 00 129. 00 130. 00 131. 00 132. 00 133. 00
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Health Financial Systems	LUTHERAN HO	OSPITAL 0	F INDIANA				In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA		Provi der (CCN: 1500			7/01/2013 5/30/2014	Worksheet S- Part I Date/Time Pr 12/1/2014 9:	epared:
1.00		2. 00					3.00		
If this facility is part of a chain home office and enter the home office	<u>e contractor name a</u>	and contr		r.					
141.00 Name: COMMUNITY HEALTH SYSTEMS 142.00 Street: 4000 MERIDIAN BLVD	Contractor's Nam					s Nur	mber: 1030		141.00
143.00 City: FRANKLIN	State:	TN		Zip (Code:		3706) / 	143. 00
								1.00	+
144.00 Are provider based physicians' costs	included in Worksh	neet A?						Y	144. 00
145.00 If costs for renal services are clai services only? Enter "Y" for yes or		line 74	are they	costs fo	r inpa	ti ent		Y	145. 00
					ł		1. 00	2.00	-
146.00 Has the cost allocation methodology	changed from the pr	evi ousl v	filed cost	report?			N N	2.00	146. 00
Enter "Y" for yes or "N" for no in c enter the approval date (mm/dd/yyyy)	olumn 1. (See CMS P								
47.00 Was there a change in the statistica					1		N		147. 0
148.00 Was there a change in the order of a					_		N		148. 0
49.00 Was there a change to the simplified no.	cost finding metho	d? Enter	"Y" for ye	s or "N"	for		N		149. 0
jiio.			Part A	Part	В	Ti	tle V	Title XIX	
			1.00	2. 0			3.00	4.00	
Does this facility contain a provide or charges? Enter "Y" for yes or "N"									
55.00 Hospi tal			N	N			N	N	155. 0
56.00 Subprovi der - IPF			N	N			N	N	156. 0
57. 00 Subprovi der - I RF 58. 00 SUBPROVI DER			N	N			N	N	157. 0 158. 0
59. 00 SNF			N	N			N	l N	159. 0
60.00 HOME HEALTH AGENCY			N	N	i		N	N	160. 0
161.00 CMHC				N			N	N	161. 0
								1.00	
Multicampus					. 66	- + CD	CA-0	l N	1/5 0
65.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no.	us nospitai that na	is one or	more campu	ses in a	rrere	nt CB:	SAS?	IN IN	165. 0
Enter 1 101 years 1 11 101 1101	Name	Ci	ounty	State	Zip (Code	CBSA	FTE/Campus	
	0		1. 00	2. 00	3. (00	4. 00	5. 00	
66.00 If line 165 is yes, for each								0. 0	0 166. 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									
								1.00	
Health Information Technology (HIT)									
167.00 s this provider a meaningful user u							+60	Y	167. 0
168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HIT			user (IIne	10/ IS	Y), (enter	rne		0168. 0
169.00 If this provider is a meaningful use			not a CAH (line 105	is "N	"), eı	nter the	0. 5	0169.00
transition factor. (see instructions									
						Bec	gi nni ng	Endi na	

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)

Begi nni ng

1. 00

10/01/2012

Endi ng

2.00

09/30/2013

	Financial Systems L AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	LUTHERAN HOSPITAL OF			Peri od:	eu of Form CMS- Worksheet S-2	
					From 07/01/2013 o 06/30/2014	Date/Time Pre	
					Y/N	12/1/2014 9:5 Date	5 a
	<u> </u>				1.00	2.00	
	General Instruction: Enter Y for all YES responded/yyyy format. COMPLETED BY ALL HOSPITALS	ponses. Enter N for	all NO re	esponses. Enter	all dates in	the	
0	Provider Organization and Operation Has the provider changed ownership immediate	Ly prior to the heai	nni na of	the cost	N	<u> </u>	1
,,,	reporting period? If yes, enter the date of			instructions)			
				1. 00	2. 00	V/I 3. 00	-
0	Has the provider terminated participation in			N N	2.00	3.00	
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3,	"V" for				
0	Is the provider involved in business transact	tions, including man	agement	Υ			:
	contracts, with individuals or entities (e.g.						
	or medical supply companies) that are related officers, medical staff, management personnel						
	of directors through ownership, control, or						
	relationships? (see instructions)			Y/N	Туре	Date	
				1.00	2. 00	3. 00	
	Financial Data and Reports	normal by - Co. LLCL.	Dul-1:	N.I.		0/ /20 /2012	
0	Column 1: Were the financial statements prepaccountant? Column 2: If yes, enter "A" for			N		06/30/2013	
	or "R" for Reviewed. Submit complete copy or	enter date availabl					
0	column 3. (see instructions) If no, see instructions are the cost report total expenses and total		from	l N			
U	those on the filed financial statements? If			IN IN			
				•	Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
0	Column 1: Are costs claimed for nursing scho	ool? Column 2: If y	es, is th	ne provider is	N		1
0	the legal operator of the program? Are costs claimed for Allied Health Programs'	2 lf "V" coo instruc	tions		Υ		
0	Were nursing school and/or allied health produced			during the	N		
0	cost reporting period? If yes, see instruction				.,		
0	Are costs claimed for Intern-Resident program yes, see instructions.	ms claimed on the cu	rrent cos	st report? If	Υ		
00	Was an Intern-Resident program been initiated	d or renewed in the	current d	cost reporting	N		1
00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & P	in an Anr	roved	N		1
00	Teaching Program on Worksheet A? If yes, see		ін ан Арр	or oved	IN		'
						Y/N 1. 00	
	Bad Debts					1.00	
	Is the provider seeking reimbursement for back					Y	
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del				t reporting		
00	Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	bt collection policy	change o	during this cos		Y	1
00	Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	bt collection policy and/or co-payments w	change o	during this cos	ructions.	Y N	1
00	Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	bt collection policy and/or co-payments w	change o	during this cos yes, see inst yes, see instr	ructions.	Y N	1
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Heal th	Financial Systems	LUTHERAN HOSPITAL O	F INDIANA		In lie	eu of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		Provi der C	F	Period: From 07/01/2013 To 06/30/2014	Worksheet S Part II	repared:
				Pai	rt A	Part B	
		Descriptio	n	Y/N	Date	Y/N	
		0		1. 00	2.00	3.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT C	HILDRENS HOS	SPI TALS)			
22.00	Capital Related Cost	0.16	A			1	
22. 00 23. 00	Have assets been relifed for Medicare purpose Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.			s made durir	ng the cost		22. 00 23. 00
24. 00	Were new leases and/or amendments to existing If yes, see instructions	g leases entered in	to during th	nis cost repo	orting period?		24. 00
25. 00	Have there been new capitalized leases entereinstructions.	ed into during the	cost reporti	ng period? I	f yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	uired during the co	st reportino	g period? If	yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.						27. 00
28 00	Interest Expense Were new Loans, mortgage agreements or Letter	rs of credit entere	d into duri	na the cost r	reporting		28. 00
20.00	period? If yes, see instructions.	is or or our contors	a aa	.g : 0001 .	opo. cr.i.g		20.00
29. 00	Did the provider have a funded depreciation a treated as a funded depreciation account? If	yes, see instructi	ons		•		29. 00
30. 00	Has existing debt been replaced prior to its instructions.	scheduled maturity	with new de	ebt? If yes,	see		30. 00
31. 00	Has debt been recalled before scheduled mature instructions.	rity without issuan	ce of new de	ebt? If yes,	see		31. 00
	Purchased Services						
32. 00	Have changes or new agreements occurred in parrangements with suppliers of services? If			through cont	ractual		32. 00
33. 00	If line 32 is yes, were the requirements of 5 no, see instructions.			to competiti	ve bidding? If		33. 00
	Provi der-Based Physi ci ans					1	
34. 00	Are services furnished at the provider faciling types, see instructions.	ity under an arrang	ement with p	provi der-base	ed physi ci ans?		34. 00
35. 00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			s with the pr	rovi der-based		35. 00
	private and during the door reporting period:	,05, 500 1115114	01.0110.		Y/N	Date	
					1. 00	2. 00	
	Home Office Costs						
	Were home office costs claimed on the cost re				Y		36. 00
37. 00	If line 36 is yes, has a home office cost stallf yes, see instructions.	atement been prepar	ed by the ho	ome office?	Υ		37. 00

36.00	Were home office costs claimed on the cost report?		Υ		36. 00
37.00	If line 36 is yes, has a home office cost statement been pr	repared by the home office?	Υ		37. 00
	If yes, see instructions.				
38. 00	If line 36 is yes , was the fiscal year end of the home of	fice different from that of	Υ	12/31/2013	38. 00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home office.			
39. 00	If line 36 is yes, did the provider render services to other	er chain components? If yes,	Υ		39. 00
	see instructions.				
40.00	If line 36 is yes, did the provider render services to the	home office? If yes, see	N		40. 00
	i nstructi ons.				
		1. 00	2. 00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	LI SA	PARRI SH		41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report	CHS			42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost	(615) 465-7554	LI SA_PARRI SH@CI	HS. NET	43.00
	report preparer in columns 1 and 2, respectively.				

From 07/01/2013 To 06/30/2014 Part II Date/Time Prepared: 12/1/2014 9:55 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 11/04/2014 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer.

43.00

43.00

Enter the telephone number and email address of the cost

report preparer in columns 1 and 2, respectively.

 Heal th Financial
 Systems
 LUTHERAN

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared:

					To	06/30/2014	Date/Time Pre 12/1/2014 9:5	
							I/P Days / 0/P	o alli
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Davs	CAH Hours	Title V	
	Component	Line Number	INO.	OI BCG3	Avai I abl e	CAIT HOULS	II ti C V	
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		234	85, 410	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and				·			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF				05 440		0	6. 00
7. 00	Total Adults and Peds. (exclude observation			234	85, 410	0. 00	0	7. 00
8. 00	beds) (see instructions)	21 00		0	0	0.00	0	8. 00
8. 00	INTENSIVE CARE UNIT	31. 00 31. 01		-	7, 300	0. 00 0. 00	0	8. 00
8. 02	PEDIATRIC INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 02		20 24	8, 760	0.00	0	8. 02
8. 03	CARDIO INTENSIVE CARE UNIT	31. 02		84	30, 660	0.00	0	8. 03
9. 00	CORONARY CARE UNIT	32. 00		24	8, 760	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	32.00		27	0, 700	0.00	· ·	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			386	140, 890	0.00	0	14.00
15. 00	CAH visits				·		0	15. 00
16.00	SUBPROVIDER - IPF	40. 00		0	0		0	16. 00
17.00	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)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)			386				26. 25 27. 00
28. 00	Observation Bed Days			300			0	28.00
29. 00	Ambulance Trips						U	29.00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see l'instruction)							31.00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room			Ĭ	Ĭ			32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
					. '		-	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

outpatient days (see instructions)

LTCH non-covered days

0

0

32.00

32.01

33.00

12/1/2014 9:55 am Full Time Equivalents I/P Days / O/P Visits / Trips Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 20, 460 3, 758 51, 738 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 18.262 10, 186 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 20, 460 3, 758 51, 738 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 8.00 PEDIATRIC INTENSIVE CARE UNIT 8.01 0 88 906 8.01 8.02 NEONATAL INTENSIVE CARE UNIT 0 674 4,545 8.02 7, 379 8.03 CARDIO INTENSIVE CARE UNIT 1, 590 28,006 8.03 9.00 CORONARY CARE UNIT 425 7, 206 9.00 2.442 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 NURSERY 1, 969 13.00 143 13.00 Total (see instructions) 2,031.33 14.00 30, 281 6,678 94, 370 8.14 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 0 0.00 0.00 16.00 17 00 SUBPROVIDER - IRF 17 00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 20.00 OTHER LONG TERM CARE 21 00 21 00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 0 0 Ω 24.10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26, 25 26, 25 2,031.33 27 00 Total (sum of lines 14-26) 8 14 27 00 28. 00 Observation Bed Days 752 28.00 29.00 Ambul ance Trips 29.00 0 Employee discount days (see instruction) 30.00 0 30.00 31.00 Employee discount days - IRF 0 31.00

32.00

32.01

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared:
 Heal th Financial
 Systems
 LUTHERAN

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 150017

				То	06/30/2014	Date/Time Prep 12/1/2014 9:55	
		Full Time		Di scha	arges	12/1/2014 7. 30	o alli
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1 00		11. 00	12. 00	13.00	14.00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	5, 667	1, 028	18, 500	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			3, 098	o		2. 00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
8. 01 8. 02	PEDIATRIC INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT						8. 01 8. 02
8. 03	CARDIO INTENSIVE CARE UNIT						8. 03
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	5, 667	1, 028	18, 500	14.00
15. 00	CAH visits		_		_	_	15. 00
16.00	SUBPROVI DER - I PF	0. 00	0	0	0	0	16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER						17. 00 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	RURAL HEALTH CLINIC						26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25 27. 00
28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF					ļ	31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days					l	33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provi der CCN: 150017

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared:

					T	06/30/2014	Date/Time Pre 12/1/2014 9:5	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷	
				Worksheet A-6)	3)	col. 4	col. 5)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1.00	SALARIES Total salaries (see	200. 00	104, 079, 412	0	104, 079, 412	4, 188, 065. 00	24. 85	1.00
	instructions)	200.00	.0.,0,,,		101/07//112	.,	233	
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3.00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
	В		_					
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0.00	4. 00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4. 01
5.00	Physician-Part B		0	0	0	0.00		
6. 00 7. 00	Non-physician-Part B	21. 00	0	0	0	0. 00 0. 00		
7.00	Interns & residents (in an approved program)	21.00	0	0	U	0.00	0.00	7.00
7. 01	Contracted interns and		0	0	0	0.00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office personnel		0	0	0	0.00	0.00	8. 00
9.00	SNF	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		2, 481, 758	475, 001	2, 956, 759	115, 517. 72	25. 60	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		13, 595	0	13, 595	519. 75	26. 16	11. 00
12. 00	Care Contract Labor: Top Level		95, 689	0	95, 689	429. 82	222, 63	12.00
	management and other		•					
	management and administrative services							
13. 00	Contract Labor: Physician-Part		539, 437	0	539, 437	3, 601. 00	149. 80	13. 00
14.00	A - Administrative		0		0	0.00	0.00	14.00
14. 00	Home office salaries & wage-related costs		0	0	0	0. 00	0.00	14. 00
15. 00	Home office: Physician Part A		7, 895, 360	0	7, 895, 360	110, 010. 00	71. 77	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16. 00
	Physicians Part A - Teaching]
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		21, 545, 122	0	21, 545, 122			17. 00
	instructions)		2.70.07.122		2.70.07.122			
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		672, 743	0	672, 743			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
	В		_					
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25.00	approved program)				0			25.00
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	720, 074	0	720, 074	25, 196. 00	28. 58	26. 00
27. 00	Administrative & General	5. 00	10, 280, 456			·		
28. 00	Administrative & General under		0	0	0	0.00		1
20.00	contract (see inst.)	4 00	0		0	0.00	0.00	29. 00
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	1, 697, 225	0	1, 697, 225	0. 00 72, 469. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32.00	Housekeepi ng	9. 00	1, 748, 247	0	1, 748, 247			
33. 00	Housekeeping under contract (see instructions)		0	١	U	0. 00	0.00	33. 00
34.00	Di etary	10. 00	2, 737, 970	-1, 507, 680	1, 230, 290			
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36. 00	Cafeteri a	11. 00	0	1, 544, 259	1, 544, 259	114, 187. 41	13. 52	
37. 00	Maintenance of Personnel	12.00	0	0	0	0.00		
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	4, 442, 002 1, 359, 737		1, 525, 972 1, 760, 071			38. 00 39. 00
40. 00		15. 00	5, 636, 234		5, 636, 234			40.00
		,						

Health Financial Systems	L	UTHERAN HOSPIT	PITAL OF INDIANA In Lieu of Form (2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 07/01/2013		
				'	To 06/30/2014		
						12/1/2014 9: 5	<u>am</u>
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col . 5)	
			Worksheet A-6)	3)	col. 4		
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	1, 895, 941	812, 151	2, 708, 09	2 135, 125. 00	20. 04	41.00
Records Li brary							
42.00 Social Service	17. 00	0	1, 956, 174	1, 956, 17	4 62, 764. 00	31. 17	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43.00

HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 07/01/2013 To 06/30/2014		pared:
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		104, 079, 412	0	104, 079, 41:	2 4, 188, 065. 00	24. 85	1. 00
	instructions)							
2.00	Excluded area salaries (see		2, 481, 758	475, 001	2, 956, 75	9 115, 517. 72	25. 60	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		101, 597, 654	-475, 001	101, 122, 65	3 4, 072, 547. 28	24. 83	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		8, 544, 081	0	8, 544, 08	1 114, 560. 57	74. 58	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		21, 545, 122	0	21, 545, 12:	0.00	21. 31	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		131, 686, 857					
7.00	Total overhead cost (see		30, 517, 886	-475, 000	30, 042, 88	6 1, 377, 671. 00	21. 81	7. 00
	instructions)							

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150017	From 07/01/2013	Worksheet S-3 Part IV Date/Time Prepared:

	To 06/30/2014	Date/Time Prep 12/1/2014 9:55	pared: 5 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 258, 144	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	10, 711, 851	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	203, 327	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	89, 033	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	-1, 231	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	33, 639	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	913, 039	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	6, 026, 920	17. 00
18.00	Medicare Taxes - Employers Portion Only	1, 409, 522	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	1, 003, 776	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
22.00	instructions)) Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	22, 648, 020	
24.00	Part B - Other than Core Related Cost	22, 048, 020	24.00
25 00	OTHER EMPLOYEE BENEFITS	-430, 153	25 00
25.00	OTHER EWILDIEL DENETITS	-430, 133	25.00

∐oal +b	Financial Systems	LUTHERAN HOSPITAL C	DE INDIANA		In Lie	u of Form CMS-2	0552 10
	TAL CONTRACT LABOR AND BENEFIT COST	LUTTIERAN TIOSFITAL C		CCN: 150017	Peri od: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part V	pared:
	Cost Center Description				Contract Labor	Benefit Cost	
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Ident						
1. 00	Total facility's contract labor and benefit	cost			0	0	1. 00
2.00	Hospi tal				0	0	2. 00
3. 00	Subprovi der - IPF				0	0	3. 00
4.00	Subprovi der - IRF					_	4. 00
5. 00	Subprovi der - (Other)				0	0	
6. 00	Swing Beds - SNF				0	0	6. 00
7. 00	Swing Beds - NF				0	0	7. 00
8. 00	Hospi tal -Based SNF						8. 00
9. 00	Hospi tal -Based NF						9. 00
10.00	Hospi tal -Based OLTC						10.00
11.00	Hospi tal -Based HHA						11.00
12.00	Separately Certified ASC						12.00
13.00	Hospi tal -Based Hospi ce						13. 00
14.00	Hospital -Based Health Clinic RHC						14. 00
15.00	Hospital-Based Health Clinic FQHC						15. 00
16.00	Hospi tal -Based-CMHC						16.00
17. 00	Renal Dialysis				0	0	
18. 00	Other				0	0	18. 00

HOSPITAL UNCOMPRISATED AND INDIGENT CARE DATA	Heal th	Financial Systems LUTHERAN HOSPITAL OF	I NDI ANA		In Lie	u of Form CMS-2	2552-10		
Incorporated and Indigent care cost computation	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150017		Worksheet S-10	0		
Incompensated and indigent care cost computation 1.00						D . /T' D			
Uncompensated and Indigent care cost computation					10 06/30/2014				
Uncompensated and indigent care cost computation 0.00						127 17 2011 7. 0	o din		
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)						1. 00			
Medicaid (See Instructions for each line) 47,171,837 2.0									
Net revenue from Medicaid 47,171,837 2.00 2	1.00		ded by li	ne 202 column	8)	0. 161561	1. 00		
3.00 10 you receive DSH or supplemental payments from Medicaid?	0.00					47 474 007	0.00		
1			navmonts	from Modicaio	12	IN			
Medical d charges		1	, ,	II olii wedi carc	1 :	0			
Medical d cost (line 1 times line 6) 34,543,150 7.00 8.00 0 1 1 1 1 1 1 1 1									
8.00		1							
State Children's Heal th Insurance Program (SCHIP) (see instructions for each line) 9, 00 0.00 0.00 0.00 0.00 0.10 0.00	8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	es 2 and 5; if		8. 00		
9.00 Not revenue from stand-alone SCHIP 0 0 0 0 0 0 0 0 0									
10.00 Stand-alone SCHIP charges 0 10.00 11.00 Stand-alone SCHIP cost (line 1 times line 10) 0 11.00 12.00 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 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			ons for e	ach line)					
11. 00 Stand-al one SCHIP cost (line 1 times line 10) 11. 00 12. 00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero) 12. 00 20. 00 13. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 15. 00 15. 00 16. 913, 445 14. 00 15. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 14. 00 16. 913, 445 16. 00 16. 913, 445						-			
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 1,996,099 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 10) 10.00 10.0						_			
enter zero) Other state or local government indigent care program (see instructions for each line) 13. 00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 16, 913, 445 14. 00 10) 15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unrel mbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 736, 454 19. 00 20. 00 Total initial obligation of patients approved for charity care (at full 6, 839, 529 1, 223, 476 8, 063, 005 20. 00 21. 00 Total initial obligation of patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21. 00 22. 00 Partial payment by patients approved for charity care (line 1 1, 105, 001 197, 666 1, 302, 667 21. 00 23. 00 Cost of charity care (line 21 minus line 22) 1, 088, 847 179, 403 1, 265, 250 23. 00 24. 00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care p		1	l: no 11 m	inua lina O.	if . zono thon	-			
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17. 00 Private grants, donations, or endowment income restricted to funding charity care (Sovernment grants, appropriations or transfers for support of hospital operations (Stand 16) 19. 00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines (Stand 16) 10									
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Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients patients									
8, 12 and 16) Uninsured patients Total (col. 1 patients Pa					s (sum of lines	736, 454			
patients patients + col. 2) 20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20) 22.00 Partial payment by patients approved for charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 2 times line 28) 3.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4.742, 403 29, 00 6.007, 653 30.00		8, 12 and 16)							
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			nse (line	1 times line	28)				
31.00 lotal unreimbursed and uncompensated care cost (line 19 plus line 30) 6,744,107 31.00			20)						
	31.00	liotal unreimbursed and uncompensated care cost (line 19 plus line)	e 30)			6, 744, 107	31.00		

	Financial Systems	LUTHERAN HOSPITAL	OF INDIANA		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	F	Period: From 07/01/2013	Worksheet A	
					o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
						(col. 3 +-	
		1.00	2.00	3. 00	4. 00	<u>col. 4)</u> 5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		6, 356, 295	6, 356, 295			
2.00	00200 CAP REL COSTS-MVBLE EQUIP	700 074	15, 103, 594	15, 103, 594		20, 597, 860	
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMITTING	720, 074 10, 280, 456	1, 138, 217 100, 302, 876	1, 858, 291 110, 583, 332		15, 626, 621 40, 073, 399	4. 00 5. 01
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	10, 280, 430	100, 302, 870	110, 363, 332		48, 494, 448	
7. 00	00700 OPERATION OF PLANT	1, 697, 225	9, 501, 671	11, 198, 896		11, 191, 813	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 319, 950	1, 319, 950	-74	1, 319, 876	
9.00	00900 HOUSEKEEPI NG	1, 748, 247	1, 234, 312	2, 982, 559		2, 982, 559	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 737, 970	3, 442, 272	6, 180, 242 (2, 856, 081 3, 584, 948	
13. 00	01300 NURSING ADMINISTRATION	4, 442, 002	1, 017, 420	5, 459, 422		1, 718, 963	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 359, 737	40, 772, 131	42, 131, 868		6, 096, 137	1
15. 00	01500 PHARMACY	5, 636, 234	26, 184, 685	31, 820, 919			•
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 895, 941	1, 084, 027	2, 979, 968		4, 376, 479	
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0 2, 785, 941	2, 785, 941	_,,,	2, 125, 305 0	17. 00 21. 00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		2, 765, 941	2, 700, 941	-2, 785, 941 2, 785, 941	2, 785, 941	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	178, 102	110, 358	288, 460		288, 384	
23. 01	02301 PHARMACY RESIDENCY PROGRAM	156, 737	25, 063	181, 800	0	181, 800	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	17 (00 000		0.4.0.47.005		22 542 222	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	17, 620, 303 14, 350, 394	6, 626, 782 3, 333, 330	24, 247, 085 17, 683, 724		22, 542, 820 0	1
31.00	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 141, 036	620, 542	2, 761, 578		894, 996	
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	2, 141, 030	020, 342	2, 701, 370	2, 752, 477	2, 752, 477	
31. 03	03101 CARDIO INTENSIVE CARE UNIT	0	0	C	12, 296, 057	12, 296, 057	1
32. 00	03200 CORONARY CARE UNIT	0	0	C	4, 486, 796		1
40.00	04000 SUBPROVI DER - I PF	0	0	(4.47	0	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	61, 477	61, 477	272, 240	333, 717	43.00
50. 00	05000 OPERATING ROOM	8, 451, 902	12, 865, 631	21, 317, 533	-3, 963, 051	17, 354, 482	50.00
51.00	05100 RECOVERY ROOM	2, 799, 775	730, 080	3, 529, 855	-3, 529, 855	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		.,	1, 384, 727	1
53.00	05300 ANESTHESI OLOGY	120, 836	3, 990, 324	4, 111, 160		3, 956, 580	1
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 PET SCAN	3, 613, 216 550, 213	2, 136, 340 63, 166	5, 749, 55 <i>6</i> 613, 379		5, 561, 956 196, 887	1
56. 00	05600 RADI OI SOTOPE	353, 944	1, 780, 768	2, 134, 712		1, 564, 130	1
57.00	05700 CT SCAN	642, 653	201, 899	844, 552		837, 452	
58. 00	05800 MRI	374, 374	35, 865	410, 239		0	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	4, 470, 469 3, 709, 962	10, 221, 652 1, 327, 512	14, 692, 121 5, 037, 474		14, 465, 671 4, 408, 187	1
66. 00	06600 PHYSI CAL THERAPY	2, 183, 248	616, 864	2, 800, 112			
	06700 OCCUPATI ONAL THERAPY	515, 108	46, 461	561, 569			67. 00
68. 00	06800 SPEECH PATHOLOGY	228, 996	25, 789	254, 785		0	
69. 00	06900 ELECTROCARDI OLOGY	3, 132, 380	1, 751, 483	4, 883, 863		1, 079, 353	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(1, 393, 284 17, 574, 253	1, 393, 284 17, 574, 253	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	(18, 785, 922	18, 785, 922	
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	Ö	Č	24, 190, 648	24, 190, 648	
74. 00	07400 RENAL DIALYSIS	0	1, 981, 576	1, 981, 57 <i>6</i>		1, 981, 576	1
76.00	03140 CARDIO CATH LAB	0	0	(E47 054	2, 131, 659	2, 131, 659	1
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	434, 420	82, 931	517, 351 (4, 482, 693 470, 210	
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		7 470, 210	470, 210	70.02
90.00	09000 CLI NI C	2, 039, 151	857, 964	2, 897, 115			90.00
91.00	09100 EMERGENCY	3, 347, 388	1, 890, 072	5, 237, 460	-225	5, 237, 235	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	2, 114, 068	4, 445, 631	6, 559, 699	-267, 163	6, 292, 536	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	1, 815, 524	1, 815, 524	0	1, 815, 524	96. 00
10E 0	SPECIAL PURPOSE COST CENTERS		ما		1 / 4 / 544	1 / 4/ 544	105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	0	(1, 646, 511 757, 277	
118.00		104, 046, 561	267, 888, 475	371, 935, 036			
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	313	313			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT		456, 341 0	456, 341 (456, 341 0	194. 00
	07950 CLOSED PSTCH UNIT		0	(2, 055, 843	2, 055, 843	
	207952 SENI OR CI RCLE	32, 851	41, 254	74, 105			194. 02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	183, 135	183, 135	194. 03
200.00	TOTAL (SUM OF LINES 118-199)	104, 079, 412	268, 386, 383	372, 465, 795	0	372, 465, 795	<u> </u> 200. 00

 Health Financial
 Systems
 LUTHERAN HOR

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 150017 | Peri od: From 07/01/2013 To 06/30/2014

Worksheet A
Date/Time Prepared: 12/1/2014 9:55 am

				am
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	6, 725, 632	17, 103, 083		1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	690, 762	21, 288, 622		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-7, 868	15, 618, 753		4. 00
5. 01 00540 ADMITTING	-32, 983, 137	7, 090, 262		5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	-2, 935, 557	45, 558, 891	Ę	5. 02
7.00 00700 OPERATION OF PLANT	-70, 120	11, 121, 693	l e e e e e e e e e e e e e e e e e e e	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	90, 501	1, 410, 377		8. 00
9. 00 00900 HOUSEKEEPI NG	0	2, 982, 559		9. 00
10. 00 01000 DI ETARY	0	2, 856, 081		0.00
11. 00 01100 CAFETERI A	-2, 134, 940	1, 450, 008		1.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-15, 700	1, 703, 263		3.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	6, 096, 137		4. 00 5. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-20, 136	7, 214, 551 4, 356, 343		6. 00
17. 00 01700 SOCIAL SERVICE	20, 130	2, 125, 305		7. 00
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRV	o	2, 120, 000	l e	1. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o	2, 785, 941		2. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	288, 384		3. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	0	181, 800	23	3. 01
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-2, 805, 240	19, 737, 580	l e e e e e e e e e e e e e e e e e e e	0.00
31.00 03100 INTENSIVE CARE UNIT	0	0		1.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	894, 996	l de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	1. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	-90, 080	2, 662, 397		1. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	0	12, 296, 057		1. 03
32. 00 03200 CORONARY CARE UNIT	0	4, 486, 796	l e	2.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	0	0 330, 037		0.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	-3, 680	330, 037	4.	3. 00
50. 00 05000 OPERATING ROOM	-450, 006	16, 904, 476	50	0. 00
51. 00 05100 RECOVERY ROOM	0	0		1. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	l o	1, 384, 727		2. 00
53. 00 05300 ANESTHESI OLOGY	-3, 822, 768	133, 812		3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-7, 016	5, 554, 940		4. 00
54. 01 05401 PET SCAN	0	196, 887	54	4. 01
56. 00 05600 RADI 0I SOTOPE	0	1, 564, 130	56	6. 00
57.00 05700 CT SCAN	0	837, 452		7. 00
58. 00 05800 MRI	0	0		8. 00
60. 00 06000 LABORATORY	-202, 500	14, 263, 171		0.00
65. 00 06500 RESPIRATORY THERAPY	0	4, 408, 187		5. 00
66. 00 06600 PHYSI CAL THERAPY	0	3, 321, 235		6.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	O O		7. 00 8. 00
69. 00 06900 ELECTROCARDI OLOGY		1, 079, 353	l e	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		1, 393, 284	l de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	0.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	17, 574, 253		1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	18, 785, 922	l e e e e e e e e e e e e e e e e e e e	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	24, 190, 648	73	3.00
74.00 07400 RENAL DIALYSIS	o	1, 981, 576	74	4. 00
76.00 03140 CARDIO CATH LAB	0	2, 131, 659	76	6. 00
76. 01 03050 ENDOSCOPY	0	4, 482, 693	l e	6. 01
76. 02 03051 CARDI AC REHAB	0	470, 210	76	6. 02
OUTPATIENT SERVICE COST CENTERS	000 41	0.400.45=		0.00
90. 00 09000 CLI NI C	-203, 136	3, 403, 455	l e	0.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	-174, 600	5, 062, 635	l e e e e e e e e e e e e e e e e e e e	1.00
OTHER REIMBURSABLE COST CENTERS			9,	2. 00
95. 00 09500 AMBULANCE SERVI CES	-3, 059, 970	3, 232, 566	OI	5. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	-1, 815, 524	3, 232, 300		6. 00
SPECIAL PURPOSE COST CENTERS	1,015,524	<u> </u>	^^	0. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	1, 646, 511	109	5. 00
106. 00 10600 HEART ACQUISITION		757, 277	l e e e e e e e e e e e e e e e e e e e	6. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-43, 295, 083	326, 400, 975		8. 00
NONREI MBURSABLE COST CENTERS		, , , , , , , ,		-
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	313	190	0. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	456, 341		2. 00
194.00 07950 CLOSED PSYCH UNIT	0	O		4. 00
194. 01 07951 MARKETI NG	0	2, 055, 843	l e	4. 01
194. 02 07952 SENI OR CI RCLE	0	74, 105		4. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	0	183, 135		4. 03
200.00 TOTAL (SUM OF LINES 118-199)	-43, 295, 083	329, 170, 712	200	0. 00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 07/01/2013 | To 06/30/2014 | Date/Time Prepared: 12/1/2014 9:55 am Provider CCN: 150017

	1				12/1/2014 9: 55 at	m
		Increases	0.1	0.11		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFITS	3.00	4.00	5.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 773, 222	1	1. 00
	TOTALS			13, 773, 222		
	B - OXYGEN					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	877, 894	1	1. 00
2. 00	PATI ENT	0. 00	0	0		2. 00
3. 00		0.00	o	Ö		3. 00
0.00	TOTALS — — — —	— — 	o			
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	5, 409, 093		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0	•	3. 00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	o	0		5. 00
7. 00		0.00	0	Ö		7. 00
8.00		0.00	O	0	8	3. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0	1	0.00
11. 00 12. 00		0. 00 0. 00	0	0	1	1. 00 2. 00
13. 00		0.00	0	0		2. 00 3. 00
14. 00		0.00	o	Ö		4. 00
15. 00		0.00	0	O		5. 00
16.00		0.00	0	0		5. 00
17. 00		0.00	0	0		7. 00
18.00		0.00	0	0		3. 00
19. 00 20. 00		0. 00 0. 00	0	0		9. 00 0. 00
21. 00		0.00	0	0		1. 00
22. 00		0.00	o	Ö		2. 00
23.00		0.00	0	0	23	3. 00
24. 00		0.00	0	0		4. 00
25. 00		0.00	0	0		5. 00
26. 00			0	5, 409, 093	26	5. 00
	D - OTHER CAPITAL COSTS		<u> </u>	3, 407, 073		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	314, 624	1	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	О	3, 757, 152	2	2. 00
3.00	CAP REL COSTS-MVBLE EQUIP		0	8 <u>5, 1</u> 73	3	3. 00
	TOTALS		0	4, 156, 949		
1. 00	E - MARKETING DEPARTMENT MARKETING	194. 01	307, 237	1, 746, 856		1. 00
1.00	TOTALS		307, 237	1, 746, 856	'	1.00
	F - CNO RECLASS	L	00.720.7	177107000		
1.00	NURSING ADMINISTRATION	1300	274, 624	0	1	1.00
	TOTALS		274, 624	0		
1 00	G - MEDICAL SUPPLIES	71 00	ما	1/ /0/ 250		
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	16, 696, 359	'	1. 00
2.00	IMPL. DEV. CHARGED TO	72.00	o	18, 785, 922	2	2. 00
	PATIENTS			,		
3.00	OPERATI NG ROOM	5000	0	77 <u>7, 5</u> 69	3	3. 00
	TOTALS		0	36, 259, 850		
1. 00	H - DRUGS / IVS DRUGS CHARGED TO PATIENTS	73. 00	0	24, 190, 648		1. 00
1.00	TOTALS			24, 190, 648	'	1.00
	I - A&G COSTS		<u> </u>	21/170/010		
1.00	OTHER ADMINISTRATIVE AND	5. 02	5, 332, 548	61, 025, 108		1.00
	GENERAL					
2.00	DI ETARY	10.00	36, 579	259, 413		2.00
3. 00 4. 00	CENTRAL SERVICES & SUPPLY MARKETING	14. 00 194. 01	400, 334 1, 249	1, 204, 654 501		3. 00 4. 00
5. 00	OTHER NONREIMBURSABLE COST	194.01	166, 515	16, 620		i. 00 5. 00
	CENTERS					
	TOTALS		5, 937, 225	62, 506, 296		
	J - RADI OLOGY COSTS					
1.00	RADI OLOGY-DI AGNOSTI C	54. 00 54. 01	924, 587 35, 040	99, 031		1.00
2. 00 3. 00	PET SCAN	54. 01 0. 00	35, U40	161, 847 0		2. 00 3. 00
5.00	TOTALS — — — —		959, 627		3	. 00
	· ·	ı	/ 52/	, 0, 0	ı	

						0 06/30/20	14 Date/IIme Prepar 12/1/2014 9:55 a	
		Increases					127 17 20 1 7 100 4	
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	K - DIETARY							
1.00	CAFETERI A	<u>11.</u> 00	<u>1, 544, 2</u> 59	<u>2, 040, 6</u> 89			1	1.00
	TOTALS		1, 544, 259	2, 040, 689				
	L - MISC DEPARTMENT							
1.00	OTHER ADMINISTRATIVE AND	5. 02	422, 330	35, 961			1	1.00
	GENERAL							
2.00	MEDICAL RECORDS & LIBRARY	16. 00	812, 151	615, 647				2.00
3.00	SOCI AL SERVI CE	17. 00	1, 956, 174	169, 131				3.00
4.00	OPERATING ROOM	50.00	2, 799, 774	730, 080				4.00
5.00	CARDI AC REHAB	76. 02	407, 559	62, 651				5.00
6.00	PHYSI CAL THERAPY	66. 00	744, 104	72, 250			· ·	6. 00
7.00	ELECTROENCEPHALOGRAPHY	70.00	939, 717	453, 567				7.00
8.00	CARDIO CATH LAB	76. 00	1, 188, 201	943, 458				8.00
9.00	ENDOSCOPY	<u>76.</u> 01	2, 890, 456	<u>1, 592, 2</u> 37				9.00
	TOTALS		12, 160, 466	4, 674, 982				
	M - ORGAN ACQUISITION							
1.00	KIDNEY ACQUISITION	105.00	0	1, 646, 511				1.00
2.00	HEART ACQUISITION	106. 00	0	757, 277				2.00
3.00	CLINIC	90.00	<u>463, 3</u> 42	<u>269, 1</u> 00			3	3.00
	TOTALS		463, 342	2, 672, 888				
	N - ICU COSTS		-1					
1. 00	PEDIATRIC INTENSIVE CARE UNIT	31. 01	761, 018	133, 978				1. 00
2.00	NEONATAL INTENSIVE CARE UNIT	31. 02	2, 141, 036	611, 441			2	2.00
3.00	CARDIO INTENSIVE CARE UNIT	31. 03	9, 915, 162	2, 380, 895				3.00
4.00	CORONARY CARE UNIT	32.00	3, 674, 214	812, 582				4.00
	TOTALS		16, 491, 430	3, 938, 896				
	O - LABOR AND DELIVERY							
1.00	NURSERY	43.00	267, 764	4, 476				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 111, 063	273, 664				2.00
	TOTALS		1, 378, 827	278, 140				
	P - INTERNS AND RESIDENTS							
1.00	I&R SERVICES-OTHER PRGM	22. 00	0	2, 785, 941			-	1.00
	COSTS APPRV							
	TOTALS		0	2, 785, 941				
500.00	Grand Total: Increases		39, 517, 037	165, 573, 222			500	0.00

Health Financial Systems RECLASSIFICATIONS

CLASSIFICATIONS Provider CCN: 150017

Peri od: Worksheet A-6 From 07/01/2013 To 06/30/2014 Date/Ti me Prepared:

In Lieu of Form CMS-2552-10

12/1/2014 9:55 am

Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - EMPLOYEE BENEFITS 5.02 OTHER ADMINISTRATIVE AND 13, 773, 222 0 1.00 GENERAL TOTALS o 13, 773, 222 B - OXYGEN 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 94, 027 0 1.00 ANESTHESI OLOGY 0 2.00 53.00 154, 580 0 2.00 3.00 RESPIRATORY THERAPY 65. 00 0 629, 287 0 3.00 TOTALS 877.894 C - RENTAL AND LEASE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 50, 620 10 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 2.00 4.00 4.892 0 2.00 3.00 ADMITTING 5.01 0 12, 319 0 3.00 116, 704 4.00 OTHER ADMINISTRATIVE AND 5.02 0 0 4.00 GENERAL 5.00 OPERATION OF PLANT 7.00 0 7,083 0 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 8.00 74 6.00 7.00 DI ETARY 10.00 0 35, 205 0 7.00 NURSING ADMINISTRATION o 0 8.00 13.00 3,690 8.00 0 CENTRAL SERVICES & SUPPLY 0 9 00 14 00 1 361 387 9 00 0 10.00 PHARMACY 15.00 0 415, 720 10.00 11.00 MEDICAL RECORDS & LIBRARY 16.00 o 31, 287 0 11.00 PARAMED ED PRGM-(SPECIFY) 0 12.00 23.00 0 12.00 76 ADULTS & PEDIATRICS 0 0 30 00 47, 298 13 00 13 00 14.00 INTENSIVE CARE UNIT 31.00 0 5, 875 0 14.00 PEDIATRIC INTENSIVE CARE 0 15.00 31.01 9, 101 15.00 UNI T 0 16,00 OPERATING ROOM 50.00 0 651, 551 16, 00 RADI OLOGY-DI AGNOSTI C 0 0 17.00 54.00 989, 534 17.00 18.00 RADI OI SOTOPE 56.00 0 570, 582 0 18.00 0 19.00 CT SCAN 57.00 7, 100 19.00 0 LABORATORY 60.00 0 226, 450 20.00 20.00 PHYSICAL THERAPY 0 21.00 66.00 0 295, 231 21.00 ELECTROCARDI OLOGY 69.00 273, 386 0 22.00 22.00 0 23.00 **ENDOSCOPY** 76.01 o 3, 574 23.00 CLINIC 90.00 0 24.00 22, 966 0 24.00 25.00 **EMERGENCY** 91.00 0 225 0 25.00 26.00 AMBULANCE SERVICES 95.00 0 267, 163 0 26.00 TOTALS 5, 409, 093 D - OTHER CAPITAL COSTS 1.00 OTHER ADMINISTRATIVE AND 5.02 0 4, 156, 949 12 1.00 GENERAL 2.00 0.00 2.00 0 0 13 3.00 0.00 0 12 3.00 TOTALS 4, 156, 949 - MARKETING DEPARTMENT ADMI TTI NG 5. 01 307, 237 1, 746, 856 1.00 1.00 0 TOTALS 307, 237 1, 746, 856 CNO RECLASS OTHER ADMINISTRATIVE AND 1.00 5.02 274, 624 0 1.00 GENERAL TOTALS 0 274, 624 G - MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY 1.00 14. 00 36, 185, 305 0 1.00 RADI OLOGY-DI AGNOSTI C 0 24, 797 2.00 54.00 0 2.00 ELECTROCARDI OLOGY 4<u>9, 7</u>48 3.00 69.00 0 3.00 **TOTALS** 0 36, 259, 850 H - DRUGS / IVS 1 00 PHARMACY 15. 00 0 24, 190, 648 0 1 00 24, 190, 648 TOTALS - A&G COSTS 1.00 ADMI TTI NG 5. 01 5, 937, 225 62, 506, 296 0 1.00 2 00 0 00 2 00 0 0 3.00 0.00 0 0 0 3.00 0 4.00 0.00 0 4.00 0.00 5 00 5 00 0 TOTALS 5, 937, 225 62, 506, 296 J - RADIOLOGY COSTS 1.00 RADI OLOGY-DI AGNOSTI C 54.00 35, 040 161, 847 0 1.00 2. 00 2 00 PET SCAN 54 01 550, 213 63, 166 0 3.00 MRI 58.00 374, 374 35, 865 0 3.00 TOTALS 959, 627 260, 878

Provider CCN: 150017

Peri od: From 07/01/2013 To 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Decreases

	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6, 00	7, 00	8.00	9. 00	10, 00		
	K - DIETARY						
1.00	DI ETARY	10.00	1, 544, 259	2, 040, 689	0		1.00
	TOTALS — — — — —		1, 544, 259	2, 040, 689			
	L - MISC DEPARTMENT						
1.00	RECOVERY ROOM	51.00	2, 799, 775	730, 080	0		1. 00
2.00	ELECTROCARDI OLOGY	69.00	2, 101, 057	1, 380, 319	O		2. 00
3.00	OCCUPATIONAL THERAPY	67.00	515, 108	46, 461	0		3. 00
4.00	SPEECH PATHOLOGY	68.00	228, 996	25, 789	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	3, 190, 654	820, 739	0		5. 00
6.00	OPERATING ROOM	50.00	2, 890, 456	1, 592, 237	0		6. 00
7.00	ENDOSCOPY	76. 01	434, 420	79, 357	0		7. 00
8.00		0.00	0	0	0		8. 00
9.00		0.00	0_	0	0		9. 00
	TOTALS		12, 160, 466	4, 674, 982			
	M - ORGAN ACQUISITION						
1.00	OPERATING ROOM	50.00	463, 342	2, 672, 888	0		1.00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0_	0	0		3. 00
	TOTALS		463, 342	2, 672, 888			
	N - ICU COSTS						
1.00	PEDIATRIC INTENSIVE CARE	31. 01	2, 141, 036	611, 441	0		1.00
	UNI T						
2.00	INTENSIVE CARE UNIT	31. 00	14, 350, 394	3, 327, 455	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0_	0	0		4. 00
	TOTALS		16, 491, 430	3, 938, 896			
	O - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30. 00	1, 378, 827	278, 140	0		1. 00
2.00		0.00	•	0	0		2. 00
	TOTALS		1, 378, 827	278, 140			_
	P - INTERNS AND RESIDENTS						1
1.00	I&R SERVICES-SALARY &	21. 00	0	2, 785, 941	0		1. 00
	FRI NGES APPRV				<u> </u>		
	TOTALS		0	2, 785, 941			
500.00	Grand Total: Decreases		39, 517, 037	165, 573, 222			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150017 Peri od: Worksheet A-7 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 12/1/2014 9:55 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 9, 573, 476 0 1.00 541, 192 10, 539, 929 0 541, 192 2.00 Land Improvements 0 2.00 152, 714, 654 0 3. 00 3.00 28, 724 28, 724 Buildings and Fixtures 0 0 4.00 Building Improvements 17, 075, 613 2, 794, 210 2, 794, 210 0 4.00 5.00 Fixed Equipment 45, 986, 381 110, 697 110, 697 0 5.00 124, 459, 167 0 6.00 Movable Equipment 9, 530, 358 9, 530, 358 0 6.00 0 7.00 21, 351 21, 351 HIT designated Assets 1, 482, 299 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 361, 831, 519 13, 026, 532 13, 026, 532 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 361, 831, 519 13, 026, 532 O 13, 026, 532 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 9, 573, 476 0 1.00 2.00 Land Improvements 11, 081, 121 0 2.00 152, 743, 378 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 19, 869, 823 4.00 5.00 Fi xed Equipment 46, 097, 078 0 5.00 Movable Equipment 133, 989, 525 0 6.00 6.00 7.00 HIT designated Assets 1, 503, 650 0 7.00

374, 858, 051

374, 858, 051

0

0

8.00

9.00

10.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

Heal th	Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150017	Peri od: From 07/01/2013 To 06/30/2014	Worksheet A-7 Part II Date/Time Pre 12/1/2014 9:5	pared: 5 am
			SU	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	6, 356, 295	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	15, 103, 594	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	21, 459, 889	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 356, 295		·	·	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15, 103, 594				2.00
	T 1 1 (C11 1 C)	1	04 450 000	I .			

0 0 0

6, 356, 295 15, 103, 594 21, 459, 889

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 07/01/2013 To 06/30/2014		
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 - col. 2)	instructions)		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	193, 267, 797	0	193, 267, 797	0. 515576	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	181, 590, 253	0	181, 590, 253			2.00
3.00	Total (sum of lines 1-2)	374, 858, 050		374, 858, 050			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT		1 0	,	4 215 072	F0 (20	1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	1	(1,010,770		1.00
2. 00 3. 00	Total (sum of lines 1-2)	0	ļ ~		14, 707, 198 19, 023, 171	5, 409, 093 5, 358, 473	2. 00 3. 00
3.00	Total (Sull of Titles 1-2)	0	·	I <u> </u>		5, 358, 473	3.00
			30	JIVIIVIART OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI					47.400	4 00
1.00	CAP REL COSTS-BLDG & FIXT	8, 765, 954				,,	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 087, 158			,		2.00
3.00	Total (sum of lines 1-2)	9, 853, 112	399, 797	3, 757, 152	2 0	38, 391, 705	3. 00

| Period: | Worksheet A-8 | From 07/01/2013 | To 06/30/2014 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 150017

Expense Classification on North-Seet A 1.00 1					To	06/30/2014	Date/Time Prep 12/1/2014 9:55	
Cost Center Description Resis/Cade (2) Amount Cent Center I nee P Next A.2 Set							12/1/2014 9.33	o alli
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00								
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00								
Triving trained Triving trained Copy Copy		Cost Center Description						
Investment Income = CAP RTL OCCAP RTL COSTS-MOWILL FIDURP 2.00 0 2.00	1. 00		1.00					1. 00
Investment income - other	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
Chapter 2) Chapter 3) Chapter 4) Col Irade, quantity, and time of scanners (chapter 8) Col Chapter 5) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 6) Col Chapter 7) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 8) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col Chapter 9) Col	3 00			0		0.00	0	3 00
0 0 0 0 0 0 0 0 0 0		(chapter 2)						
Color Colo		di scounts (chapter 8)		U			0	
Sentral of provider space by Sentral	5. 00			0		0. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Stations excluded) (chapter 21) 0 0.00 0.	6.00	Rental of provider space by	В	-1, 204, 307	CAP REL COSTS-BLDG & FIXT	1. 00	9	6. 00
21)	7.00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
Chapter 21 0		, , ,						
Parking of (chapter 21) A -8-2 -13,575,430 0 0.00 0	8. 00			0		0.00	О	8. 00
adjustment		Parking Lot (chapter 21)				0.00	_	
Chapter 23)	10. 00	1 3	A-8-2	-13, 575, 430			0	10. 00
12.00 Related organization 13.00 Laundry and I linen service 0 13.00 Laundry and I linen service 0 0 0 0 0 15.00 1	11. 00		В	-7, 016	RADI OLOGY-DI AGNOSTI C	54. 00	0	11. 00
13.00 Laundry and I linen service 0 0.00 0.13.00 15.00 1	12. 00	Related organization	A-8-1	7, 783, 577			0	12. 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 17.00 0 17.00 0 17.00 0 18.00 0	13. 00			0		0.00	0	13. 00
and others				-2, 134, 940	CAFETERI A			
Supplies to other than Datients 17.00 Sale of drugs to other than Datients 17.00 Sale of drugs to other than Datients 18.00 Sale of medical records and Datients Da		and others		0				
17. 00 Sale of drugs to other than patients 0 0 0 0 0 0 0 0 17. 00 18. 00 Sale of medical records and abstracts 0 0 0 0 0 0 0 0 18. 00 19. 00 Nursing school (tuition, fees, books, etc.) 0 0 0 0 0 0 0 0 20. 00 Vending machines B -31,850 OTHER ADMINISTRATIVE AND 5. 02 0 20. 00 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 10 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 22. 00 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 0 22. 01 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0 0 0 22. 02 0 0 0 0 0 0 0 0 0	16.00			U		0.00	0	16.00
patients	17. 00			0		0. 00	0	17. 00
abstracts	18 00	patients		0		0.00	0	18 00
books_ etc.) vending machines B		abstracts		0				
CENERAL Comparison of income from imposition of interest, finance or penal ty charges (chapter 21) Charges (chapter 21) Charges (chapter 21) Charges (chapter 21) Charges (chapter 21) Charges (chapter 21) Charges (chapter 21) Charges (chapter 24) Charges (chapter 24) Charges (chapter 24) Charges (chapter 25) Chapter 26 Chapter 26 Chapter 27 Chapter 27 Chapter 27 Chapter 28 Chapter 28 Chapter 28 Chapter 29 Chapter	19.00			U		0.00	0	19.00
Interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of I imitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of I imitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OSTS-MUBLE EQUIP A - 8-78, 287 CAP REL COSTS-MUBLE EQUIP 2.00 9 27.00 27.00 28.00 Non-physicians' assistant 0 0.00 0.29.00 0.00 0.90 0.00 0.90 0.00 0.90 0.00 0.00 0.90 0.00 0.	20. 00	Vending machines	В	-31, 850		5. 02	0	20. 00
Charges (chapter 21)	21. 00			0		0.00	o	21. 00
overpayments and borrowings to repay Medicare overpayments 23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26. 00 (costSS-BLDG & FIXT 27. 00 (costS-BLDG & FIXT 28. 00 No-physician Anoshnetist 29. 00 Physicians' assistant 30. 00 (costSS-BLDG & FIXT 30. 00 (costSSS-BLDG & FIXT 30. 00 (costSSS-BLDG & FIXT 30. 00 (costSSSS-BLDG & FIXT 30. 00 (costSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS		charges (chapter 21)						
23.00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) Adj ustment for physical threapy costs in excess of limitation (chapter 14) A-8-3 OPHYSICAL THERAPY 66.00 24.00	22. 00	overpayments and borrowings to		Ü		0.00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00 (Chapter 21) 27.00 Depreciation - CAP REL A 243, 605 CAP REL COSTS-MVBLE EQUIP 2.00 9 27.00 (COSTS-BLDG & FIXT 5.00) 28.00 Non-physician Anesthetist 0 0*** Cost Center Deleted *** 19.00 28.00 (Physicians' assistant 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00		A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	20.00	therapy costs in excess of		J		33. 33		20.00
1 imitation (chapter 14) Utilization review -	24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00 27.00 Depreciation - CAP REL A 243, 605 CAP REL COSTS-MVBLE EQUIP 2.00 9 27.00 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29.00 2								
Chapter 21) Depreciation - CAP REL A -878, 287 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00	25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest A 243, 605 CAP REL COSTS-MVBLE EQUIP 2. 00 9 27. 00 28. 00 0 **** Cost Center Deleted *** 19. 00 0 29. 00 0 0 29. 00 0 30. 00 4-8-3 0 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 99 31. 00 ADULTS & PEDIATRICS 30. 00 31. 00 31. 00 32. 00 32. 00	07.00	(chapter 21)		070 007	OAD DEL COCTO DI DO A FLYT	1 00		0/ 00
COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest O**** Cost Center Deleted **** 19. 00 28. 00 0 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 00 30. 99 A-8-3 OSPEECH PATHOLOGY 68. 00 31. 00 0 32. 00	26.00	COSTS-BLDG & FLXT	A	-878, 287	CAP REL COSIS-BLDG & FIXI	1.00	9	
28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 0 **** Cost Center Deleted **** 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	27. 00		A	243, 605	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 OCCUPATIONAL THERAPY 67.00 30.00		Non-physician Anesthetist		0	*** Cost Center Deleted ***		0	
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY		-	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 SPEECH PATHOLOGY 68. 00 31. 00 0 0 0 0 0 32. 00								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest								
	32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
	33. 00		A	-31, 502, 516	ADMI TTI NG	5. 01	0	33. 00

Heal th	Financial Systems	L	UTHERAN HOSPIT	AL OF INDIANA	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				eriod: rom 07/01/2013	Worksheet A-8	
					o 06/30/2014		pared:
						12/1/2014 9:5	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	TRALLIU NO DEVENUES	1.00	2.00	3.00	4. 00	5. 00	00.01
33. 01	TRAI NI NG REVENUES	В		NURSI NG ADMI NI STRATI ON	13. 00	0	00.01
33. 02	OTHER MISC REVENUES	В		OTHER ADMINISTRATIVE AND	5. 02	0	33. 02
33. 03	PATIENT PHONES WAGE COST	A		GENERAL OTHER ADMINISTRATIVE AND	5. 02	0	33. 03
33. 03	PATTENT PHONES WAGE COST	A		GENERAL	5.02	0	33.03
33. 04	PATIENT PHONES BENEFITS COST	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	n	33. 04
33. 05	PATIENT PHONES EXPENSE	A	· ·	ADMITTING	5. 01	o O	33. 05
33. 06	PATIENT PHONES DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 06
00.00	COST		3, 55 .	NEE	2.00	ĺ	00.00
33. 07	PATIENT TV - CABLE EXPENSE	A	-70, 120	OPERATION OF PLANT	7. 00	0	33. 07
33. 08	PATIENT TV DEPRECIATION	A	-10, 736	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 08
33. 09	MARKETI NG	A	-73, 979	OTHER ADMINISTRATIVE AND	5. 02	0	33. 09
				GENERAL			
33. 10	LEGAL FEES	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 10
				GENERAL		_	
33. 11	PHYSICIAN RECRUITING	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 11
33. 12	LOBBYING IN ASSOCIATION DUES	A		GENERAL OTHER ADMINISTRATIVE AND	5. 02	0	33. 12
33. 12	LUBBTING IN ASSOCIATION DUES	A		GENERAL	5.02	0	33. 12
33. 13	CHARI TABLE CONTRIBUTIONS	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 13
				GENERAL		_	
33. 14	PENALTI ES	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 14
				GENERAL			
33. 15	EQUITY IN AFFILIATES	A	110, 131	OTHER ADMINISTRATIVE AND	5. 02	0	33. 15

GENERAL

GENERAL

GENERAL

-43, 295, 083

-679, 467 OTHER ADMINISTRATIVE AND

-29, 251 OTHER ADMINISTRATIVE AND

GENERAL 2, 369, 841 OTHER ADMINI STRATI VE AND

5. 02

5.02

5.02

33. 16

33. 17

33. 18

50.00

TOTAL (sum of lines 1 thru 49)

INTERCOMPANY LEASE RECEIPTS

(Transfer to Worksheet A,

NON-COMEPETE AGREEMENT

EXPENSES

VALET SERVICE

33. 16

33. 17

33. 18

50.00

column 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: 150017 Peri od: Worksheet A-8-1 From 07/01/2013
To 06/30/2014 Date/Time Prepared: OFFICE COSTS

				To 06/30/2014	Date/Time Pre	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
1 00	HOME OFFICE COSTS:	CAD DEL COCTO DI DO A FLYT	DI DECT CADITAL INTEDECT	0 (20 242		1 00
1.00	l control of the cont	li de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	DIRECT CAPITAL INTEREST	8, 630, 242	0	1.00
2.00			PASI CAPITAL - BLDG	42, 272	0	2.00
3. 00 4. 00			PASI CAPITAL - EQUIP PASI OPERATING	21, 147	0	3.00
4. 00 4. 01		-	POOLED CAPITAL - BLDG	763, 134	0	4. 00 4. 01
			POOLED CAPITAL - BLDG	135, 712	0	4. 01
4. 02				1, 087, 158	U	
4. 03		OTHER ADMINISTRATIVE AND GEN		8, 262, 148	0 410 222	4. 03
4. 04	1			1, 047, 460		
4. 05	1		CIG ASSETS	737, 600		4. 05
4.06			HLS - CAPITAL	149, 474	0	4. 06
4. 07			HLS - OPERATING	1, 257, 941	1, 316, 914	4. 07
4. 08		OTHER ADMINISTRATIVE AND GEN		0	3, 257, 739	4. 08
4. 09		OTHER ADMINISTRATIVE AND GEN		0	5, 432	4. 09
4. 10		OTHER ADMINISTRATIVE AND GEN		0	105, 644	4. 10
4. 11	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	1, 199, 847	4. 11
4. 12	1	OTHER ADMINISTRATIVE AND GEN		0	251, 942	4. 12
4. 13	1	OTHER ADMINISTRATIVE AND GEN		0	313, 108	4. 13
4. 14	1	OTHER ADMINISTRATIVE AND GEN		0	20, 202	4. 14
4. 15	1	OTHER ADMINISTRATIVE AND GEN		0	180, 064	4. 15
4. 16	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	37, 867	4. 16
4. 17	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	88, 620	4. 17
4. 18	l control of the cont	OTHER ADMINISTRATIVE AND GEN	l .	0	49, 791	4. 18
4. 19			PASI COLLECTION FEES	0	1, 949, 012	4. 19
4. 21			EBOS FEES	0	10, 670	
4. 22			PASI LIEN UNIT COLLECTION FE	0	273, 155	4. 22
4. 23		OTHER ADMINISTRATIVE AND GEN	INTEREST EXPENSE	0 404 555	1, 487, 500	
5. 00	TOTALS (sum of lines 1-4).			22, 134, 288	14, 350, 711	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.			1		

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 COMMUNITY HEALT 100.00	6. 00
7.00	В	0. 00 PASI 100. 00	7. 00
8.00	E	0. 00 HOSPI TAL LAUNDR 100. 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

2.00 42, 272 9 3.00 21, 147 9 4.00 763, 134 0 4.01 135, 712 11 4.02 1, 087, 158 11 4.03 8, 262, 148 0 4.04 -1, 370, 763 0 4.05 -647, 381 9 4.06 149, 474 9 4.07 -58, 973 0 4.08 -3, 257, 739 0 4.09 -5, 432 0 4.10 -105, 644 0 4.11 -1, 199, 847 0 4.12 -251, 942 0 4.13 -313, 108 0 4.14 -20, 202 0 4.15 -180, 064 0 4.16 -37, 867 0	OTTTOL	00313				To 06/30/2014	Date/Time Pre 12/1/2014 9:5	epared: 55 am
COJ		Net	Wkst. A-7 Ref.					
Col. 5)* Col. 50 7.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED		Adjustments						
A. COSTS NOURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00		(col. 4 minus						
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00		col. 5)*						
HOME OFFICE COSTS:		6. 00	7. 00					
1. 00 8, 630, 242 11 2. 00 42, 272 9 3. 00 21, 147 9 4. 00 763, 134 0 4. 01 135, 712 11 4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0				MENTS REQUIRED AS A RESULT OF TRAN	SACTIONS WITH RELATED C	RGANIZATIONS OR (CLAIMED	
2.00 42, 272 9 3.00 21, 147 9 4.00 763, 134 0 4.01 135, 712 11 4.02 1, 087, 158 11 4.03 8, 262, 148 0 4.04 -1, 370, 763 0 4.05 -647, 381 9 4.06 149, 474 9 4.07 -58, 973 0 4.08 -3, 257, 739 0 4.09 -5, 432 0 4.10 -105, 644 0 4.11 -1, 199, 847 0 4.12 -251, 942 0 4.13 -313, 108 0 4.14 -20, 202 0 4.15 -180, 064 0 4.16 -37, 867 0								
3.00 4.00 763,134 0 4.01 135,712 11 4.02 1,087,158 11 4.03 8,262,148 0 4.04 -1,370,763 0 4.05 -647,381 9 4.06 149,474 9 4.07 -58,973 0 4.08 -3,257,739 0 4.09 -5,432 0 4.10 -105,644 0 4.11 -1,199,847 0 4.12 -251,942 0 4.13 -313,108 0 4.14 14.14 -20,202 0 4.15 -180,064 0 4.16 -37,867	1.00							1. 00
4. 00 763, 134 0 4. 01 135, 712 11 4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	2.00							2. 00
4. 01 135, 712 11 4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	3.00							3. 00
4. 02 1, 087, 158 11 4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0				I .				4. 00
4. 03 8, 262, 148 0 4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0				I .				4. 01
4. 04 -1, 370, 763 0 4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 02
4. 05 -647, 381 9 4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 03
4. 06 149, 474 9 4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 04
4. 07 -58, 973 0 4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	4.05							4. 05
4. 08 -3, 257, 739 0 4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 06
4. 09 -5, 432 0 4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	4.07							4. 07
4. 10 -105, 644 0 4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0	4.08	-3, 257, 739	0					4. 08
4. 11 -1, 199, 847 0 4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0 4. 1 -37, 867 0	4.09							4. 09
4. 12 -251, 942 0 4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0 4. 1 -4. 1 4. 1 -37, 867 0	4. 10	-105, 644	0					4. 10
4. 13 -313, 108 0 4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0 4. 1 4. 1	4. 11	-1, 199, 847	0					4. 11
4. 14 -20, 202 0 4. 15 -180, 064 0 4. 16 -37, 867 0								4. 12
4. 15								4. 13
4.16 -37,867 0 4.1								4. 14
								4. 15
4 17 _88 620 0 4 1	4. 16							4. 16
	4. 17	-88, 620						4. 17
	4. 18	-49, 791	0					4. 18
								4. 19
								4. 21
		-273, 155	0					4. 22
								4. 23
5.00 7,783,577 5.0	5.00	7, 783, 577						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.

 	cordinate i dilaret 27 the dimedite difference of cordinate be friended the cordinate for this parti-	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	FED 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.

CIMDUI	Schicit under title Aviii.	
6.00	HOSP COMPANY	6. 00
7.00	COLLECTI ONS	7. 00
8.00	LAUNDRY	8. 00
9.00		9. 00
10.00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
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- 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 In Lieu of Form CMS-2552-10 Peri od: Worksheet A-8-2 From 07/01/2013 Date/Time Prepared: 12/1/2014 P. 55 am Provider CCN: 150017

					1	o 06/30/2014	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	JJ alli
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		OTHER ADMINISTRATIVE AND	934, 300	922, 503	11, 797	171, 400	79	1. 00
2. 00		GENERAL MEDICAL RECORDS & LIBRARY	44, 692	0	44, 692	171, 400	298	2. 00
3.00		ADULTS & PEDIATRICS	2, 805, 240		·	0		3. 00
4. 00		NEONATAL INTENSIVE CARE UNIT	90, 080	90, 080		0		4. 00
5.00	1	NURSERY	3, 680			0	0	5. 00
6.00	50.00	OPERATING ROOM	450, 006	450, 006	0	0	0	6. 00
7.00	53. 00	ANESTHESI OLOGY	3, 822, 768	3, 822, 768	0	0	0	7. 00
8.00	60.00	LABORATORY	202, 500	202, 500	0	0	0	8. 00
9.00	90. 00	CLI NI C	203, 136	203, 136	0	0	0	9.00
10.00	91. 00	EMERGENCY	174, 600	174, 600	0	0	0	10.00
11. 00		AMBULANCE SERVICES	3, 059, 970	3, 059, 970	0	0	0	11.00
12.00	96. 00	DURABLE MEDICAL EQUIP-RENTED	1, 815, 524	1, 815, 524	0	0	0	12.00
200.00			13, 606, 496				377	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Li mi t		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	9.00	Educati on	12 13. 00	14.00	
1 00	1.00	2.00 OTHER ADMINISTRATIVE AND	8.00		12.00		14.00	1. 00
1. 00		GENERAL	6, 510	320	0	0	J	1.00
2.00		MEDICAL RECORDS & LIBRARY	24, 556	1, 228	0	0	0	2. 00
3.00		ADULTS & PEDIATRICS	0	1		0	0	3. 00
4.00	31. 02	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	4. 00
5.00	43. 00	NURSERY	0	0	0	0	0	5.00
6.00	50. 00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	7. 00
8.00		LABORATORY	0	0	0	0	0	8.00
9. 00		CLI NI C	0	0	0	0	0	9. 00
10. 00		EMERGENCY	0	0	0	0	0	10. 00
11. 00		AMBULANCE SERVICES	0	0	0	0		11. 00
12. 00	96. 00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	_	12. 00
200.00			31, 066			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16, 00	17. 00	18. 00		
1.00		OTHER ADMINISTRATIVE AND	0			927, 790		1. 00
		GENERAL	_	,,,,,,	, ===	,		
2.00	16. 00	MEDICAL RECORDS & LIBRARY	0	24, 556	20, 136	20, 136		2.00
3.00	30. 00	ADULTS & PEDIATRICS	0	0	0	2, 805, 240		3.00
4.00	31. 02	NEONATAL INTENSIVE CARE UNIT	0	0	0	90, 080		4. 00
5.00		NURSERY	0	0	0	3, 680		5. 00
6.00		OPERATING ROOM	0	0	0	450, 006		6. 00
7.00		ANESTHESI OLOGY	0	0	0	3, 822, 768		7. 00
8.00		LABORATORY	0	0	0	202, 500		8. 00
9.00		CLINIC	0	0	0	203, 136		9. 00
10.00		EMERGENCY	0	0	0	174, 600		10.00
11. 00		AMBULANCE SERVICES	0	0	0	3, 059, 970		11. 00
12.00	96. 00	DURABLE MEDICAL EQUIP-RENTED	0		0	1, 815, 524		12.00
200. 00	1		0	31, 066	25, 423	13, 575, 430	I	200. 00

	Financial Systems	LUTHERAN HOSPIT		001 450047 5		u of Form CMS-	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150017 F	eriod: rom 07/01/2013	Worksheet B Part I	
					o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
			CAPI TAL REI	LATED COSTS		12/1/2014 7.3	Jam
			DI DO A FLAT	I 18/81 5 5011 8		45.41.771.110	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	ADMITTING	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1.00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	17, 103, 083	17, 103, 083	8			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	21, 288, 622		21, 288, 622	1		2. 00
4. 00 5. 01	OO400 EMPLOYEE BENEFITS DEPARTMENT OO540 ADMITTING	15, 618, 753 7, 090, 262	447, 218 368, 630			8, 112, 355	4. 00 5. 01
5. 01	00560 OTHER ADMINISTRATIVE AND GENERAL	45, 558, 891	741, 439			0, 112, 333	5. 02
7. 00	00700 OPERATION OF PLANT	11, 121, 693	3, 697, 478			0	1
8.00	00800 LAUNDRY & LINEN SERVICE	1, 410, 377	21, 444			0	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 982, 559 2, 856, 081	71, 997 692, 892			0	7.00
11. 00	01100 CAFETERI A	1, 450, 008	072, 072			0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 703, 263	163, 838		237, 518	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 096, 137	299, 212			0	14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	7, 214, 551 4, 356, 343	171, 289 182, 942			0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	2, 125, 305	123, 243			0	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0) c	o	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	2, 785, 941	0 000	0	0	0	22. 00
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PHARMACY RESIDENCY PROGRAM	288, 384 181, 800	69, 060 0	403	l	0	
20.01	INPATIENT ROUTINE SERVICE COST CENTERS	101,000		1	21,070		20.01
30.00	03000 ADULTS & PEDI ATRI CS	19, 737, 580	2, 532, 461			399, 833	
31.00	03100 I NTENSI VE CARE UNI T	004.004	104 (17	0	1	0 700	
31. 01 31. 02	02080 PEDIATRIC INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	894, 996 2, 662, 397	104, 617 264, 300			9, 790 57, 912	•
31. 03	03101 CARDIO INTENSIVE CARE UNIT	12, 296, 057	944, 392			263, 438	•
32. 00	03200 CORONARY CARE UNIT	4, 486, 796	367, 747	83, 510	571, 891	102, 095	•
40.00	04000 SUBPROVI DER - I PF	0	12.020	0	-	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	330, 037	13, 038	1, 521	41, 677	6, 891	43. 00
50.00	05000 OPERATI NG ROOM	16, 904, 476	2, 468, 392	4, 512, 882	1, 229, 305	1, 475, 377	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	1, 384, 727 133, 812	1, 910		172, 937 18, 808	28, 595 172, 273	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 554, 940	378, 421	1		370, 372	
54. 01	05401 PET SCAN	196, 887	41, 192	1		23, 447	54. 01
56.00	05600 RADI OI SOTOPE	1, 564, 130		1		118, 229	
57. 00 58. 00	05700	837, 452	47, 449 0	49, 366	100, 029	301, 516 0	1
	06000 LABORATORY	14, 263, 171	406, 933	731, 447	695, 828	669, 659	
	06500 RESPI RATORY THERAPY	4, 408, 187	137, 189	236, 823	577, 456	216, 945	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 321, 235	290, 377	220, 749	455, 642	72, 472	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	1, 079, 353	323, 521	326, 061	160, 525	249, 224	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 393, 284	35, 915	501, 459	146, 267	35, 393	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 574, 253 18, 785, 922	0		0	400, 802 828, 977	
73. 00	07300 DRUGS CHARGED TO PATIENTS	24, 190, 648	0		0	1, 323, 555	
74. 00	07400 RENAL DIALYSIS	1, 981, 576	189, 604	3, 954	. 0	37, 193	•
76. 00	03140 CARDIO CATH LAB	2, 131, 659	154, 549			315, 032	
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	4, 482, 693	166, 107 0			200, 363	1
76. 02	OUTPATIENT SERVICE COST CENTERS	470, 210	0	32, 762	63, 437	14, 082	76. 02
90.00	09000 CLI NI C	3, 403, 455	487, 909	12, 668	389, 513	12, 975	90.00
91. 00	09100 EMERGENCY	5, 062, 635	481, 724	356, 459	521, 021	359, 133	1
92. 00	O9200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	3, 232, 566	11, 032	293, 088	329, 055	27, 933	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	1
105 5	SPECIAL PURPOSE COST CENTERS	4 (1) = 2 -1	F0 0:=				105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	1, 646, 511 757, 277	50, 267 0				105. 00 106. 00
118.00		326, 400, 975	_				
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	313	57, 407				190.00
194.00 194.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT	456, 341 0	0	3, 024			192. 00 194. 00
	07951 MARKETI NG	2, 055, 843	o	1	-		194. 01
	•	· · · · · · · · · · · · · · · · · · ·		<u> </u>	·		-

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014	Part Date/Time Pre	narod.
				10 00/30/2014	12/1/2014 9:5	
		CAPI TAL REI	ATED COSTS			
		DI DO 4 FINT			45111 771 110	
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	
	for Cost Allocation			BENEFITS DEPARTMENT		
	(from Wkst A			DEPARTMENT		
	col. 7)					
	0	1. 00	2.00	4. 00	5. 01	
194. 02 07952 SENI OR CI RCLE	74, 105	0		0 5, 113	0	194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	183, 135	0	88, 08	25, 918	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0 0		201. 00
202.00 TOTAL (sum lines 118-201)	329, 170, 712	17, 103, 083	21, 288, 62	2 16, 087, 843	8, 112, 355	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150017 Peri

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2013 | Part | | To 06/30/2014 | Date/Time Prepared: |

			1	0 06/30/2014	Date/lime Pre 12/1/2014 9:5	
Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE		
	5A. 01	5. 02	7.00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS		,	,			
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	52, 492, 986	52, 492, 986				5. 01 5. 02
7. 00 00700 OPERATION OF PLANT	15, 442, 094					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 431, 821	271, 654	33, 251			8.00
9. 00 00900 HOUSEKEEPI NG	3, 353, 192				4, 101, 018	9. 00
10. 00 01000 DI ETARY	3, 806, 659				241, 735	10.00
11. 00 01100 CAFETERI A	1, 690, 372			0	0	11. 00
13. 00 01300 NURSING ADMINISTRATION	2, 111, 757	400, 655	254, 046	0	57, 160	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	7, 038, 843				104, 388	1
15. 00 01500 PHARMACY	8, 370, 112				59, 759	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	5, 008, 059				63, 824	16.00
17. 00 01700 SOCIAL SERVICE	2, 553, 026	484, 375	191, 099	0	42, 997	17. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	2 705 041	528, 565	0	0	0	21.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	2, 785, 941 385, 569			4, 594	24, 093	23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	206, 196		107,004	4, 374	24, 073	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	200, 170	07, 121				20.01
30. 00 03000 ADULTS & PEDI ATRI CS	28, 202, 908	5, 350, 854	3, 926, 802	623, 113	883, 520	30.00
31. 00 03100 INTENSIVE CARE UNIT	0		0		0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 151, 359	218, 443	162, 217	11, 816	36, 498	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	3, 438, 965	652, 461	409, 820	13, 525	92, 208	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	15, 268, 405	2, 896, 813	1, 464, 364	213, 665	329, 478	31. 03
32. 00 03200 CORONARY CARE UNIT	5, 612, 039	1, 064, 750	570, 224	71, 259		32. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40. 00
43. 00 04300 NURSERY	393, 164	74, 593	20, 217	0	4, 549	43. 00
ANCILLARY SERVICE COST CENTERS	24 500 422	E 044 004	2 027 450	242.270	0/1 1/7	
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	26, 590, 432 0		3, 827, 459 0		861, 167 0	50. 00 51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	1, 586, 259	1	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	326, 803		l ~	0	666	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 553, 313				132, 023	54.00
54. 01 05401 PET SCAN	824, 551				14, 371	1
56. 00 05600 RADI OI SOTOPE	1, 843, 684				33, 474	1
57. 00 05700 CT SCAN	1, 335, 812					57.00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	16, 767, 038	3, 181, 143	630, 986	2, 326	141, 970	60.00
65. 00 06500 RESPI RATORY THERAPY	5, 576, 600				47, 862	65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 360, 475	827, 295	450, 254	11	101, 306	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 138, 684					
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 112, 318				12, 530	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 975, 055 19, 614, 899			0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	25, 514, 203			0	0	73.00
74. 00 07400 RENAL DIALYSIS	2, 212, 327			0	66, 149	74.00
76. 00 03140 CARDI O CATH LAB	4, 210, 236		239, 642		53, 919	76.00
76. 01 03050 ENDOSCOPY	5, 817, 813					ı
76. 02 03051 CARDI AC REHAB	580, 491		0	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	4, 306, 520	817, 059	756, 546	26, 643	170, 221	90.00
91. 00 09100 EMERGENCY	6, 780, 972	1, 286, 527	746, 956	202, 835	168, 063	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
OTHER REIMBURSABLE COST CENTERS	0.000.474	700 704	47.407		0.040	05.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	3, 893, 674 0		17, 107 0		3, 849	95. 00
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	96. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	1, 713, 914	325, 174	77, 943	0	17 537	105. 00
106. 00 10600 HEART ACQUISITION	786, 151			0		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	326, 165, 691	51, 922, 856		1, 736, 726		
NONREI MBURSABLE COST CENTERS	0207.007071	0177227000	10/202/01/	1,700,720	1,000,770	1 101 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	62, 324	11, 824	89, 014	0	20, 028	190. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	459, 365			0		192. 00
194.00 07950 CLOSED PSYCH UNIT	0	0	0	0	0	194. 00
194. 01 07951 MARKETI NG	2, 106, 979	399, 749	0	0		194. 01
194. 02 07952 SENI OR CI RCLE	79, 218		0	0		194. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	297, 135		0	0	0	194. 03
200.00 Cross Foot Adjustments	0	•				200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 07/01/2013 Fo 06/30/2014		
Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5A. 01	5. 02	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118-201)	329, 170, 712	52, 492, 986	18, 371, 86°	1, 736, 726	4, 101, 018	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2013 | Part |
| To 06/30/2014 | Date/Time Prepared: | 12/1/2014 9:55 am | Provider CCN: 150017

				06/30/2014	12/1/2014 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11 00	10.00	SUPPLY	45.00	
CENEDAL CEDVICE COCT CENTEDS	10. 00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP			•			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
5. 01 00540 ADMI TTI NG						5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
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	5, 845, 006					10.00
11. 00 01100 CAFETERI A	0	2, 011, 080				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	o	23, 795	1			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	Ö	63, 666		9, 006, 304		14. 00
15. 00 01500 PHARMACY	o	91, 927	1	220, 601	10, 596, 025	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	ol	81, 268	1	7, 509	0	16.00
17. 00 01700 SOCIAL SERVICE	o	37, 757	1	1, 315	0	17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	o	0.,	o	0	0	21. 00
22. 00 02200 Lar Services-Other Prom Costs Apprv	o	0	o o	5	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	o	3, 428	o	342	0	23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	o	3, 453	1	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	-,			-1		
30. 00 03000 ADULTS & PEDIATRICS	2, 431, 753	408, 188	804, 659	335, 523	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0	0	0	0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	52, 129	14, 349	37, 704	11, 773	0	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	335, 831	43, 073		54, 636	0	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	1, 155, 855	217, 507	491, 237	204, 425	0	31. 03
32.00 03200 CORONARY CARE UNIT	227, 484	74, 375		81, 599	0	32.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	114, 670	5, 417	13, 266	9, 018	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	186, 406	391, 293	1, 064, 934	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	22, 506	55, 047	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	5, 780	0	337	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	104, 049	223, 085	73, 732	0	54.00
54. 01 05401 PET SCAN	0	863	1, 736	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	7, 056	17, 536	4, 835	0	56. 00
57. 00 05700 CT SCAN	0	16, 101	31, 840	11, 790	0	57. 00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0	114, 008	0	607, 235	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	87, 523	0	64, 638	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	54, 058	0	18, 230	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	26, 835	1	4, 573	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	21, 643	1	63, 490	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2, 638, 225	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 968, 405	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	10, 596, 025	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	7, 486	0	74. 00
76. 00 03140 CARDI O CATH LAB	0	23, 620		118, 645	0	76. 00
76. 01 03050 ENDOSCOPY	0	71, 547		175, 159	0	76. 01
76. 02 03051 CARDI AC REHAB	0	11, 973	0	2, 511	0	76. 02
OUTPATIENT SERVICE COST CENTERS	اه	15 440	100.004	70.004		
90. 00 09000 CLI NI C	0	45, 113		70, 921	0	90.00
91. 00 09100 EMERGENCY	0	81, 193	165, 843	166, 695	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	ام	44 275		1/ 01	0	05 00
95. 00 09500 AMBULANCE SERVICES	0	44, 375		16, 815	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS	ما	F 070	l ol	ما	0	105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	5, 279	1	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	4 217 722	3, 015	1	0 005 400		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	4, 317, 722	2, 001, 146	2, 847, 413	9, 005, 402	10, 596, 025	1118.00
NONREI MBURSABLE COST CENTERS	^I	^		T _x ,	^	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 212 505	0		46		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 312, 585	0	0	0		192.00
194. 00 07950 CLOSED PSYCH UNIT	O O	((10		0		194. 00
194. 01 07951 MARKETI NG	O O	6, 618		768		194. 01
194. 02 07952 SENI OR CI RCLE	214 400	726		88		194. 02
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	214, 699	2, 590	0	O	0	194. 03
200.00 Cross Foot Adjustments		^			^	200.00
201.00 Negative Cost Centers	0	0	0	· υ	0	201. 00

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150017 I	Peri od:	Worksheet B	
				From 07/01/2013		
				To 06/30/2014		
					12/1/2014 9:5	<u>5 am </u>
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OI	N SERVICES &		
				SUPPLY		
	10.00	11. 00	13.00	14.00	15. 00	
202.00 TOTAL (sum lines 118-201)	5, 845, 006	2, 011, 080	2, 847, 41	9, 006, 304	10, 596, 025	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150017 Peri

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2013 | Part | | To 06/30/2014 | Date/Time Prepared: | 12/1/2014 9:55 am

				LUTERNO	DEGL DENTO	12/1/2014 9:5	5 am
				INTERNS &	RESIDENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES_OTHER	PARAMED ED	
	oost center bescription	RECORDS &	SOUTHE SERVICE	Y & FRINGES	PRGM COSTS	PRGM	
		LI BRARY		APPRV	APPRV		
		16.00	17. 00	21.00	22. 00	23. 00	
<u> </u>	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMI TTI NG						5. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
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	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 394, 487					16. 00
17. 00	01700 SOCI AL SERVI CE	0	3, 310, 569	7			17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	3, 314, 511		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	598, 262	23. 00
23. 01	02301 PHARMACY RESIDENCY PROGRAM	0	0	0	0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00	03000 ADULTS & PEDIATRICS	315, 133	163, 141	0	380, 104	435, 119	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	7, 716	3, 995		15, 204	2, 250	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	45, 644	1		288, 879	10, 126	1
31. 03	03101 CARDIO INTENSIVE CARE UNIT	207, 631	107, 489		0	42, 530	1
32.00	03200 CORONARY CARE UNIT	80, 467	41, 657		0	21, 377	32. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
43. 00	04300 NURSERY	5, 432	2, 812	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS	T					
50. 00	05000 OPERATING ROOM	1, 163, 481	602, 525		897, 047	15, 977	50.00
51. 00	05100 RECOVERY ROOM	0	0	1	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	22, 538	l		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	135, 779	l		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	291, 913	l		0	0	54.00
54. 01	05401 PET SCAN	18, 480	l		0	0	54. 01
56. 00	05600 RADI OI SOTOPE	93, 183	l		0	0	56. 00
57. 00	05700 CT SCAN	237, 643	123, 026	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	527, 799			0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	170, 987	88, 518		30, 408	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	57, 120	29, 570	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	196, 428	1	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	27, 895	14, 441	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	315, 897			0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	653, 367			0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 043, 174	l		0	0	73. 00
74.00	· ·	29, 314	l		0	0	74.00
76. 00	03140 CARDI O CATH LAB	248, 296			121, 633	4, 501	76. 00
76. 01	03050 ENDOSCOPY	157, 918	l		0	0	76. 01
76. 02	03051 CARDI AC REHAB	11, 099	5, 746	0	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS	10.00/			4 400 404	00.050	
90.00	09000 CLI NI C	10, 226			1, 429, 194	29, 253	90.00
91.00	09100 EMERGENCY	283, 055	146, 535	0	O	26, 328	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS				ام		
95.00		22, 016			0	0	95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96. 00
105 0	SPECIAL PURPOSE COST CENTERS	4.633	0.500		51	~	105 00
	10500 KIDNEY ACQUISITION	4, 833			0		105. 00
	10600 HEART ACQUISITION	10, 023	l		0 1/2 4/2	10, 801	
118. 00		6, 394, 487	3, 310, 569	0	3, 162, 469	598, 262	JI 18. 00
100 0	NONREI MBURSABLE COST CENTERS	_	_		ما	^	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES				152, 042		192.00
	07950 CLOSED PSYCH UNIT	0	0	<u>0</u>	0		194. 00
	07951 MARKETI NG	0	0	<u>0</u>	0		194. 01
	207952 SENIOR CIRCLE	0	1	J O	0		194. 02
194.03	3 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	O	0	194. 03

Heal th Finar	ncial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS	Provi der CCN: 150017			Peri od:	Worksheet B	
					From 07/01/2013	Part I	
				[To 06/30/2014		
						12/1/2014 9:5	<u>5 am</u>
				I NTERNS 8	RESIDENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALA	R SERVI CES-OTHER	PARAMED ED	
	·	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
		LI BRARY		APPRV	APPRV		
		16.00	17.00	21.00	22.00	23. 00	
200.00	Cross Foot Adjustments				0 0	0	200. 00
201. 00	Negative Cost Centers		0		0 0	0	201. 00
202.00	TOTAL (sum lines 118-201)	6, 394, 487	3, 310, 569		0 3, 314, 511	598, 262	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems LUTHERAN HOSPITAL OF INDIANA COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150017 Peri od: Worksheet B From 07/01/2013 Part I 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Intern & Cost Center Description **PHARMACY** Subtotal Total RESI DENCY Residents Cost **PROGRAM** & Post Stepdown Adjustments 23.01 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMITTING 5.01 5. 01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 02301 PHARMACY RESIDENCY PROGRAM 248, 770 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 44, 260, 817 -380, 104 43, 880, 713 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 0 0 1, 725, 453 -15, 204 1, 710, 249 31.01 02060 NEONATAL INTENSIVE CARE UNIT 5, 514, 873 -288, 879 5, 225, 994 31 02 31 02 31. 03 03101 CARDIO INTENSIVE CARE UNIT 22, 599, 399 0 22, 599, 399 31.03 03200 CORONARY CARE UNIT 0 8, 155, 565 0 8, 155, 565 32.00 32.00 0 04000 SUBPROVI DER - I PF 0 40.00 40.00 04300 NURSERY 0 643, 138 643, 138 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 40, 987, 895 -897, 047 40, 090, 848 50 00 51.00 05100 RECOVERY ROOM 00000000000000000 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 1, 998, 973 0 1, 998, 973 52 00 52 00 53.00 05300 ANESTHESI OLOGY 604, 621 604, 621 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 11, 826, 071 0 11, 826, 071 54.00 05401 PET SCAN 1, 089, 879 0 1, 089, 879 54.01 54.01 0 05600 RADI OI SOTOPE 56.00 2, 546, 579 2, 546, 579 56.00 57.00 05700 CT SCAN 2, 126, 328 0 2, 126, 328 57.00 58.00 05800 MRI 0 58.00 22, 245, 742 06000 LABORATORY n 22, 245, 742 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 7, 343, 930 -30, 408 7, 313, 522 65.00 66.00 06600 PHYSI CAL THERAPY 5, 898, 319 5, 898, 319 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 495, 048 3, 495, 048 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 708, 768 0 2, 708, 768 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 24, 503, 049 0 24, 503, 049 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 27, 296, 369 0 27, 296, 369 72.00 07300 DRUGS CHARGED TO PATIENTS 42, 782, 921 0 42, 782, 921 73.00 248, 770 73.00 07400 RENAL DIALYSIS 3.044.186 3. 044. 186 74.00 0 74.00 0 03140 CARDIO CATH LAB 76.00 0 6, 043, 353 -121, 633 5, 921, 720 76.00 76.01 03050 ENDOSCOPY 0 7, 927, 673 7, 927, 673 76.01 03051 CARDI AC REHAB 76.02 0 721, 954 721, 954 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 7, 790, 974 -1, 429, 194 6, 361, 780 90.00 10, 055, 002 09100 EMERGENCY 0 10, 055, 002 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 4, 747, 964 0 4, 747, 964 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105 00 2, 147, 182 2, 147, 182 0 0 106.00 10600 HEART ACQUISITION 0 964, 332 0 964, 332 106.00 SUBTOTALS (SUM OF LINES 1-117) 248, 770 -3, 162, 469 320, 633, 888 118.00 323, 796, 357 118.00 NONREI MBURSABLE COST CENTERS

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014	Part I	narad.
					Date/Time Pre 12/1/2014 9:5	pareu: <u>5 am</u>
Cost Center Description	PHARMACY	Subtotal	Intern &	Total		
	RESI DENCY		Residents Cos	t		
	PROGRAM		& Post			
			Stepdown			
			Adjustments			
	23. 01	24. 00	25.00	26.00		
200.00 Cross Foot Adjustments	0	0		0 0		200. 00
201.00 Negative Cost Centers	0	0		0 0		201. 00
202.00 TOTAL (sum lines 118-201)	248, 770	329, 170, 712	-3, 314, 51	1 325, 856, 201		202. 00

| Peri od: | Worksheet B | From 07/01/2013 | Part | I | To 06/30/2014 | Date/Time Prepared: Provider CCN: 150017

Cost Center Description					То	06/30/2014	Date/Time Pre 12/1/2014 9:5	
Accidence Received Reliable Control				CAPI TAL REI	LATED COSTS		1	<u> </u>
BRIENTS PRINTENT		Coot Contar Decemintion	Di mantin	DIDC 0 FLVT	M/DLE FOULD	Cubtatal	EMDL OVEE	
CEREBAL SERVICE DOST CENTERS D. 2.00 2.00 2.00 4.00 0.00		cost center bescription		BLDG & FIXI	MARTE EGOLA	Subtotai		
DEBERAL SERVICE COST CENTERS			Capi tal					
Company Comp				1.00	0.00	0.4	4.00	
1.00 001000 CAP MEL COSIS*-BLEG & FINT		GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
4.00 0.000 D.000	1.00							1.00
5.01 DOS-40] ANNI TILIKS 13 361, 630 25, 261 393, 991 18, 315 5 0 7 7 7 7 7 7 7 7 7								ı
5.02 0.0560 OTHER ADMINISTRATIVE AND GENERAL 0 741, 439 5, 339, 654 6, 061, 073 24, 869 5, 00 0.0560 24, 869 5, 00 0.0560 24, 869 5, 00 0.0560 27, 444 26, 70 0.0500			0	l				1
0.0000 DOTOD DEPENTION OF PELANT 0 3,697.778 358,750 4,066.228 7,702 7,00			0	l				l
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000		00700 OPERATION OF PLANT	0	l			· ·	•
10.00 01000 DETARY		1 1	0	l				1
11.00 01100 CAFETERIA 0			0					•
13.00 01300 NURSH NO ADMINI STRATION 0 10.3 838 7.1 83 170.795 6.925 13.00		1 1	0	1				•
15.00 01500 PARBIACY 0 171, 280 106, 992 228, 281 25, 577 15.00 170, 00 17			0	1	_	-		
16. 00 01-600 MEDI CAL RECORDS & LIBRARY 0 182, 942 47,259 233, 201 12, 289 16. 00 21. 00 21. 00 20. 00 20. 01 23, 243 8, 877 17. 00 21. 00 20. 00			0	l				1
17.00 01700 SOCIAL SERVICE 0 123, 243 0 123, 244 8, 877 17.00 22.00 0200 18R SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 0 0 22.00 23.00 023			0	l				ł
21.00 02100 IAS SERVICES-SALARY S, FRINGES APPRV 0 0 0 0 0 0 0 22 0.00 220.00 02200 IAS SERVICES-STHER PROBLE OSTS APPRV 0 0 0 0 0 0 0 0 0 23.00 0300 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 7711 23.01 0230 PARAMED ED PROMI-(SPECITY) 0 0 0 0 0 0 0 0 0		I I	0	l				•
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ANCILLARY SERVICE COST CENTERS 50.00			0	1				ł
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S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 5,042 52.00			0				•	•
54.00 05400 RADI OLOGY-DI AGNOSTI C	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	5, 042	52. 00
54.01 DEAD DET SCAN 0 41, 192 557, 571 598, 763 1,59 54. 01			0	l				•
56.00 0500		1 1	0	l				•
57.00 05700 CT SCAN 0 47,449 49,366 96,815 2,916 57.00 58.00 05800 MRI 0 0 0 0 0 0 58.00 05800 MRI 0 0 0 0 0 0 0 0 58.00 06000 LABORATORY 0 406,933 731,447 1,138,380 20,287 60.00 65.00 065000 RESPIRATORY THERAPY 0 137,189 236,823 374,012 16,836 65.00 66.			0	l				•
60.00 06000 LABORATORY 0 406, 933 731, 447 1, 138, 380 20, 287 60.00	57. 00	I I	0	l		96, 815		1
65.00 06500 RESPIRATORY THERAPY 0 137, 189 236, 823 374, 012 16, 836 65. 00 66.00 06600 PHYSI CAL THERAPY 0 290, 377 220, 749 511, 126 13, 284 66. 00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69.00 06900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69. 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 35, 915 501, 459 537, 374 4, 264 70. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 189, 604 3, 954 193, 558 0 74. 00 76.00 03140 CARDI O CATH LAB 0 154, 549 1, 424, 053 1, 578, 602 5, 392 76. 00 76.01 03050 ENDOSCOPY 0 166, 107 518, 751 684, 858 13, 117 76. 01 76.02 03051 CARDI AC REHAB 0 0 0 32, 762 32, 762 1, 850 76.02 03051 CARDI AC REHAB 0 0 487, 909 12, 668 500, 577 11, 356 90. 00 79.00 09000 CLINIC 0 487, 790 12, 668 500, 577 11, 356 90. 00 79.00 09000 CLINIC 0 0 0 0 0 0 79.00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09500 AMBULANCE SERVICES 0 11, 032 293, 088 304, 120 9, 594 79.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 17, 045, 676 21, 189, 792 38, 235, 468 466, 785 118, 00 79.00 190.00 190.00 PHYSI CI ANS 'PRIVATE OFFICES 0 0 3, 024 3, 024 0 192, 00 79.00 194.00 09750 CLOSED PSYCH UNIT 0 0 0 0 0 0 79.40 0194, 00 09750 CLOSED PSYCH UNIT 0 0 0 0 0 0 79.40 0194, 00 0194, 00 0194, 00 79.40 0194, 00 0194, 00 0194, 00 79.40 0194, 00 0194, 00 0194, 00		I I	0	1		- 1		•
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69. 00 06900 ELECTROCARDI OLOGY 0 323, 521 326, 061 649, 582 4, 680 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 35, 915 501, 459 537, 374 4, 264 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 73. 00		06700 OCCUPATIONAL THERAPY	0	1			0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0	0	0	0		
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 189, 604 3, 954 193, 558 0 74. 00 76. 00 03140 CARTH LAB 0 154, 549 1, 424, 053 1, 578, 602 5, 392 76. 00 76. 01 03050 ENDOSCOPY 0 166, 107 518, 751 684, 858 13, 117 76. 01 76. 02 03051 CARDI AC REHAB 0 0 0 32, 762 32, 762 1, 850 76. 00 09000 CLI NI C 0 487, 909 12, 668 500, 577 11, 356 90. 00 79. 00 09100 EMERGENCY 0 481, 724 356, 459 838, 183 15, 190 79. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 92. 00 79. 00 09500 AMBULANCE SERVI CES 0 11, 032 293, 088 304, 120 9, 594 79. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79. 00 10500 KI DNEY ACQUI SI TI ON 0 50, 267 11, 004 61, 271 0 105. 00 79. 00 10600 HEART ACQUI SI TI ON 0 70, 045, 676 21, 189, 792 38, 235, 468 466, 785 79. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 3, 024 3, 024 0 192. 00 794. 00 19750 LOSED PSYCH UNIT 0 0 0 0 0 0 794. 00 07950 LOSED PSYCH UNIT 0 0 0 0 0 0 794. 00 07950 LOSED PSYCH UNIT 0 0 0 0 0 794. 00 07950 LOSED PSYCH UNIT 0 0 0 0 0 795. 00 07950 LOSED PSYCH UNIT 0 0 0 0 0 795. 00 0 0 0 0 0 0 0 796. 00 0 0 0 0 0 797. 00 0 0 0 0 0 799. 00 0 0 0 0 0 799. 00 0 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799. 00 0 0 0 799.		I I	Ö	0 0		0		
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105. 00	96.00		0		<u> </u>	U	0	96.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 17, 045, 676 21, 189, 792 38, 235, 468 466, 785 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 57, 407 4, 604 62, 011 0 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 024 3, 024 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 194. 00 194. 01 194. 01 197. 01 19	105.00		0	50, 267	11, 004	61, 271	0	105. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 57, 407 4, 604 62, 011 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 024 3, 024 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 0 0 3, 120 3, 120 1, 400 194. 01	106.00	10600 HEART ACQUISITION	_	0	16, 157	16, 157	0	106. 00
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 57, 407 4, 604 62, 011 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 3, 024 3, 024 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 194. 00 194. 01 194. 01 07951 MARKETI NG 0 0 3, 120 3, 120 1, 400 194. 01	118.00		0	17, 045, 676	21, 189, 792	38, 235, 468	466, 785	J118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	190. 00		0	57. 407	4.604	62. 011	0	190, 00
194. 01 07951 MARKETI NG 0 0 3, 120 3, 120 1, 400 194. 01			0	0			0	192. 00
194. 01 07951 MARKETING 0 0 3, 120 1, 400 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 0 0 149 194. 02	194.00	07950 CLOSED PSYCH UNIT	0	0	0	0	0	194. 00
174. 02 07702 SLINI ON CINCLE U U U U 149 194. 02			0	0			1, 400	194. 01
	174. UZ	- O 7 7 3 2 SENT ON OF NOLE	1 0	<u> </u>	1 0	U	149	1174. UZ

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014		pared:
					12/1/2014 9:5	5 am
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	88, 08	2 88, 082	756	194. 03
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	17, 103, 083	21, 288, 62	38, 391, 705	469, 090	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150017

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared: |

				'	0 06/30/2014	Date/lime Pre 12/1/2014 9:5	
	Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE		
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	412 207					4.00
5. 01 5. 02	OO540 ADMITTING OO560 OTHER ADMINISTRATIVE AND GENERAL	412, 206					5. 01 5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	31, 599		61, 015		8. 00
9. 00	00900 HOUSEKEEPI NG	Ö	74, 002			207, 220	1
10.00	01000 DI ETARY	0	84, 009			12, 215	1
11. 00	01100 CAFETERI A	0	37, 305		0	0	1
13.00	01300 NURSING ADMINISTRATION	0	46, 604	60, 908	0	2, 888	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0			0	5, 275	1
15. 00	01500 PHARMACY	0			0	3, 020	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0			0	3, 225	
17. 00	01700 SOCIAL SERVICE	0	56, 343	45, 817	0	2, 173	1
21. 00 22. 00	O2100 L&R SERVICES-SALARY & FRINGES APPRV O2200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	61, 483		0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		8, 509		161	0 1, 217	1
23. 00	02301 PHARMACY RESIDENCY PROGRAM			23, 074	0	1, 217	1
20.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1,001				20.01
30.00	03000 ADULTS & PEDIATRICS	20, 344	622, 372	941, 467	21, 893	44, 645	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	498			415	1, 844	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	2, 947	75, 895		475	4, 659	1
31. 03	03101 CARDIO INTENSIVE CARE UNIT	13, 404	336, 958		7, 507	16, 648	1
32.00	03200 CORONARY CARE UNIT	5, 195	123, 852	136, 713		6, 483	
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	
43. 00	04300 NURSERY	351	8, 677	4, 847	0	230	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	74, 511	586, 824	917, 647	12, 025	43, 514	50.00
51. 00	05100 RECOVERY ROOM	74, 311		917, 047	12,023	43, 314	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 455	_		0	Ő	1
53.00	05300 ANESTHESI OLOGY	8, 765		710	0	34	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 845	188, 763	140, 681	3, 066	6, 671	54.00
54.01	05401 PET SCAN	1, 193	18, 197	15, 314	0	726	54. 01
56.00	05600 RADI OI SOTOPE	6, 016	1		0	1, 691	56. 00
57. 00	05700 CT SCAN	15, 341	29, 480	17, 640		836	1
58. 00	05800 MRI	0	0	0	0	0	
60.00	06000 LABORATORY	34, 073			82	7, 174	1
65. 00 66. 00	06500 RESPIRATORY THERAPY	11, 038	l ·		233	2, 418	1
67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	3, 687	96, 231 0	107, 950	0	5, 119 0	1
68. 00	06800 SPEECH PATHOLOGY	0			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	12, 681	47, 199	120, 272	230	5, 703	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 801	46, 617		0	633	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 393			0		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	42, 179		0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	67, 343			0	0	
74. 00	07400 RENAL DI ALYSI S	1, 892				3, 342	1
76. 00	03140 CARDIO CATH LAB	16, 029					
76. 01	03050 ENDOSCOPY	10, 195		61, 752			1
76.02	03051 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	717	12, 811	0	0	0	76. 02
90. 00	09000 CLINIC	660	95, 041	181, 385	936	8, 601	90.00
	09100 EMERGENCY	18, 273					1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 2/3	147, 047	179,000	7, 120	0, 472	92.00
, 00	OTHER REIMBURSABLE COST CENTERS		1				1
95.00	09500 AMBULANCE SERVICES	1, 421	85, 929	4, 101	0	194	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	312			0		105. 00
	10600 HEART ACQUISITION	647	l ·		0		106. 00
118. 00	,	412, 206	6, 039, 645	4, 383, 381	61, 015	206, 208	J118. 00
100.00	NONREI MBURSABLE COST CENTERS	_	1 275	24 244	^	1 010	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 375 10, 138		0		190. 00 192. 00
	07950 CLOSED PSYCH UNIT		10, 138		0		194.00
	07951 MARKETI NG		46, 499	0			194. 00
	07952 SENI OR CI RCLE	0	1, 748		l 0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	l o	6, 557		l		194. 03
200.00]				200. 00
201.00		0	0	0	0	0	201. 00

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA				u of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014		narod:
				10 00/30/2014	12/1/2014 9:5	
Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE		
		AND GENERAL				
	5. 01	5. 02	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118-201)	412, 206	6, 105, 962	4, 404, 72	22 61, 015	207, 220	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150017

	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	12/1/2014 9: 5 PHARMACY	
		10.00	11. 00	13. 00	14. 00	15. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-BLDG & FTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00540 ADMI TTI NG						5. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 118, 479					9. 00 10. 00
11. 00	01100 CAFETERI A	0	44, 313				11.00
13.00	01300 NURSING ADMINISTRATION	0	524	1			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 403	1	949, 991		14. 00
15. 00	01500 PHARMACY	0	2, 026	0	23, 269	580, 571	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	1, 791	0	792	0	
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	832 0		139	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o	76	Ö	36	0	1
23. 01	02301 PHARMACY RESIDENCY PROGRAM	0	76	0	0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	465, 333	8, 994	81, 637	35, 391	0	
31. 00 31. 01	03100 INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT	0 9, 975	0 316	_	0 1, 242	0	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	64, 263	949		5, 763	0	31. 01
31. 02	03101 CARDIO INTENSIVE CARE UNIT	221, 180	4, 793		21, 563	0	31. 02
32. 00	03200 CORONARY CARE UNIT	43, 530	1, 639		8, 607	0	
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	1
43.00	04300 NURSERY	21, 943	119	1, 346	951	0	43. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	0	4, 107		112, 328	0	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0 496	_	0	0	
53. 00	05300 ANESTHESI OLOGY	0	127	1	36	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 293		7, 777	0	54.00
54. 01	05401 PET SCAN	O	19	1	0	0	1
56.00	05600 RADI OI SOTOPE	0	155	1, 779	510	0	56. 00
57. 00	05700 CT SCAN	0	355	1	1, 244	0	57. 00
58. 00	05800 MRI	0	0	1	0	0	
60.00	06000 LABORATORY	0	2, 512	1	64, 051	0	60. 00 65. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	1, 929 1, 191		6, 818 1, 923	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 171		1, 723	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	Ö	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	591	0	482	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	477	0	6, 697	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		278, 278	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		313, 115	0	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 790	580, 571 0	1
	03140 CARDI O CATH LAB	0	520	5, 971	12, 515	0	1
76. 01	03050 ENDOSCOPY	0	1, 577		18, 476	0	
	03051 CARDI AC REHAB	0	264		265	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	994		7, 481	0	
	09100 EMERGENCY	0	1, 789	16, 821	17, 583	0	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	0	978	O	1, 774	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	1	0	0	
	SPECIAL PURPOSE COST CENTERS			-1			1
	10500 KIDNEY ACQUISITION	0	116	0	0		105. 00
	10600 HEART ACQUISITION	0	66		0		106. 00
118. 00		826, 224	44, 094	288, 825	949, 896	580, 571	J118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	l ol	F	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	251, 171	0	1	0		192. 00
	07950 CLOSED PSYCH UNIT	0	0	- 1	ol		194. 00
	07951 MARKETI NG	0	146	0	81		194. 01
	07952 SENI OR CIRCLE	0	16		9		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	41, 084	57	0	0	0	194. 03
200.00			_			_	200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2013 To 06/30/2014	Part II Date/Time Pre	narod:
					12/1/2014 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI (N SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
202.00 TOTAL (sum lines 118-201)	1, 118, 479	44, 313	288, 82	949, 991	580, 571	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150017

Peri od: Worksheet B From 07/01/2013 Part II To 06/30/2014 Date/Time Prepared:

12/1/2014 9:55 am INTERNS & RESIDENTS PARAMED ED MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Cost Center Description RECORDS & Y & FRINGES PRGM COSTS PRGM LI BRARY **APPRV APPRV** 23.00 16.00 17.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMITTING 5.01 5. 01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 426, 831 16.00 01700 SOCIAL SERVICE 17.00 237, 424 17.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21 00 0 0 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 61, 483 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 C 105, 944 23.00 23.00 02301 PHARMACY RESIDENCY PROGRAM 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 21,028 11, 737 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 515 287 31.01 02060 NEONATAL INTENSIVE CARE UNIT 3.046 31 02 1,700 31 02 31. 03 03101 CARDIO INTENSIVE CARE UNIT 13,855 7, 733 31.03 03200 CORONARY CARE UNIT 32.00 5, 369 2, 997 32.00 04000 SUBPROVI DER - I PF 40.00 0 C 40.00 04300 NURSERY 362 202 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 77, 774 42, 601 50 00 51.00 05100 RECOVERY ROOM 51.00 05200 DELIVERY ROOM & LABOR ROOM 1,504 52 00 839 52 00 05300 ANESTHESI OLOGY 9,060 5,057 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 479 10, 872 54.00 05401 PET SCAN 1, 233 54.01 54.01 688 05600 RADI OI SOTOPE 3, 471 56.00 6, 218 56.00 57.00 05700 CT SCAN 15,858 8,851 57.00 58.00 05800 MRI 58.00 06000 LABORATORY 35, 219 19, 657 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 11, 410 6,368 65.00 66.00 06600 PHYSI CAL THERAPY 3,812 2, 127 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 C 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 13, 107 7, 316 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,861 1, 039 70.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 21.079 11, 765 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 43, 598 24, 334 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 69, 610 38, 852 73.00 07400 RENAL DIALYSIS 1.956 74.00 1, 092 74.00 03140 CARDIO CATH LAB 76.00 16, 568 9, 248 76.00 76.01 03050 ENDOSCOPY 10,538 5, 882 76.01 03051 CARDI AC REHAB 741 413 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 682 381 90.00 09100 EMERGENCY 18,888 10, 542 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 469 820 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 105 00 323 180 106.00 10600 HEART ACQUISITION 669 373 106.00 426, 831 SUBTOTALS (SUM OF LINES 1-117) 118.00 237, 424 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 0 194.00 07950 CLOSED PSYCH UNIT 0 194.00 194. 01 07951 MARKETI NG 194. 01 0 194. 02 07952 SENI OR CIRCLE 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 194.03

Health Financial Systems	LUTHERAN HOSPI	TAL OF INDIANA		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eri od:	Worksheet B	
				rom 07/01/2013 o 06/30/2014	Date/Time Pre	pared:
					12/1/2014 9:5	5 am
			INTERNS &	RESI DENTS		
Cost Center Description	MEDICAL RECORDS &	SOCI AL SERVI CE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	
	LI BRARY		APPRV	APPRV	PRGIVI	
	16.00	17. 00	21.00	22. 00	23. 00	
200.00 Cross Foot Adjustments			C	61, 483	105, 944	200. 00
201.00 Negative Cost Centers	C	0	C	0		201. 00
202.00 TOTAL (sum lines 118-201)	426, 831	237, 424	[C	61, 483	105, 944	202. 00

	Financial Systems	LUTHERAN HUSPITA		001 450047 5		U OF FORM CMS-2552	2-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 07/01/2013 To 06/30/2014		ed:
	Cost Center Description	PHARMACY RESI DENCY PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23. 01	24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMI TTI NG						5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL					· · · · · · · · · · · · · · · · · · ·	5. 02
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE					· · · · · · · · · · · · · · · · · · ·	7. 00 3. 00
9. 00	00900 HOUSEKEEPING					· · · · · · · · · · · · · · · · · · ·	9. 00
10.00	01000 DI ETARY					l .	0. 00
11.00	01100 CAFETERI A					l .	1.00
13. 00 14. 00	O1300 NURSI NG ADMINI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY					l I	3. 00 4. 00
15. 00	01500 PHARMACY						5. 00
	01600 MEDICAL RECORDS & LIBRARY					l I	5. 00
17. 00	01700 SOCIAL SERVICE					l I	7. 00
21. 00 22. 00	O2100 L&R SERVICES-SALARY & FRINGES APPRV O2200 L&R SERVICES-OTHER PRGM COSTS APPRV					l I	1.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)						3. 00
23. 01	02301 PHARMACY RESIDENCY PROGRAM	5, 338				l .	3. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS		7, 886, 138 0	1			0.00
31.00	03100 INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT		214, 791			l .	1. 00 1. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT		663, 832			l I	1. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT		2, 255, 162				1. 03
32. 00	03200 CORONARY CARE UNIT		823, 282	1		l .	2. 00
40. 00 43. 00	04000 SUBPROVI DER - PF 04300 NURSERY		0 54, 802) C		l .	0. 00 3. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		01,002	-1	01,002	10	<i>7.</i> 00
50.00	05000 OPERATI NG ROOM		8, 928, 133			l .	0. 00
51.00	05100 RECOVERY ROOM		40.034	1		l I	1.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		49, 926 33, 459				2. 00 3. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		2, 368, 653			l .	4. 00
54. 01	05401 PET SCAN		636, 468			l I	4. 01
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN		204, 038	1			6. 00 7. 00
58. 00	05800 MRI		193, 498 0				3. 00
60.00	06000 LABORATORY		1, 842, 748				0. 00
65. 00	06500 RESPI RATORY THERAPY		605, 133		,	l I	5. 00
	06600 PHYSI CAL THERAPY		746, 450				5. 00
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		0				7. 00 3. 00
69. 00	06900 ELECTROCARDI OLOGY		861, 843				9. 00
	07000 ELECTROENCEPHALOGRAPHY		614, 115	1	614, 115		0. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		728, 206 856, 107	1			1.00
73. 00			1, 319, 449		,		3. 00
74.00	07400 RENAL DIALYSIS		321, 941				4. 00
76.00	03140 CARDIO CATH LAB		1, 799, 228	•		l I	5. 00
76. 01	03050 ENDOSCOPY 03051 CARDI AC REHAB		954, 383 49, 823	1		l .	6. 01 6. 02
70.02	OUTPATIENT SERVICE COST CENTERS		47, 023	,	47,023	70). UZ
90.00	09000 CLI NI C		820, 669				0. 00
91.00			1, 281, 621				1.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			C)	92	2. 00
95. 00	09500 AMBULANCE SERVICES		410, 400) C	410, 400	95	5. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		0			l .	5. 00
405.00	SPECIAL PURPOSE COST CENTERS		110 500		110 500	105	
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION		119, 599 35, 262				5. 00
118.00		0				l I	3. 00
	NONREI MBURSABLE COST CENTERS	-	21/211/121		31,311,131		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		85, 744			l I	0.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT		264, 333			l I	2. 00 4. 00
	07951 MARKETING		51, 246				4. 00 4. 01
194. 02	07952 SENI OR CI RCLE		1, 922	: c	1, 922	194	1. 02
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS		136, 536	o C	136, 536	194	1. 03

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B
				From 07/01/2013	Part II
				To 06/30/2014	Date/Time Prepared:
					12/1/2014 9:55 am
Cost Center Description	PHARMACY	Subtotal	Intern &	Total	
	RESI DENCY		Residents Cos	t	
	PROGRAM		& Post		
			Stepdown		
			Adjustments		
	23. 01	24.00	25. 00	26.00	
200.00 Cross Foot Adjustments	5, 338	172, 765		0 172, 765	200. 00
201.00 Negative Cost Centers	0	0)	0 0	201. 00
202.00 TOTAL (sum lines 118-201)	5, 338	38, 391, 705		0 38, 391, 705	202. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	LUTHERAN HOSPI		CCN: 150017 P	<u> </u>	wof Form CMS-2 Worksheet B-1	
COST ALLOCATION - STATISTICAL BASIS		Frovider	F	rom 07/01/2013		
			Т	o 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	CAPITAL RE	LATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMITTING	Reconciliation	
	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	(GROSS CHAR		
			DEPARTMENT (GROSS	GES)		
			SALARI ES)			
GENERAL SERVICE COST CENTERS	1.00	2. 00	4. 00	5. 01	5A. 02	
1.00 O0100 CAP REL COSTS-BLDG & FIXT	716, 220	ol				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		9, 982, 305				2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	18, 728					4.00
5. 01 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	15, 437 31, 049			1, 984, 598, 649 0	-52, 492, 986	5. 01 5. 02
7. 00 00700 OPERATION OF PLANT	154, 838				02, 172, 700	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	898		0	0	0	8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	3, 015 29, 016				0	9. 00 10. 00
11. 00 01100 CAFETERI A	29,010		1, 544, 259		o o	11. 00
13.00 01300 NURSING ADMINISTRATION	6, 86			0	0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	12, 530 7, 173			0	0 0	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	7, 173				0	16.00
17.00 01700 SOCIAL SERVICE	5, 161		1, 956, 174		0	17. 00
21.00 02100 L&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	(-	0	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)	2, 892	-1	178, 102	0	0	22. 00 23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM		1			0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10/ 051	1 400 004	1/ 2/1 /7/	07 00/ 570	0	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	106, 051	1, 409, 094	16, 241, 476 0	97, 806, 578 0	0	30. 00 31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	4, 38	1 11, 021	761, 018	2, 394, 923	ő	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	11, 068				0	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	39, 548 15, 400					31. 03 32. 00
40. 00 04000 SUBPROVI DER - PF	15, 400		3,074,214		0	40.00
43. 00 04300 NURSERY	546	713	267, 764	1, 685, 765	0	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	103, 368	2, 116, 105	7, 897, 878	361, 071, 239	0	50.00
51. 00 05100 RECOVERY ROOM	103, 300	. 1	0	0 0 0 0 0 0	o o	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		-	1, 111, 063		0	52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	80 15, 847		120, 836 4, 502, 763		0	53. 00 54. 00
54. 01 05400 RADI OLOGI - DI AGNOSTI C	1, 725				0	54. 00
56. 00 05600 RADI OI SOTOPE	4, 018	4, 823	353, 944	28, 920, 949	i e	56. 00
57. 00 05700 CT SCAN 58. 00 05800 MRI	1, 987	7 23, 148	642, 653	73, 756, 438	0 1 0	57. 00 58. 00
60. 00 06000 LABORATORY	17, 041	342, 978	4, 470, 469	163, 810, 992		60.00
65. 00 06500 RESPI RATORY THERAPY	5, 745	111, 047	3, 709, 962	53, 068, 637	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	12, 160		2, 927, 352	17, 728, 066	0 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		1	0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	13, 548	-	1, 031, 323	_	Ö	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 504	235, 136	939, 717		l	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS			0	98, 043, 620 202, 783, 096	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		o o	ő	323, 765, 854	ő	73. 00
74. 00 07400 RENAL DI ALYSI S	7, 940			9, 098, 177	0	74.00
76. 00 03140 CARDI 0 CATH LAB 76. 01 03050 ENDOSCOPY	6, 472 6, 956				0	76. 00 76. 01
76. 02 03051 CARDI AC REHAB	0, 750				0	76. 02
OUTPATIENT SERVICE COST CENTERS			·			
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	20, 432 20, 173					90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	20, 173	107, 143	3, 347, 366	87, 830, 370		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	462					95.00
96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS		0	0	0	0	96. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	2, 105	5, 160	0	1, 500, 085	0	105. 00
106. 00 10600 HEART ACQUISITION	712.01			3, 110, 700		106.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	713, 816	9, 935, 963	102, 851, 486	1, 984, 598, 649	-52, 492, 986	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 404	2, 159	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES			0	0		192. 00
194. 00 07950 CLOSED PSYCH UNIT 194. 01 07951 MARKETI NG		l .	0 308, 486	0		194. 00 194. 01
	1	-1 1, 403	1 550, 400		<u> </u>	1

Heal th Finan	cial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der	CCN: 150017	Peri od:	Worksheet B-1	
					From 07/01/2013 To 06/30/2014		
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE) BENEFITS	(GROSS CHAR	Reconciliation	
				DEPARTMENT (GROSS SALARI ES)	GES)		
		1. 00	2. 00	4. 00	5. 01	5A. 02	
194. 02 07952	SENIOR CIRCLE	0		0 32, 8!	51 0	0	194. 02
194. 03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	41, 30	2 166, 5°	15 0	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	17, 103, 083	21, 288, 62	2 16, 087, 8	8, 112, 355		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	23. 879650	2. 13263	6 0. 1556!	0. 004088		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			469, 0	412, 206		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part II)			0. 0045	0. 000208		205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Provi der CCN: 150017 Peri od: From 07/01/2013 To 06/30/2014 Worksheet B-1 To 06/30/2014 Date/Time Prepared: 12/1/2014 9: 55 am

LAUNDRY & HOUSEKEEPING DI ETARY
LI NEN SERVI CE (SQUARE FEET) (MEALS SERVED) Cost Center Description OTHER ADMI NI STRATI VE OPERATION OF PLANT

		<u>'</u>	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	
			5. 02	7. 00	8. 00	9. 00	10. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2. 00		CAP REL COSTS-BLDG & TTXT						2.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		ADMITTI NG						5. 01
5.02		OTHER ADMINISTRATIVE AND GENERAL	276, 677, 726					5. 02
7.00	1	OPERATION OF PLANT	15, 442, 094	496, 168				7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	1, 431, 821 3, 353, 192	898 3, 015		492, 255		8. 00 9. 00
10. 00		DIETARY	3, 806, 659	29, 016		29, 016	714, 581	10.00
11. 00		CAFETERI A	1, 690, 372	0		0	0	11. 00
13.00	1	NURSING ADMINISTRATION	2, 111, 757	6, 861	0	6, 861	0	13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	7, 038, 843	12, 530		12, 530	0	14. 00
15.00	1	PHARMACY	8, 370, 112	7, 173		7, 173	0	15. 00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	5, 008, 059 2, 553, 026	7, 661 5, 161		7, 661	0	16. 00 17. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRV	2, 555, 020	5, 101	1	5, 161 0	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	2, 785, 941	0	Ö	0	Ö	22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)	385, 569	2, 892	5, 674	2, 892	0	23. 00
23. 01		PHARMACY RESIDENCY PROGRAM	206, 196	0	0	0	0	23. 01
		ENT ROUTINE SERVICE COST CENTERS		10/ 051	7/0/00	10/ 051	007.004	
30.00	1	ADULTS & PEDIATRICS	28, 202, 908	106, 051		106, 051	297, 294	
31. 00 31. 01		INTENSIVE CARE UNIT PEDIATRIC INTENSIVE CARE UNIT	1, 151, 359	0 4, 381		0 4, 381	0 6, 373	31. 00 31. 01
31. 01	1	NEONATAL INTENSIVE CARE UNIT	3, 438, 965	11, 068		11, 068	41, 057	31. 01
31. 03		CARDIO INTENSIVE CARE UNIT	15, 268, 405	39, 548		39, 548	141, 309	
32.00		CORONARY CARE UNIT	5, 612, 039	15, 400		15, 400	27, 811	32. 00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40. 00
43. 00		NURSERY	393, 164	546	0	546	14, 019	43. 00
50. 00		_ARY SERVICE COST CENTERS OPERATING ROOM	26, 590, 432	103, 368	422, 765	103, 368	0	50. 00
51. 00	1	RECOVERY ROOM	20, 390, 432	103, 306	_	0 103, 366	0	51.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	1, 586, 259	Ö		0	Ö	52. 00
53.00		ANESTHESI OLOGY	326, 803	80	0	80	0	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	8, 553, 313	15, 847	107, 796	15, 847	0	54. 00
54. 01	1	PET SCAN	824, 551	1, 725		1, 725	0	54. 01
56. 00		RADI OI SOTOPE	1, 843, 684	4, 018		4, 018	0	56.00
57. 00 58. 00	05800	CT SCAN	1, 335, 812	1, 987 0		1, 987 0	0	57. 00 58. 00
60. 00	1	LABORATORY	16, 767, 038	17, 041	_	_	0	60.00
65. 00		RESPI RATORY THERAPY	5, 576, 600	5, 745		5, 745	0	65. 00
66. 00		PHYSI CAL THERAPY	4, 360, 475	12, 160	14	12, 160	0	66. 00
67. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00		SPEECH PATHOLOGY	0	12.540	0	0	0	68. 00
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	2, 138, 684 2, 112, 318	13, 548 1, 504		13, 548 1, 504	0	69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	17, 975, 055	1, 304		1, 304	0	71.00
	1	IMPL. DEV. CHARGED TO PATIENTS	19, 614, 899			_	0	
	1	DRUGS CHARGED TO PATIENTS	25, 514, 203	0	0	0	0	73. 00
74.00		RENAL DIALYSIS	2, 212, 327	7, 940		7, 940	0	74. 00
76. 00		CARDIO CATH LAB	4, 210, 236	6, 472		6, 472	0	76. 00
76. 01 76. 02	1	ENDOSCOPY CARDI AC REHAB	5, 817, 813 580, 491	6, 956 0		6, 956 0	0	76. 01 76. 02
70.02		TIENT SERVICE COST CENTERS	380, 491	0	0	0	0	70.02
90. 00		CLINIC	4, 306, 520	20, 432	32, 908	20, 432	0	90.00
91.00		EMERGENCY	6, 780, 972	20, 173			0	91. 00
92.00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05.00		REI MBURSABLE COST CENTERS	0.000 (7.1					
95. 00	1	AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	3, 893, 674 0	462 0		462 0	0 0	95. 00 96. 00
96. 00		AL PURPOSE COST CENTERS	U	U	0	0	0	90.00
105.00		KIDNEY ACQUISITION	1, 713, 914	2, 105	0	2, 105	0	105. 00
		HEART ACQUISITION	786, 151	0		0		106. 00
118. 00	-	SUBTOTALS (SUM OF LINES 1-117)	273, 672, 705	493, 764	2, 145, 118	489, 851	527, 863	118. 00
40		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	62, 324	2, 404		2, 404		190.00
		PHYSICIANS' PRIVATE OFFICES CLOSED PSYCH UNIT	459, 365 0	0	0	0	160, 470 0	194. 00
		MARKETI NG	2, 106, 979	0	0	0		194. 00
		SENI OR CIRCLE	79, 218	Ö	o o	Ö	0	194. 02
194. 03	07953	OTHER NONREIMBURSABLE COST CENTERS	297, 135	0	0	0	26, 248	194. 03
200.00	<u> </u>	Cross Foot Adjustments						200. 00

Heal th	Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2013	Worksheet B-1	
					Γο 06/30/2014		
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		AND GENERAL	(SQUARE FEET)	(POUNDS OF			
		(ACCUM. COST)		LAUNDRY)			
		5. 02	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	52, 492, 986	18, 371, 861	1, 736, 72	4, 101, 018	5, 845, 006	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 189726	37. 027501	0. 80961	8. 331084	8. 179627	203. 00
204.00	Cost to be allocated (per Wkst. B,	6, 105, 962	4, 404, 722	61, 01	5 207, 220	1, 118, 479	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 022069	8. 877481	0. 02844	0. 420961	1. 565224	205.00
	11)						

COST CALLOCATION STATISTICAL DASIS Provider ORL 150017 Provider CALLOCATION COST CALLOCATION COST CALLOCATION CALLOCATIO			LUTHERAN HOSPIT				eu of Form CMS-:	
Cost Center Description	COST A	ALLOCATION - STATISTICAL BASIS		Provi der			Worksheet B-1	
Cost Center Description							Date/Time Pre	pared:
CETTE S. MONINGSTANT IN SERVICES RECULS STORMS SERVICES STORMS SERVICES STORMS SERVICES		Cost Center Description	CAFETERIA	NURSLNG	CENTRAL	PHΔRMΔCV		5 am
COUNTRY SERVICE COST CENTERS 1.00 15.00 14.00 15.00 16.00 10.0		cost defiter bescription						
BERSIAL SERVICE COST CENTERS						REQUIS.)		
				7	7		,	
CREAM_SERVICE_COST_CAPILES			11 00			15.00		
2.00 CORDO CAP REL CUSTS -WINELE EQUIP 2.00 CORDO CAP REL CUSTS -WINELE EQUIP 4.00 CORDO CAP REL CUSTS -WINELE EQUI		GENERAL SERVICE COST CENTERS	111.00	10.00	11.00	101.00	10.00	
4.00 ODADO INTERNET IS DEPARTMENT A								1
5.01 0.0540 ADMITTING								1
5.02 0.0500 O.0500							1	
7.00 00700 GERATION OF PLANT 100 001000 CALEFERIA N 100 001000 CALEFERIA N 100 001000 CALEFERIA N 100 001000 CALEFERIA N 11.00 011000 CALEFERIA SERVICES & SUPPLY 11.00 011000 CALEFERIA N 11.00 011								1
9.00 00000 MUSICKEET INS								1
10.00 101000 DIETARY								1
11.00 01100 CAFETERIA 10.0, 752 1.00 01100 CAFETERIA 10.0, 1752 1.00 01100 CENTRAL SERVICES & SUPPLY 5.089 57,472,552 5.6997,555 1.30,104								1
13.00 01300 IURISI NO ZOMINI STRATION 1,002 57,472,505 56,997,955 1.0 1.0 01300 IURISI NO ZOMINI STRATION 1,002 1.0 0.0 0.0 1.396,104 1.0 0.			160, 752					1
15.00 101000 PHARMACY 17.348		01300 NURSI NG ADMI NI STRATI ON	1, 902	57, 472, 552				1
16.00 16-00 MEDICAL RECORDS & LIBRARY 6,496 0 47,523 0 1,984,598,404 16,00 17,00 1700 01			1	1				1
17.00 01700 SOCIAL SERVICE 3.018				1			l	
21.00 02.00 AR SERVICES-SALARY & FINNES APPRIVED 0 0 0 0 22.00		I I		1		0	l '	1
22.00 02200 ABN SERVICES-OTHER PROM COSTS APPRV 0 0 2.90 0 0 22.00 23.01 02300 PARAMED ED PREAM-CSPECIES 7.74 0 0 0 0 0 23.01 02300 PARAMED ED PREAM-CSPECIES 7.74 0 0 0 0 0 0 23.01 02300 PARAMED ED PREAM-CSPECIES 7.75 0 0 0 0 0 0 0 0 0			1	1		Ö	·	1
1,230	22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	C	o	29	0	0	1
IMPARTIENT ROUTINE SERVICE COST CENTERS		1 1	1	1	· ·			1
30.00 30.00 ADULTIS & PEDIATRICS 32, 628 16, 241, 477 2, 123, 399 0 97, 806, 578 30, 00 31, 00 310, 10 100, 100 10 10 10 10	23. 01		276) <u> </u>	0	O	0	23.01
31.00 0.03100 INTERSIYE CARE UNIT	30. 00		32, 628	16, 241, 477	2, 123, 399	0	97, 806, 578	30.00
31.02 02000 NEONATAL INTENSIVE CARE UNIT 17,3 86 9,915; 102 1,293,731 0 14,166,360 31.02 3				1				1
31.03 (3010) CARDIO I NITENSIVE CARE UNIT		i i				_	1	1
32.00 0 30200 CORDINARY CARE UNIT 5, 945 3, 674, 214 516, 409 0 24, 974, 258 32.00 0 0 3000 NURSERY F 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_		
40.00 04000 04000 04000 0 0 0								
MOLILLARY SERVICE COST CENTERS			1			_	1	1
50.00	43.00		433	267, 764	57, 070	0	1, 685, 765	43. 00
51.00 05100 RECOVERY ROOM LABOR ROOM 1.799 1.111, 063 0 0 0 0 6.994, 934 52.00 52.00 05200 DELIVERY ROOM LABOR ROOM 1.799 1.111, 063 0 0 0 0 0 0 0 0 0	FO 00		14 000	7 007 070	/ 720 F74	0	2/1 071 220	1 50 00
52.00 05200 DELLYREY ROOM & LABOR ROOM 1.799 1.111. 063 0 0 6.994, 934 52. 00 53.00 53.00 63.00 ARSTHESI LOGY 46.2 0 2.132 0 42. 141. 130 53. 00 53.00 ARSTHESI LOGY 69.9 335. 040 0 0 5.735. 464 54. 01 0 0 0 0 5.735. 464 54. 01 0 0 0 0 0 0 5.735. 464 54. 01 0 0 0 0 0 0 0 0 0			14, 900					1
54.00 05400 RADI DLOCY-DI AGNOSTIC 8.317 4.502, 763 466, 625 0 90, 599, 823 54.00 156.00 05600 RADI DISTORE 564 353, 944 30, 597 0 28, 920, 949 56.00 157.00 05700 CT SCAN 1, 287 642, 653 74, 616 0 73, 756, 438 57.00 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 MRI 0 0 0 0 0 0 0 158.00 05800 RESPI RATIORY THERAPY 9, 113 0 3, 842, 969 0 163, 810, 992 60.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 05600 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 66.00 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 115, 371 0 17, 728, 066 72, 00 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 18, 85, 76, 858 0 77, 06, 26, 30 159.00 07000 RESPI RATIORY THERAPY 4, 321 0 18, 85, 76, 858 0 77, 06, 26, 30 159.00 07000 RESPI RATIORY THERAPY 74, 00			1, 799	1			l	1
54.01 05401 PET SCAN 69 35, 040 0 0 5, 735, 464 54.00		I I	1	1		0		1
56.00 OSGO RADIO I SOTOPE 564 333, 944 30, 597 0 28, 920, 949 56, 00 58, 00 07, 00 5700 CT SCAN 1, 287 642, 653 74, 616 0 73, 756, 438 57, 00 58, 00 0800 MRI 0 0 0 0 0 0 0 0 0								1
57.00 OSTOO CT SCAN 1,887 642,653 74,616 0 73,756,438 57.00		I I				_		1
58. 00 05800 MR 0 0 0 0 0 0 0 58. 00 0. 00 06000 LABORATORY 9,113 0 3,842,969 0 163,810,992 60. 00 065.00 06500 RESPIRATORY THERAPY 6,996 0 409,068 0 53,068,637 65. 00 066.00 06600 PRYSI CAL THERAPY 4,321 0 115,371 0 17,728,066 66. 00 067.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 08. 00 06900 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 070.00 07000 ELECTROCARDI OLOGY 2,145 0 28,942 0 60,964,769 69.00 071.00 071000 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 16,696,359 0 98,043,620 71.00 072.00 072000 IMPL. DEV. CHARGED TO PATIENTS 0 0 18,785,922 0 202,783,096 72.00 073.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 18,785,922 0 24,190,648 323,765,854 73.00 074.00 07400 RENAL DIALYSIS 0 0 0 0 47,379 0 076.00 03140 CABDIO CATH LAB 1,888 1,188,201 75,0858 0 77,062,563 76.00 076.01 03050 EMDOSCOPY 5,719 2,890,456 1,108,515 0 49,012,568 76.00 076.02 03051 CARDIAC REHAB 957 0 15,894 0 3,444,797 076.02 0000 0000 CLINIC C 3,606 2,502,494 448,830 0 3,173,904 077.00 09000 CHINEC SERVICES 3,547 0 106,413 0 6,83,008 079.00 09000 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 09000 09000 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 0 09000 09000 URBALE REDICAL EQUIP -RENTED 0 0 0 0 0 0 0 0 0						-		1
65.00 05500 RESPIRATORY THERAPY 6,996 0 409,068 0 53,068,637 65.00	58.00	05800 MRI		1	0	0	0	58. 00
66.00 06600 PMSI CAL THERAPY 0 0 115, 371 0 17, 728, 066 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68.00 06900 069000 SPEECH PATHOLOGY 2,145 0 28,942 0 60,964,769 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 16,696,359 0 98,043,620 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 16,696,359 0 98,043,620 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 18,785,922 0 020,783,096 72.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 24,190,648 323,765,854 73.00 74.00 07400 REVAL DI LALYSI S 0 0 0 47,379 0 9,098,177 74.00 76.00 07400 REVAL DI LALYSI S 0 0 0 47,379 0 9,098,177 74.00 76.00 07400 CARDI LA BREWLE CARDED TO PATI ENTS 0 0 0 47,379 0 9,098,177 74.00 76.00 07400 CARDI LA BREWLE CARDED TO PATI ENTS 0 0 0 0 3,444,797 76.00 07500 ENDOSCOPY 5,719 2,890,456 1,108,515 0 49,012,568 76.00 76.01 07500 CARDI LA BREWLE COST CENTERS 0 0 0 3,173,904 90.00 76.02 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 3,173,904 90.00 76.02 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.02 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.02 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.00 07500 DRUGS				1		_		1
67. 00 06700 05CUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0		I I				-		1
68. 00 66800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 2, 145 0 28, 942 0 60, 964, 769 80, 00 70. 00 07000 ELECTROCENCEPHALOGRAPHY 1, 730 0 401, 802 0 8, 657, 668 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 16, 696, 359 0 98, 043, 620 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 18, 785, 922 0 2022, 783, 096 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 47, 379 0 9, 098, 177 74. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 47, 379 0 9, 098, 177 74. 00 76. 00 03401 CARDIO CATH LAB 1, 88 1, 188, 201 750, 858 0 77, 062, 563 76. 00 76. 01 03050 ENDOSCOPY 5, 719 2, 890, 456 1, 108, 515 0 49, 012, 568 76. 01 76. 02 03051 CARDIA C REHAB 957 0 15, 894 0 3, 444, 797 79. 00 09000 CLINI C 3, 606 2, 502, 494 448, 830 0 3, 173, 904 90. 00 79. 00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 79. 00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 70. 00 09000 NIDMENY ACQUI SITI ON 242 0 0 0 0 0 3, 110, 700 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 3, 110, 700 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 3, 110, 700 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 0 0 0 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 0 0 0 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 0 0 0 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 0 0 0 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 0 0 0 0 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 0 0 0 0 70. 00 10500 FIRST HOUSE COST CENTERS 0 0 0 0 0 0 0 0 0 70. 00 10500 KIDNEY ACQUI SITI ON 2421 0 0 0 0 0 0 0 0 0		I I				-	,,	1
70. 00 070000 07000 07000 070000 070000 070000 070000 07000 070000 070000 070000 070000 0700000 0700000000			-			_		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 16, 696, 359 0 98, 043, 620 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 18, 785, 922 0 202, 783, 096 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 24, 190, 648 323, 765, 854 73. 00 74				1		0		
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 18, 785, 922 0 202, 783, 096 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 47, 379 0 9, 098, 177 74. 00 74.			1, 730	1		0		1
73. 00						0		
76. 00 03140 CARDI O CATH LAB 1,888 1,188,201 750,858 0 77,062,563 76. 00 76. 01 03050 ENDOSCOPY 5,719 2,890,456 1,108,515 0 49,012,568 76. 01 76. 02 03051 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 76. 02 00 00 00 0 0 0 0 0			Č	Ö		-		1
76. 01 03050 CARDI AC REHAB 957 0 15,894 0 49,012,568 76. 01 76. 02 03051 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 0200 03051 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 0200 03051 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 0200 03051 CARDI AC REHAB 957 0 15,894 0 3,444,797 76. 02 0200 03051 CARDI AC REHAB 957 0 10,895 0 0 0 0 0 0 0 0 0			C	o		0		1
76. 02 03051 CARDIAC REHAB 957 0 15,894 0 3,444,797 76. 02 0179ATI ENT SERVICE COST CENTERS 90. 00 0900 CLI NI C 3,606 2,502,494 448,830 0 3,173,904 90. 00 91. 00 09100 EMERGENCY 6,490 3,347,388 1,054,953 0 87,850,570 91. 00 0920 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 106,413 0 6,833,008 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_		1
OUTPATI ENT SERVI CE COST CENTERS 3,606 2,502,494 448,830 0 3,173,904 90.00 91.00 90.00 EMERGENCY 6,490 3,347,388 1,054,953 0 87,850,570 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 92.00 00 00 00 00 00 00 00		i i				_		1
90. 00	70.02		757) 0	15, 674	<u> </u>	3, 444, 777	70.02
92. 00	90.00		3, 606	2, 502, 494	448, 830	0	3, 173, 904	90.00
OTHER REI MBURSABLE COST CENTERS 3, 547 0 106, 413 0 6, 833, 008 95. 00		i i	6, 490	3, 347, 388	1, 054, 953	0	87, 850, 570	1
95. 00	92. 00							92.00
96. 00	95. 00		3,547	0	106, 413	0	6, 833, 008	95. 00
105. 00 10500 KI DNEY ACQUI SITION 422 0 0 0 0 0 1,500,085 105. 00 106.		I I		1				1
106. 00			_					
118.00 SUBTOTALS (SUM OF LINES 1-117) 159,958 57,472,552 56,991,845 24,190,648 1,984,598,649 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 194.00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 0 194.00 194.01 07951 MARKETI NG 529 0 4,862 0 0 194.01 194.02 07952 SENI OR CI RCLE 58 0 555 0 0 194.02				1		0		
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 194.00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194.00 194.01 07951 MARKETI NG 529 0 4,862 0 0 194.01 194.02 07952 SENI OR CI RCLE 58 0 555 0 0 194.02 194.02 07952 195.02 195.02 195.02 195.02 195.03 195.02 195.02 195.02 195.02 196.04 196.02 195.02 195.02 196.05 196.05 196.05 196.06 196.05 196.05 196.07 196.07 196.08 196.08				1	Ŭ	0 24 190 648		
190. 00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 293 0 0 190. 00 192. 00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02	110.00		137, 730	31, 412, 332	30, 771, 043	24, 170, 040	1, 704, 370, 047	1110.00
194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	293	0	0	190. 00
194. 01 07951 MARKETI NG 529 0 4, 862 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 58 0 555 0 0 194. 02			0	이	0	0		
194. 02 07952 SENIOR CIRCLE 58 0 555 0 0 194. 02			C		0	0	l	1
				1		0	l	1
				1		-		

Health Fina	ncial Systems L	UTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTE'S)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LI BRARY	
			(DIRECT NRSING	(COSTED		(GROSS CHAR	
			HRS)	REQUIS.)		GES)	
		11. 00	13.00	14.00	15. 00	16. 00	
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 011, 080	2, 847, 413	9, 006, 30	10, 596, 025	6, 394, 487	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 510451	0. 049544	0. 15801	2 0. 438022	0.003222	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)	44, 313	288, 825	949, 99	580, 571	426, 831	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 275661	0. 005025	0. 01666	0. 024000	0. 000215	205. 00

	Financial Systems ALLOCATION - STATISTICAL BASIS	LUTHERAN HOSPITA		CCN: 150017 Pe	In Lie	u of Form CMS-: Worksheet B-1	
C031 F	ALLOCATION - STATISTICAL BASIS		i i ovi dei		om 07/01/2013	Date/Time Pre	pared:
			INTERNS &	RESI DENTS		12/1/2014 9:5	5 am
	Cost Center Description	SOCI AL SERVI CE (GROSS CHAR GES)			PARAMED ED PRGM (ASSI GNED TI ME)	PHARMACY RESI DENCY PROGRAM (ASSI GNED TI ME) 23. 01	
	GENERAL SERVICE COST CENTERS	17.00	21100	221 00	20.00	20.0.	
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMITTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00
9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 984, 598, 649					9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
21. 00 22. 00 23. 00 23. 01	02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY) 02301 PHARMACY RESI DENCY PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0	10, 900	10, 900	66, 466 O	10, 000	21. 00 22. 00 23. 00 23. 01
30.00	03000 ADULTS & PEDIATRICS	97, 806, 578	1, 250	1, 250	48, 341	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	
31. 01 31. 02	02080 PEDIATRIC INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	2, 394, 923 14, 166, 369	50 950	50 950	250 1, 125	0	
31. 03	03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705	0	0	4, 725	0	1
32. 00	03200 CORONARY CARE UNIT	24, 974, 258	0	0	2, 375	0	
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	0 1, 685, 765	0	0	0	0	
43.00	ANCI LLARY SERVI CE COST CENTERS	1,065,765	O	U _I	<u> </u>		43.00
50.00	05000 OPERATING ROOM	361, 071, 239	2, 950	2, 950	1, 775	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	6, 994, 934 42, 141, 130	0	0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	90, 599, 823	0	0	0	0	1
54. 01	05401 PET SCAN	5, 735, 464	0	0	0	0	1
56.00	05600 RADI OI SOTOPE	28, 920, 949	0	0	0	0	
57.00	05700 CT SCAN 05800 MRI	73, 756, 438	0	0	0	0	57. 00 58. 00
	06000 LABORATORY	163, 810, 992	0	0	ol Ol	0	
	06500 RESPI RATORY THERAPY	53, 068, 637	100	100	Ö	0	1
66.00	06600 PHYSI CAL THERAPY	17, 728, 066	0	0	0	0	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	O O	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	60, 964, 769	o	0	Ö	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	8, 657, 668	o	0	0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	98, 043, 620 202, 783, 096	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	323, 765, 854	0	0	o	10, 000	1
74. 00	07400 RENAL DIALYSIS	9, 098, 177	0	0	0	0	
76.00	03140 CARDI O CATH LAB	77, 062, 563	400	400	500	0	
76. 01 76. 02	03050 ENDOSCOPY 03051 CARDI AC REHAB	49, 012, 568 3, 444, 797	0	0	0	0	
70.02	OUTPATIENT SERVICE COST CENTERS	0, 111, 777	<u> </u>	o _l	91		70.02
90.00	09000 CLI NI C	3, 173, 904	4, 700	4, 700	3, 250	0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	87, 850, 570	0	0	2, 925	0	91. 00 92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	6, 833, 008	0	0	0	0	95. 00
96. 00		0	0	0	0	0	
	10500 KIDNEY ACQUISITION	1, 500, 085	0	0	0		105. 00
	10600 HEART ACQUISITION	3, 110, 700	0	0	1, 200		106.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1, 984, 598, 649	10, 400	10, 400	66, 466	10, 000	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	O	0	O	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	500	500	0		192.00
	007950 CLOSED PSYCH UNIT 107951 MARKETING	0	0	0	0		194. 00 194. 01
- 74.0	1/07 YO I INPURIENT THO	<u> </u>	ΟĮ		υ _l	0	11/4.01

Health Finar	ncial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 07/01/2013 To 06/30/2014		
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE PRGM COSTS	R PARAMED ED PRGM	PHARMACY RESI DENCY	
		(GROSS CHAR	APPRV	APPRV	(ASSI GNED	PROGRAM	
		GES)	(ASSI GNED	(ASSI GNED	TIME)	(ASSI GNED	
			TIME)	TIME)		TIME)	
		17. 00	21. 00	22. 00	23. 00	23. 01	
194. 02 07952	SENIOR CIRCLE	0	0		0	0	194. 02
194. 03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	3, 310, 569	0	3, 314, 51	1 598, 262	248, 770	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 001668	0. 000000	304. 08357	9. 001023	24. 877000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	237, 424	0	61, 48	3 105, 944	5, 338	204. 00
	1	1	1				1

0. 000000

5. 640642

1. 593958

0. 533800 205. 00

Unit cost multiplier (Wkst. B, Part

near th Trhaneral Systems	LOTTILITY HOST I TALE	01 1140174474		111 2100	a or rorm omo z	1002 10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150017	Peri od:	Worksheet C	
				From 07/01/2013	Part I	
				To 06/30/2014	Date/Time Pre	pared:
					12/1/2014 9: 5	5 am
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		

Total Cost				Ti tl	e XVIII	Hospi tal	PPS	
NOTE COST CENTER Part COST				<u>'</u>				
INPATIENT ROUTINE SERVICE COST CENTERS 1.00		Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
Part Col.								
INPATI ENT ROUTI NE SERVICE COST CENTERS				,				
INPATI ENT ROUTI NE SERVICE COST CENTERS 43, 880, 713 30, 00 4, 00 5, 00								
30. 00 03000 ADULTS & PEDI ATRIC S 43, 880, 713 0 0 0 0 0 0 0 0 0				2. 00	3.00	4. 00	5. 00	
31 00 03100 INTERSIVE CARE UNIT 0 0 0 0 0 0 1.10 249 1.31 02 1.30 1.30 1.30 02060 PEDIATRIC INTENSIVE CARE UNIT 1,710,249 1,710,249 0, 1,710,249 1.31 02 02060 NEONATAL INTENSIVE CARE UNIT 22,599,399 22,599,399 0,22,599,399 0,22,599,399 1.32 03 03200 CORDINARY CARE UNIT 22,599,399 22,599,399 0,22,599,399 1.32 03 03200 CORDINARY CARE UNIT 8,155,565 8,155,565 0 8,155,565 32 00 04 00 04000		INPATIENT ROUTINE SERVICE COST CENTERS			•			
31.00 03100 INTERSIVE CARE UNIT 0 0 0 0 31.00 31.01 02080 PEINATRIC INTERSIVE CARE UNIT 1,710,249 1,710,249 0 1,710,249 0 1,710,249 31.02 02080 NEONATAL INTENSIVE CARE UNIT 22,599,399 22,599,399 0 22,599,399 10,230 1,030 1,030 1,000 1	30.00	03000 ADULTS & PEDI ATRI CS	43, 880, 713		43, 880, 713	0	43, 880, 713	30.00
31 02 02060 NEOMATAL INTENSIVE CARE UNIT	31.00	03100 INTENSIVE CARE UNIT					0	31.00
31 02 02060 NEOMATAL INTENSIVE CARE UNIT	31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249		1, 710, 249	0	1, 710, 249	31. 01
31 03 101 CARDIO INTENSIVE CARE UNIT	31. 02		5, 225, 994		5, 225, 994	0	5, 225, 994	31. 02
32.00 03200 CORONARY CARE LINIT 8, 155, 565 0 8, 155, 565 0 0 40.00 04.00 05.00	31. 03	03101 CARDIO INTENSIVE CARE UNIT	22, 599, 399		22, 599, 399	0	22, 599, 399	31. 03
40.00 04000 04000 0400 040, 040, 04	32.00		8, 155, 565		8, 155, 565	0	8, 155, 565	32.00
AS 0 04300 NURSERY 643, 138 643, 138 0 643, 138 43.00	40.00	04000 SUBPROVI DER - I PF	1					
ANCILLARY SERVICE COST CENTERS	43.00		643, 138		643, 138	0	643, 138	43.00
51.00 05100 RECOVERY ROOM 1,998,973 1,998,973 0 1,998,973 0 1,998,973 0 51.00		ANCILLARY SERVICE COST CENTERS			<u> </u>		•	1
1.998, 973 0 1.998, 973 0 1.998, 973 0 1.998, 973 52.00	50.00	05000 OPERATI NG ROOM	40, 090, 848		40, 090, 848	0	40, 090, 848	50.00
S3.00 05300 ABSTHESI OLOGY 604, 621 18, 226, 071 11, 8	51.00	05100 RECOVERY ROOM	0		0	O	0	51.00
S3.00 05300 ABSTHESI OLOGY 604, 621 18, 226, 071 11, 8	52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 998, 973		1, 998, 973	0	1, 998, 973	52. 00
54.01 05401 PET SCAN 1,089,879 1,089,879 0 1,089,879 54.01	53.00	05300 ANESTHESI OLOGY	604, 621				604, 621	53.00
54.01 05401 PET SCAN 1,089,879 1,089,879 0 1,089,879 54.01	54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 826, 071		11, 826, 071	0	11, 826, 071	54.00
56. 00 05600 RADI OI SOTOPE 2, 546, 579 2, 546, 579 0 2, 546, 579 56. 00 57. 00 05700 CT SCAN 2, 126, 328 2, 126, 328 0 2, 126, 328 57. 00 58. 00 05800 MRI 0 0 0 0 0 60. 00 06000 LABORATORY 22, 245, 742 22, 245, 742 0 22, 245, 742 66. 00 06600 RSPI RATORY THERAPY 7, 313, 522 0 7, 313, 522 0 7, 313, 522 0 7, 313, 522 0 66. 00 06600 PHYSI CAL THERAPY 5, 898, 319 0 5, 898, 319 0 5, 898, 319 0 0 0 0 0 67. 00 06700 OCCUPATI IONAL THERAPY 0 0 0 0 0 0 68. 00 68. 00 06600 OCCUPATI IONAL THERAPY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0, 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 2, 708, 768 2, 708, 768 0 2, 708, 768 0 2, 708, 768 0 71. 00 07000 ELECTROCREPHALOGRAPHY 2, 708, 768 2, 708, 768 0 2, 708, 768 0 2, 708, 768 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 24, 503, 049 24, 503, 049 0 24, 503, 049 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 27, 296, 369 27, 296, 369 0 27, 296, 369	54. 01	05401 PET SCAN	1, 089, 879		1, 089, 879	0	1, 089, 879	54. 01
57. 00 05700 CT SCAN 2, 126, 328 2, 126, 328 0 2, 126, 328 57. 00 58. 00 05800 MRI 0 0 0 0 0 60. 00 06000 LABORATORY 22, 245, 742 22, 245, 742 0 22, 245, 742 0.0 65. 00 06500 RESPI RATORY THERAPY 7, 313, 522 0 7, 313, 522 0 7, 313, 522 0 66. 00 06600 CABORATORY 5, 898, 319 0 5, 898, 319 0 5, 898, 319 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 3, 495, 048 3, 495, 048 0 3, 495, 048 60, 00 70. 00 07000 ELECTROCARDI OLOGY 3, 495, 048 3, 495, 048 0 3, 495, 048 60, 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 24, 503, 049 24, 503, 049 0 24, 503, 049 71, 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 27, 296, 369 27, 296, 369 0 27, 296, 369 72, 200 73. 00 07300 DRUGS CHARGED TO PATI ENTS 27, 296, 369 27, 296, 369 0 27, 296, 369 72, 00 74. 00 07400 RENAL DIALYSI S 3, 044, 186 3, 044, 186 3, 044, 186 0 3, 044, 1	56.00	05600 RADI OI SOTOPE			2, 546, 579	0	2, 546, 579	56. 00
58.00 05800 MR	57.00							
65. 00 06500 RESPI RATORY THERAPY 7, 313, 522 0 7, 313, 522 0 7, 313, 522 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 5, 898, 319 0 5, 898, 319 0 5, 898, 319 0 67. 00 67. 00 06700 05000 07000 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 3, 495, 048 3, 495, 048 0 3, 495, 048 0 71. 00 07000 ELECTROCARDI OLOGY 2, 708, 768 2, 708, 768 0 2, 708, 768 70. 00 70. 00 07000 ELECTROCARDI OLOGY 2, 708, 768 2, 708, 768 0 2, 708, 768 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 24, 503, 049 24, 503, 049 0 24, 503, 049 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 27, 296, 369 27, 296, 369 0 27, 296, 369 0 27, 296, 369 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 42, 782, 921 42, 782, 921 0 42, 782, 921 73. 00 74. 00 07400 RENAL DI ALYSI S 3, 044, 186 3, 044, 186 0 3, 044, 186 74. 00 76. 00 03140 CARDI O CATH LAB 5, 921, 720 5, 921, 720 0 5, 921, 720 0 76. 01 03050 ENDOSCOPY 7, 927, 673 7, 927, 673 7, 927, 673 0 7, 927, 673 7,			0					
65. 00 06500 RESPI RATORY THERAPY 7, 313, 522 0 7, 313, 522 0 7, 313, 522 65. 00 66. 00 06600 PHYSI CAL THERAPY 5, 898, 319 0 5, 898, 319 0 5, 898, 319 0 67. 00 0670 00 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	22, 245, 742		22, 245, 742	0	22, 245, 742	60.00
66. 00	65.00			l .				1
67. 00 06700 OCCUPATIONAL THERAPY O O O O O O O O O						0		1
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 3,495,048 3,495,048 0 3,495,048 0 70.00 07000 ELECTROCENCEPHALOGRAPHY 2,708,768 2,708,768 0 2,708,768 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 24,503,049 24,503,049 0 24,503,049 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 27,296,369 27,296,369 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 42,782,921 42,782,921 0 42,782,921 0 74.00 07400 RENAL DI ALYSI S 3,044,186 3,044,186 0 76.00 03140 CARDI O CATH LAB 5,921,720 5,921,720 0 76.01 03050 ENDOSCOPY 7,927,673 7,927,673 0 76.02 03051 CARDI AC REHAB 721,954 0 0UTPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 6,361,780 0 6,361,780 0 6,361,780 0 92.00 09500 MBULSANCE SERVI CES 4,747,964 4,747,964 0 4,747,964 95.00 96.00 09500 MBULANCE SERVI CES 4,747,964 4,747,964 0 4,747,964 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 96.00 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97.00 09500 MBULANCE SERVI CES 4,747,964 4,747,964 0 4,747,964 96,4332 964,33	67. 00	1 1	0	0	1			1
69. 00 06900 ELECTROCARDI OLOGY 3, 495, 048 3, 495, 048 0 3, 495, 048 69. 00 70. 00 07000 ELECTROCEPHALOGRAPHY 2, 708, 768 2, 708, 768 0 2, 708, 768 70. 00 70. 00 70. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 24, 503, 049 24, 503, 049 0 24, 503, 049 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 27, 296, 369 27, 296, 369 0 27, 296, 369 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 42, 782, 921 42, 782, 921 0 42, 782, 921 73. 00 74. 00 07400 RENAL DI ALYSIS 3, 044, 186 3, 044, 186 0 3, 044, 186 74. 00 76. 00 03140 CARDI O CATH LAB 5, 921, 720 5, 921, 720 0 5, 921, 720 0 5, 921, 720 0 5, 921, 720 0 5, 921, 720 0 5, 921, 720 0 76. 00 76. 01 03050 ENDOSCOPY 7, 927, 673 7, 927, 673 7, 927, 673 7, 927, 673 7, 927, 673 76. 01 76. 02 03051 CARDI AC REHAB 721, 954 721, 954 721, 954 721, 954 721, 954 76. 02 0000 0000 EMERGENCY 10, 055, 002 10, 055, 002 0 10, 055, 002 91. 00 09100 EMERGENCY 10, 055, 002 10, 055, 002 0 10, 055, 002 91. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 628, 657 628, 657 076, 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0			0	0	0	0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 708, 768 2, 708, 768 0 2, 708, 768 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 24, 503, 049 24, 503, 049 0 24, 503, 049 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 27, 296, 369 27, 296, 369 0 27, 296, 369 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 42, 782, 921 42, 782, 921 0 42, 782, 921 73. 00 74. 00 07400 RENAL DIALYSIS 3, 044, 186 3, 044, 186 0 3, 044, 186 74. 00 76. 00 03140 CARDI 0 CATH LAB 5, 921, 720 5, 921, 720 0 5, 921, 720 76. 00 76. 01 03050 ENDOSCOPY 7, 927, 673 7, 927, 673 0 7, 927, 673 7. 927, 673 7. 927, 673 7. 927, 673 7. 927, 673 7. 927, 673 7. 927, 954 7. 00 79. 00 09000 CLINIC 6, 361, 780 6, 361, 780 0 6, 361, 780 90. 00 791. 00 09100 EMERGENCY 10, 055, 002 10, 055, 002 10, 055, 002 91. 00 792. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 628, 657 628, 657 628, 657 628, 657 795. 00 09400 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 79ECI AL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 2, 147, 182 2, 147, 182 2, 147, 182 0, 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3, 495, 048	_				
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 24, 503, 049 24, 503, 049 0 24, 503, 049 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 27, 296, 369 27, 296, 369 0 27, 296, 369 72. 00 73. 00 70. 00 07400 RENAL DI ALYSI S 3, 044, 186 3, 044, 186 0		07000 FLECTROENCEPHALOGRAPHY						
72. 00								
73. 00 07300 DRUGS CHARGED TO PATIENTS								
74. 00 07400 RENAL DIALYSIS 3, 044, 186 3, 044, 186 0 3, 044, 186 74. 00 76. 00 03140 CARDIO CATH LAB 5, 921, 720 5, 921, 720 0 5, 921, 720 76. 00 76. 00 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 673 77. 927, 927, 927, 927, 927, 927, 927, 927,								
76. 00						0		
76. 01 03050 ENDOSCOPY 7, 927, 673 7, 927, 673 76. 01 76. 02 03051 CARDI AC REHAB 721, 954 721, 954 0 721, 954 76. 02 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 6, 361, 780 0 6, 361, 780 0 10, 055, 002 10, 055, 002 10, 055, 002 10, 055, 002 91. 00 91. 00 09100 EMERGENCY 10, 055, 002 10, 055, 002 10, 055, 002 10, 055, 002 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 628, 657 628, 657 628, 657 628, 657 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 4, 747, 964 4, 747, 964 0 4, 747, 964 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 96. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 964, 332 964, 332 106. 00 200. 00 Subtotal (see instructions) 321, 262, 545 0 321, 262, 545 200. 00 201. 00 Less Observation Beds 628, 657 628, 657 628, 657 201. 00								
76. 02 03051 CARDI AC REHAB 721, 954 76. 02 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 6, 361, 780 6, 361, 780 0 10, 055, 002 10, 055, 002 0								
OUTPATIENT SERVICE COST CENTERS 90.00 O9000 CLINI C CLIN		1 1						1
90. 00				l		-1		
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 628, 657 628, 657 628, 657 92. 00	90.00		6, 361, 780		6, 361, 780	0	6, 361, 780	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 628, 657 628, 657 628, 657 92. 00	91.00	09100 EMERGENCY	10, 055, 002		10, 055, 002	0	10, 055, 002	91.00
OTHER REIMBURSABLE COST CENTERS 4,747,964 4,747,964 0 4,747,964 95.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	628, 657				628, 657	92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00				•	·			1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00	95.00	09500 AMBULANCE SERVICES	4, 747, 964		4, 747, 964	0	4, 747, 964	95. 00
SPECIAL PURPOSE COST CENTERS	96.00	09600 DURABLE MEDICAL EQUIP-RENTED			0	0	0	96. 00
106. 00 10600 HEART ACQUI SI TI ON 964, 332 <		SPECIAL PURPOSE COST CENTERS						1
200. 00 Subtotal (see instructions) 321, 262, 545 0 321, 262, 545 0 321, 262, 545 200. 00 201. 00 Less Observation Beds 628, 657 0 628, 657	105.00		2, 147, 182		2, 147, 182		2, 147, 182	105. 00
201.00 Less Observation Beds 628,657 628,657 628,657 628,657			964, 332		964, 332			
	200.00	Subtotal (see instructions)	321, 262, 545	0	321, 262, 545	0		
202.00 Total (see instructions) 320,633,888 0 320,633,888 0 320,633,888 0 320,633,888	201.00	Less Observation Beds	628, 657		628, 657			
	202.00	Total (see instructions)	320, 633, 888	0	320, 633, 888	0	320, 633, 888	202. 00

Provider CCN: 150017

					12/1/2014 9:5	<u>5 am </u>	
				e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
		·		+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	84, 850, 577		84, 850, 57	7		30.00
31.00	03100 INTENSIVE CARE UNIT	O			ol		31.00
	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 394, 923		2, 394, 92	3		31. 01
	02060 NEONATAL INTENSIVE CARE UNIT	14, 166, 369		14, 166, 36			31. 02
4	03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705		64, 441, 70			31. 03
	03200 CORONARY CARE UNIT	24, 974, 258		24, 974, 25			32. 00
	04000 SUBPROVI DER - I PF	0			0		40.00
	04300 NURSERY	1, 685, 765		1, 685, 76	-		43. 00
	ANCI LLARY SERVI CE COST CENTERS	1,003,703		1,003,70	<u> </u>		43.00
50.00	D5000 OPERATING ROOM	202, 290, 538	158, 780, 701	361, 071, 23	9 0. 111033	0. 000000	50.00
	05100 RECOVERY ROOM	202, 240, 538	138, 780, 701	1	0. 111033		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 939, 038	55, 896	1			
	05300 ANESTHESI OLOGY						
		25, 229, 613	16, 911, 517				
	05400 RADI OLOGY-DI AGNOSTI C	35, 671, 817	54, 928, 006			0.000000	1
	05401 PET SCAN	182, 489	5, 552, 975				1
	D5600 RADI OI SOTOPE	5, 306, 125	23, 614, 824				
	05700 CT SCAN	30, 286, 909	43, 469, 529				1
	05800 MRI	0	0	l .	0. 000000		
	06000 LABORATORY	96, 118, 328	67, 692, 664			0. 000000	
	06500 RESPI RATORY THERAPY	50, 488, 396	2, 580, 241				
	06600 PHYSI CAL THERAPY	10, 912, 535	6, 815, 531	17, 728, 06		0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0		0. 000000		
	06800 SPEECH PATHOLOGY	0	0		0. 000000	0.000000	68. 00
	06900 ELECTROCARDI OLOGY	26, 017, 305	34, 947, 464	60, 964, 76	9 0. 057329	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 109, 368	7, 548, 300	8, 657, 66	8 0. 312875	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	65, 412, 497	32, 631, 123	98, 043, 62	0. 249920	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	130, 175, 126	72, 607, 970	202, 783, 09	6 0. 134609	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	225, 667, 210	98, 098, 644	323, 765, 85	4 0. 132142	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	8, 913, 747	184, 430	9, 098, 17	7 0. 334593	0.000000	74.00
	03140 CARDIO CATH LAB	38, 408, 622	38, 653, 941	77, 062, 56	3 0. 076843	0.000000	76. 00
76. 01	03050 ENDOSCOPY	8, 353, 798	40, 658, 770			0.000000	76. 01
4	03051 CARDI AC REHAB	2, 709, 062	735, 735				
	DUTPATIENT SERVICE COST CENTERS				.,	2. 22222	1
	09000 CLI NI C	343, 767	2, 830, 137	3, 173, 90	4 2.004402	0.000000	90. 00
	09100 EMERGENCY	27, 583, 754	60, 266, 816				1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 421, 100	10, 534, 901				1
	OTHER REIMBURSABLE COST CENTERS	2, 421, 100	10, 334, 701	12, 750, 00	0.040322	0.000000	72.00
	09500 AMBULANCE SERVI CES	5, 444	6, 827, 564	6, 833, 00	8 0. 694857	0.000000	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	3, 444	0, 827, 304		0. 000000		
-		<u> </u>	U		0.00000	0.00000	96.00
	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	1 500 005		1 500 00	E		105 00
		1, 500, 085	0				105. 00
	10600 HEART ACQUISITION	3, 110, 700	704 027 470			1	106. 00
200.00	Subtotal (see instructions)	1, 197, 670, 970	186, 921, 619	1, 984, 598, 64	9		200.00
201.00	Less Observation Beds	1 107 /70 070	70/ 007 /70	1 004 500			201. 00
202. 00	Total (see instructions)	1, 197, 670, 970	186, 921, 6/9	1, 984, 598, 64	9	ĺ	202. 00

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA		In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Pı	Provider CCN:	150017	From 07/01/2013	Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am
		Title XVI	H	Hosni tal	PPS

					12/1/2014 9:5	5 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
<u>[</u>	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT					31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT					31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT					31. 03
32.00	03200 CORONARY CARE UNIT					32. 00
	04000 SUBPROVIDER - IPF					40.00
	04300 NURSERY					43. 00
	ANCI LLARY SERVI CE COST CENTERS					10.00
-	05000 OPERATING ROOM	0. 111033				50. 00
1	05100 RECOVERY ROOM	0. 000000				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 285774				52.00
	05300 ANESTHESI OLOGY	0. 283774				53. 00
		1				
1	05400 RADI OLOGY-DI AGNOSTI C	0. 130531				54.00
1	05401 PET SCAN	0. 190025				54. 01
	05600 RADI OI SOTOPE	0. 088053				56. 00
	05700 CT SCAN	0. 028829				57. 00
1	05800 MRI	0. 000000				58. 00
1	06000 LABORATORY	0. 135801				60. 00
1	06500 RESPI RATORY THERAPY	0. 137813				65. 00
1	06600 PHYSI CAL THERAPY	0. 332711				66. 00
1	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
1	06800 SPEECH PATHOLOGY	0. 000000				68. 00
	06900 ELECTROCARDI OLOGY	0. 057329				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 312875				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 249920				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 134609				72. 00
73.00	07300 DRUGS CHARGED TO PATLENTS	0. 132142				73. 00
74.00	07400 RENAL DIALYSIS	0. 334593				74.00
76. 00	03140 CARDIO CATH LAB	0. 076843				76. 00
76. 01	03050 ENDOSCOPY	0. 161748				76. 01
76. 02	03051 CARDI AC REHAB	0. 209578				76. 02
	OUTPATIENT SERVICE COST CENTERS	<u> </u>				
	09000 CLI NI C	2. 004402				90. 00
91. 00	09100 EMERGENCY	0. 114456				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 048522				92. 00
	OTHER REIMBURSABLE COST CENTERS	,,				
	09500 AMBULANCE SERVICES	0. 694857				95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
	SPECIAL PURPOSE COST CENTERS	0.000000				70.00
	10500 KIDNEY ACQUISITION					105. 00
	10600 HEART ACQUISITION					106. 00
200.00	Subtotal (see instructions)					200. 00
1	1					200.00
201.00	Less Observation Beds					201.00
202. 00	Total (see instructions)					ZUZ. UU

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	1	Period: From 07/01/2013 Fo 06/30/2014		
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	43, 880, 713		43, 880, 713	3 0	43, 880, 713	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0	0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249		1, 710, 249	9 0	1, 710, 249	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	5, 225, 994		5, 225, 994	4 O	5, 225, 994	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	22, 599, 399		22, 599, 399	9 0	22, 599, 399	31. 03
32. 00 03200 CORONARY CARE UNIT	8, 155, 565		8, 155, 56!	5 0	8, 155, 565	32.00
40. 00 04000 SUBPROVI DER - I PF	0			0	0	40.00
43. 00 04300 NURSERY	643, 138		643, 138	3 0	643, 138	43.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am Provider CCN: 150017 Peri od: From 07/01/2013 To 06/30/2014 014 .. Cost Title XIX Hospi tal Charges

		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		•	+ col. 7)	Ratio	Inpati ent	
			_		Rati o	
	6.00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	84, 850, 577		84, 850, 577			30. 00
31. 00 03100 INTENSIVE CARE UNIT	0		0			31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	2, 394, 923		2, 394, 923			31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	14, 166, 369		14, 166, 369			31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	64, 441, 705		64, 441, 705			31. 02
	1					
32. 00 03200 CORONARY CARE UNIT	24, 974, 258		24, 974, 258			32.00
40. 00 04000 SUBPROVI DER - PF	0		0			40.00
43. 00 04300 NURSERY	1, 685, 765		1, 685, 765			43. 00
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	202, 290, 538	158, 780, 701	361, 071, 239		0. 000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0. 000000	0.000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 939, 038	55, 896			0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	25, 229, 613	16, 911, 517	42, 141, 130	0. 014348	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	35, 671, 817	54, 928, 006	90, 599, 823	0. 130531	0.000000	54.00
54. 01 05401 PET SCAN	182, 489	5, 552, 975	5, 735, 464	0. 190025	0.000000	54. 01
56. 00 05600 RADI 0I SOTOPE	5, 306, 125	23, 614, 824	28, 920, 949	0. 088053	0.000000	56.00
57. 00 05700 CT SCAN	30, 286, 909	43, 469, 529	73, 756, 438	0. 028829	0.000000	57.00
58. 00 05800 MRI	O	0	C	0.000000	0.000000	58. 00
60. 00 06000 LABORATORY	96, 118, 328	67, 692, 664	163, 810, 992	0. 135801	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	50, 488, 396	2, 580, 241			0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	10, 912, 535	6, 815, 531			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	1		0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	26, 017, 305	34, 947, 464	1		0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 109, 368	7, 548, 300			0. 000000	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	65, 412, 497	32, 631, 123			0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	130, 175, 126	72, 607, 970			0. 000000	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS					0. 000000	73. 00
	225, 667, 210	98, 098, 644				
74. 00 07400 RENAL DI ALYSI S	8, 913, 747	184, 430			0.000000	74.00
76. 00 03140 CARDI 0 CATH LAB	38, 408, 622	38, 653, 941			0.000000	76. 00
76. 01 03050 ENDOSCOPY	8, 353, 798	40, 658, 770			0.000000	76. 01
76. 02 03051 CARDI AC REHAB	2, 709, 062	735, 735	3, 444, 797	0. 209578	0. 000000	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	343, 767	2, 830, 137			0. 000000	90. 00
91. 00 09100 EMERGENCY	27, 583, 754	60, 266, 816		I	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 421, 100	10, 534, 901	12, 956, 001	0. 048522	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS			,			
95. 00 09500 AMBULANCE SERVICES	5, 444	6, 827, 564	6, 833, 008		0.000000	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0.000000	0.000000	96. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	1, 500, 085	0	1, 500, 085			105.00
106.00 10600 HEART ACQUISITION	3, 110, 700	0	3, 110, 700			106. 00
200.00 Subtotal (see instructions)	1, 197, 670, 970	786, 927, 679	1, 984, 598, 649			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	1, 197, 670, 970	786, 927, 679	1, 984, 598, 649			202. 00
	•		•	•		

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15001	From 07/01/2013	Worksheet C Part I Date/Time Prepared: 12/1/2014 9:55 am
			_

				12/1/2014 9:55 ar	am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	-				
30. 00 03000 ADULTS & PEDIATRICS					0. 00
31.00 03100 INTENSIVE CARE UNIT					1. 00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT				31	1. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT				31	1. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT				31	1. 03
32. 00 03200 CORONARY CARE UNIT				32	2. 00
40. 00 04000 SUBPROVI DER - I PF				40	0. 00
43. 00 04300 NURSERY				43	3.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 000000			50	0. 00
51.00 05100 RECOVERY ROOM	0. 000000			51	1. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52	2. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53	3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	4. 00
54. 01 05401 PET SCAN	0. 000000				4. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000				6. 00
57. 00 05700 CT SCAN	0. 000000			•	7. 00
58. 00 05800 MRI	0. 000000				8. 00
60. 00 06000 LABORATORY	0. 000000				0. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			•	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			1	7. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			1	8. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				0. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				1. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				3. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000				4. 00
76. 00 03140 CARDI O CATH LAB	0. 000000				6. 00
76. 01 03050 ENDOSCOPY	0. 000000				6. 01
76. 02 03051 CARDI AC REHAB	0. 000000				6. 02
OUTPATIENT SERVICE COST CENTERS	0. 000000			/0	0. 02
90. 00 09000 CLINIC	0. 000000			90	0. 00
91. 00 09100 EMERGENCY	0. 000000				1. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				2. 00
OTHER REIMBURSABLE COST CENTERS	0. 000000			72	2.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			05	5. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			l	6. 00
SPECIAL PURPOSE COST CENTERS	0.00000			70	0. 00
105. 00 10500 KIDNEY ACQUISITION				105	5. 00
106. 00 10600 HEART ACQUISITION					6. 00
200.00 Subtotal (see instructions)					0. 00
201. 00 Less Observation Beds				•	1. 00
202.00 Total (see instructions)					2. 00
202.00 10101 (366 111311 0011 0113)	ı I			1202	2.00

Heelth Financial Systems	LUTUEDAN HOCDIT	TAL OF INDIANA		lm lie	of Form CMC	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	LUTHERAN HOSPIT COSTS		CCN: 150017	Period: From 07/01/2013 To 06/30/2014		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost (col. 1 - col 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	•			
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 31.01 PEDIATRIC INTENSIVE CARE UNIT 31.02 NEONATAL INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 40.00 SUBPROVIDER - IPF 43.00 NURSERY 200.00 Total (lines 30-199) Cost Center Description	7,886,138 0 214,791 663,832 2,255,162 823,282 0 54,802 11,898,007 Inpatient Program days	Inpatient Program Capital Cost	214, 79 663, 83 2, 255, 16 823, 28	0 0 0 01 906 12 4, 545 12 28, 006 12 7, 206 0 0	0. 00 237. 08 146. 06 80. 52 114. 25 0. 00 27. 83	31. 00 31. 01 31. 02 31. 03 32. 00 40. 00
		(col. 5 x col. 6)				
	6.00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 31. 01 PEDIATRIC INTENSIVE CARE UNIT 31. 02 NEONATAL INTENSIVE CARE UNIT 31. 03 CARDIO INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 40. 00 SUBPROVIDER - IPF 43. 00 NURSERY	20, 460 0 0 7, 379 2, 442 0	0 0 0 594, 157 278, 999 0 0				30. 00 31. 00 31. 01 31. 02 31. 03 32. 00 40. 00 43. 00
200.00 Total (lines 30-199)	30, 281	3, 947, 066	1			200. 00

		LUTHERAN HOSPIT				u of Form CMS-2	2552-10
APPOR1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Pre 12/1/2014 9:5	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges		I npati ent	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOLILARY OF BUILD OF SOME OF STATERS	1.00	2.00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.000.100	2/1 071 220	0.00470	7 (4 520 2/2	1 505 040	F0 00
		8, 928, 133					50. 00 51. 00
		0	ļ			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	49, 926				213	52.00
53.00	05300 ANESTHESI OLOGY	33, 459					53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 368, 653		1			
54. 01	05401 PET SCAN	636, 468				•	
56. 00	05600 RADI OI SOTOPE	204, 038				•	
57. 00	05700 CT SCAN	193, 498	73, 756, 438				57. 00
58. 00	05800 MRI	0	0	0.00000		0	58. 00
	06000 LABORATORY	1, 842, 748					60.00
65. 00	06500 RESPI RATORY THERAPY	605, 133					
	06600 PHYSI CAL THERAPY	746, 450	17, 728, 066				
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0. 00000		0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0.00000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	861, 843		•			
	07000 ELECTROENCEPHALOGRAPHY	614, 115					
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	728, 206		•		•	
	07200 I MPL. DEV. CHARGED TO PATIENTS	856, 107					
	07300 DRUGS CHARGED TO PATIENTS	1, 319, 449					
74.00	07400 RENAL DIALYSIS	321, 941		•			
76. 00		1, 799, 228					76. 00
76. 01	03050 ENDOSCOPY	954, 383					
76. 02	03051 CARDI AC REHAB	49, 823	3, 444, 797	0. 01446	3 1, 008, 723	14, 589	76. 02
	OUTPATIENT SERVICE COST CENTERS						
$\Omega \Omega = \Omega \Omega$	00000 CLINIC	920 660	2 172 004	0 25056	0 102 560	EU U10	

820, 669

0 25, 328, 872 1, 780, 641, 259

1, 281, 621 112, 981

3, 173, 904 87, 850, 570 12, 956, 001

0. 258568

0. 014589

0.008720

0.000000

50, 048

110, 666 12, 507

0 4, 178, 492 200. 00

193, 560

7, 585, 545 1, 434, 240

0 320, 746, 192

90.00

91.00

92. 00

95.00

96.00

90.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED 200. 00 | Total (lines 50-199)

91. 00 09100 EMERGENCY

Heal th Financial	Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2552-10

Health Financial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS		<u> </u>	Period: From 07/01/2013 Fo 06/30/2014	Worksheet D Part III Date/Time Pre 12/1/2014 9:5	pared: 5 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	435, 119	'	0	435, 119	30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	0	(0	31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	2, 250			2, 250	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	0	10, 126			10, 126	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	0	42, 530	1		42, 530	31. 03
32. 00 03200 CORONARY CARE UNIT	0	21, 377			21, 377	32. 00
40. 00 04000 SUBPROVI DER - PF	0	0	(0	0	40. 00
43. 00 04300 NURSERY	0	0	(0	43.00
200. 00 Total (lines 30-199)	0	511, 402)	511, 402	200.00
Cost Center Description		Per Diem (col.	Inpatient	I npati ent		
	Days	5 ÷ col . 6)	Program Days	Program		
				Pass-Through Cost (col. 7 x		
				cost (cor. / x		
	6, 00	7.00	8. 00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS	52, 490	8. 29	20, 460	169, 613		30.00
31. 00 03100 I NTENSI VE CARE UNI T	02,170	l .		0 .07,0.0		31.00
31. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T	906			0		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	4, 545			0		31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	28, 006	1		11, 216		31. 03
32, 00 03200 CORONARY CARE UNIT	7, 206					32. 00
40. 00 04000 SUBPROVI DER - PF	0	l .		0		40.00
43. 00 04300 NURSERY	1, 969			ol o		43. 00
200.00 Total (lines 30-199)	95, 122		30, 28°	1 188, 082		200. 00
·						

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS P		Peri od: From 07/01/2013	Worksheet D Part IV
TINOUGH COSTS				Date/Time Prepared: 12/1/2014 9:55 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	Non Physician Nursing		h All Other	Total Cost

				1	0 06/30/2014	12/1/2014 9:5	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	9	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			45.033		45.033	
	O5000 OPERATING ROOM	0	0	15, 977	0	15, 977	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	05401 PET SCAN	0	0	0	0	0	54. 01
	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
	05700 CT SCAN	0	0	0	0	0	57. 00
	D5800 MRI D6000 LABORATORY	0	0	0	0	0	58. 00
	D6500 RESPI RATORY THERAPY	0	0	0	0	0	60. 00 65. 00
	06600 PHYSI CAL THERAPY	0	0	0	0	0	
1	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	66. 00 67. 00
	06800 SPEECH PATHOLOGY		0	0	0	0	68. 00
	06900 SPEECH PATHOLOGY	0	0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS		0	248, 770	0	248, 770	1
	07400 RENAL DIALYSIS		0	240,770	0	240,770	74.00
	03140 CARDIO CATH LAB		0	4, 501	0	4, 501	76.00
	03050 ENDOSCOPY		0	1, 551	0	0	76. 01
	03051 CARDI AC REHAB	0	0	0	0	0	76. 02
H-	DUTPATIENT SERVICE COST CENTERS	-1	-	-			
	09000 CLI NI C	0	0	29, 253	0	29, 253	90.00
91.00	09100 EMERGENCY	o	0	1		26, 328	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	6, 234	0	6, 234	92.00
(OTHER REIMBURSABLE COST CENTERS			<u> </u>			
	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
200.00	Total (lines 50-199)	0	0	331, 063	0	331, 063	200. 00

Health Financial Systems	LUTHERAN HOSPIT				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2013 To 06/30/2014	Part IV Date/Time Pre	nared:
				10 00/30/2014	12/1/2014 9:5	5 am
	_	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCI LLARY SERVI CE COST CENTERS			1	.1		
50. 00 05000 OPERATI NG ROOM	15, 977	361, 071, 239			64, 538, 362	
51. 00 05100 RECOVERY ROOM	0	0	1 0.00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	6, 994, 934		I	29, 897	52.00
53. 00 05300 ANESTHESI OLOGY	0	42, 141, 130			7, 717, 208	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	90, 599, 823		I	12, 580, 666	
54. 01 05401 PET SCAN	0	5, 735, 464			41, 709	54. 01
56. 00 05600 RADI OI SOTOPE	0	28, 920, 949			1, 962, 080	
57. 00 05700 CT SCAN	0	73, 756, 438		I	10, 048, 452	
58. 00 05800 MRI	0	0	0.000000		0	58. 00
60. 00 06000 LABORATORY	0	163, 810, 992		I	33, 256, 676	60.00
65. 00 06500 RESPI RATORY THERAPY	0	53, 068, 637			16, 534, 340	
66. 00 06600 PHYSI CAL THERAPY	0	17, 728, 066			4, 342, 602	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.000000	I	0	
68. 00 06800 SPEECH PATHOLOGY	0	0	0.000000	I	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	60, 964, 769			9, 872, 637	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	8, 657, 668		I .	326, 151	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	98, 043, 620		I .	20, 560, 285	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	202, 783, 096	•		39, 776, 376	
73. 00 07300 DRUGS CHARGED TO PATIENTS	248, 770			I .	69, 454, 688	
74. 00 07400 RENAL DI ALYSI S	0	9, 098, 177			4, 996, 200	
76. 00 03140 CARDI O CATH LAB	4, 501	77, 062, 563			11, 363, 079	
76. 01 03050 ENDOSCOPY	0	49, 012, 568			3, 122, 716	
76. 02 03051 CARDI AC REHAB	0	3, 444, 797	0. 000000	0.000000	1, 008, 723	76. 02
OUTPATIENT SERVICE COST CENTERS	20 252	2 172 004	0.00021	7 0 000217	102 560	

29, 253

26, 328 6, 234

3, 173, 904

87, 850, 570 12, 956, 001

0 331, 063 1, 780, 641, 259

0.009217

0.000300

0. 000481

0.000000

0.009217

0.000300

0. 000481

0.000000

193, 560

7, 585, 545 1, 434, 240

90.00

91.00

92.00

95.00

96.00

0 320, 746, 192 200. 00

90.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED 200. 00 | Total (lines 50-199)

91. 00 09100 EMERGENCY

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150017	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared:

					12/1/2014 9:	55 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 840	36, 725, 838	1, 616			50. 00
51.00 05100 RECOVERY ROOM	0	0	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	3, 257, 491	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	13, 160, 609	0			54.00
54. 01 05401 PET SCAN	0	1, 210, 328	0			54. 01
56. 00 05600 RADI 0I SOTOPE	0	6, 432, 293	0			56. 00
57. 00 05700 CT SCAN	0	9, 882, 044	0			57. 00
58. 00 05800 MRI	0	0	0			58. 00
60. 00 06000 LABORATORY	0	5, 712, 533	0			60. 00
65. 00 06500 RESPIRATORY THERAPY	0	520, 592	2 0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	122, 264	. 0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	O	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	9, 232, 650	0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	O	1, 369, 025	0			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	7, 328, 947	· 0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	21, 780, 123	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	53, 341	21, 858, 100	16, 787			73. 00
74.00 07400 RENAL DIALYSIS	o	167, 526	0			74. 00
76.00 03140 CARDIO CATH LAB	659	11, 570, 738	671			76. 00
76. 01 03050 ENDOSCOPY	O	9, 570, 731	0			76. 01
76. 02 03051 CARDI AC REHAB	O	197, 851	0			76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 784	434, 544	4, 005			90.00
91. 00 09100 EMERGENCY	2, 276	10, 982, 563				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	690	1, 997, 510	961			92.00
OTHER REIMBURSABLE COST CENTERS			•	ı.		
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	l	0	0			96. 00
200.00 Total (lines 50-199)	61, 590	173, 514, 300	27, 335			200. 00

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150017	Peri od: From 07/01/2013	Worksheet D

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111033 36, 725, 838 4, 077, 780 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 285774 0 52 00 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.014348 3, 257, 491 46, 738 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 130531 13, 160, 609 0 1, 717, 867 54.00 1, 210, 328 54.01 05401 PET SCAN 0.190025 0 0 229, 993 54.01 05600 RADI OI SOTOPE 0.088053 0 56.00 6, 432, 293 566, 383 56.00 57.00 05700 CT SCAN 0.028829 9, 882, 044 0 284, 889 57.00 05800 MRI 58.00 0.000000 0 0 58.00 0 06000 LABORATORY 5, 712, 533 775, 768 0 135801 12, 746 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 0.137813 520, 592 0 71, 744 65.00 06600 PHYSI CAL THERAPY 0. 332711 122, 264 0 40, 679 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.057329 9, 232, 650 0 0 529, 299 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 312875 1, 369, 025 0 428, 334 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 249920 7, 328, 947 0 0 1, 831, 650 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72 00 0.134609 21, 780, 123 2, 931, 801 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 132142 21, 858, 100 137, 299 2, 888, 373 73.00 07400 RENAL DIALYSIS 0 74.00 0.334593 167, 526 0 56,053 74.00 03140 CARDIO CATH LAB 0 76.00 0.076843 11, 570, 738 889, 130 76.00 0 0 03050 ENDOSCOPY 76.01 0. 161748 9, 570, 731 0 1, 548, 047 76.01 03051 CARDI AC REHAB 0. 209578 197, 851 0 41, 465 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2.004402 434, 544 871,001 90.00 0 0 91.00 09100 EMERGENCY 0. 114456 10, 982, 563 0 1, 257, 020 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.048522 1, 997, 510 96, 923 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 694857 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 200.00 Subtotal (see instructions) 173, 514, 300 12, 746 137, 299 21, 180, 937 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 173, 514, 300 12, 746 137, 299 21, 180, 937 202. 00

Health Financial Systems	LUTHERAN HOSPI TAL	OF INDIANA	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150017	Peri od: From 07/01/2013	Worksheet D Part V

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54. 01 05401 PET SCAN 54.01 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 0 0 58.00 58.00 06000 LABORATORY 60 00 60 00 1.731 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 0 0 0 0 0 0 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 143 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 03140 CARDIO CATH LAB 76.00 0 76.00 03050 ENDOSCOPY 76.01 76.01 0 76.02 03051 CARDI AC REHAB 0 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 09100 EMERGENCY 0 91.00 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 200.00 200. 00 Subtotal (see instructions) 1,731 18, 143 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 202.00 1,731 18, 143 202.00

Health Financial Systems	I NDI ANA	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150017	Peri od:	Worksheet D

From 07/01/2013 Part V To 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111033 5, 366, 800 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 285774 52 00 0 3, 387 52 00 0 05300 ANESTHESI OLOGY 53.00 0.014348 0 599, 778 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 130531 2, 111, 953 0 54.00 54.01 05401 PET SCAN 0.190025 0 472, 869 54.01 0 05600 RADI OI SOTOPE 0.088053 56.00 473, 199 0 56.00 57.00 05700 CT SCAN 0.028829 1, 793, 997 0 57.00 05800 MRI 58.00 0.000000 0 58.00 06000 LABORATORY 0 135801 3, 021, 471 60 00 60 00 0 65.00 06500 RESPIRATORY THERAPY 0.137813 158, 505 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 332711 637, 962 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.057329 808, 863 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 312875 306, 531 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 249920 1, 108, 562 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 134609 2, 829, 860 72.00 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 132142 7, 191, 255 0 73.00 07400 RENAL DIALYSIS 9, 386 74.00 74.00 0.334593 0 03140 CARDIO CATH LAB 0 76.00 0.076843 924, 252 0 76.00 03050 ENDOSCOPY Ω 76.01 0. 161748 1, 003, 789 Ω 76.01 03051 CARDI AC REHAB 0. 209578 17, 566 0 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 2.004402 90.00 09000 CLINIC 148, 203 0 0 0 91.00 09100 EMERGENCY 0. 114456 0 3, 452, 946 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.048522 531, 816 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0. 694857 95.00 09500 AMBULANCE SERVICES 95.00 0 514, 952 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 C 0 0 96.00 0 0 200.00 200.00 Subtotal (see instructions) 0 33, 487, 902 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 0 202. 00 202.00 0 33, 487, 902 0

Health Financial Systems	LUTHERAN HOSPITAL OF	F INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150017	Peri od: From 07/01/2013	Worksheet D Part V

06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 595, 892 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 968 0 52.00 05300 ANESTHESI OLOGY 0 53.00 8,606 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 275, 675 54.00 0 54. 01 05401 PET SCAN 89.857 54.01 05600 RADI OI SOTOPE 0 56.00 41, 667 56.00 57.00 05700 CT SCAN 51, 719 0 57.00 05800 MRI 0 58.00 58.00 0 06000 LABORATORY 410. 319 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 21,844 65.00 66.00 06600 PHYSI CAL THERAPY 212, 257 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 Ol 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 46, 371 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 95, 906 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 277, 052 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 380, 925 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 950, 267 0 73.00 74.00 07400 RENAL DIALYSIS 3, 140 0 74.00 03140 CARDIO CATH LAB 0 76.00 71.022 76.00 03050 ENDOSCOPY 0 76.01 162, 361 76.01 76.02 03051 CARDI AC REHAB 3,681 0 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 297, 058 90.00 0 09100 EMERGENCY 91.00 395, 210 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 25, 805 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 357, 818 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 200.00 0 200. 00 Subtotal (see instructions) 4, 775, 420 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 202.00 4, 775, 420 0 202.00

Health Financial Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150017	Peri od: From 07/01/2013	Worksheet D-1	
			To 06/30/2014	Date/Time Prep 12/1/2014 9:5	pared: 5 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)					1. 00
2.00 Inpatient days (including private room days	, excluding swing-bed	and newborn days)		52, 490	2. 00

	Cost Center Description	113	
	cost center bescription	1. 00	
	PART I - ALL PROVIDER COMPONENTS	11.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	52, 490	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	52, 490	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		l
4.00	Semi-private room days (excluding swing-bed and observation bed days)	51, 738	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7 00
7. 00	reporting period	۷	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	20, 460	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		l
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	υĮ	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)		13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	ő	
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		l
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	1
21. 00	Total general inpatient routine service cost (see instructions)	43, 880, 713	21. 00
22. 00	Swing-Ded cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
04.00	x line 18)		04.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	٠Į	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	In line 20)	ĭ	25.00
26. 00	Total swing-bed cost (see instructions)	o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	43, 880, 713	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		l
	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28. 00
	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	43, 880, 713	
200	27 minus line 36)	, 500, , 10	1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		I
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		I
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	835. 98	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	17, 104, 151	•
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	17, 104, 151	41.00

33.00	Average per dreii private room cost dirrerential (irrie 54 x irrie 51)	0.00	33.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	43, 880, 713	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	835. 98	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	17, 104, 151	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	17, 104, 151	41.00

IVII U I	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150017	Peri od:	Worksheet D-1	2552
					From 07/01/2013 To 06/30/2014	Date/Time Pre	
			Ti tl	e XVIII	Hospi tal	12/1/2014 9: 5 PPS	5 an
	Cost Center Description	Total Inpatient Cost	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42
. 00	Intensive Care Type Inpatient Hospital Units			0.0	,0 0		72
. 00	INTENSIVE CARE UNIT	0	0	0.0	00 0	0	43
. 01	PEDIATRIC INTENSIVE CARE UNIT	1, 710, 249				0	
. 02	NEONATAL INTENSIVE CARE UNIT	5, 225, 994				0	43
. 03	4	22, 599, 399					
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	8, 155, 565	7, 206	1, 131. 7	2, 442	2, 763, 782	44
. 00	SURGICAL INTENSIVE CARE UNIT						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00	10					1. 00	10
00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			ine)		42, 563, 212 68, 385, 629	
00	PASS THROUGH COST ADJUSTMENTS	+1 till ough +0) (See mistractive	113)		00, 303, 027	7/
00	Pass through costs applicable to Program in	patient routine	services (from	Wkst. D, sum	of Parts I and	4, 135, 148	50
. 00	Pass through costs applicable to Program in and IV)	patient ancillar	ry services (fr	om Wkst. D, s	sum of Parts II	4, 240, 082	51
. 00	Total Program excludable cost (sum of lines	50 and 51)				8, 375, 230	52
. 00	Total Program inpatient operating cost excl		lated, non-phy	sician anesth	etist, and	60, 010, 399	
	medical education costs (line 49 minus line	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION						١.,
. 00	Program discharges Target amount per discharge					0 0. 00	
. 00	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient opera	ting cost and ta	rget amount (I	ine 56 minus	line 53)	ő	1
00	Bonus payment (see instructions)	3	,		,	0	58
. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, ι	pdated and co	empounded by the	0.00	59
00	market basket	anat manamt um	datad by the	المعاممة المعامم		0.00	1,0
. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. 00 0	
. 00	which operating costs (line 53) are less that						"
	amount (line 56), otherwise enter zero (see instructions)						
. 00							62
. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST					0	63
. 00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	cost reporti	ng period (See	0	64
	instructions)(title XVIII only)				5 (
. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65
00	instructions)(title XVIII only)			E) (11 11 10 11 1			١,,
. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line	64 plus line 6	5)(title XVII	I only). For	0	66
. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 c	f the cost re	portina period	0	67
	(line 12 x line 19)				5 1		
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repo	rting period	0	68
00	(line 13 x line 20)	routing costs (lino 47 : lino	40)		_	40
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER I					0	69
. 00	Skilled nursing facility/other nursing faci		·				70
. 00	Adjusted general inpatient routine service						71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost applicated program general impatient routing company						73
. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient		,		Part II column		74
. 00	26, line 45)	TOURTHE SELVICE	, costs (110III W	or Koricet D, P	art ii, corumii		'
. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76
. 00	Program capital -related costs (line 9 x line						77
00	, ,		unavil dare ::	5)			78
00	Aggregate charges to beneficiaries for excellator and program routine service costs for com			*	us line 70)		80
00	Inpatient routine service costs for com		Timi tati Ui	(1110 /0 11111	11110 77)		81
	Inpatient routine service cost limitation ()				82
. 00	Reasonable inpatient routine service costs	•	ıs)				83
. 00	Program inpatient ancillary services (see i						84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		ıı ougrı 85)				86
00	Total observation bed days (see instructions					752	87
. 00							
	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			835. 98	88

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2013 To 06/30/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	7, 886, 138	43, 880, 713	0. 17971	8 628, 657	112, 981	90.00
91.00 Nursing School cost	0	43, 880, 713	0. 00000	0 628, 657	0	91.00
92.00 Allied health cost	435, 119	43, 880, 713	0. 00991	628, 657	6, 234	92.00
93.00 All other Medical Education	0	43, 880, 713	0. 00000	0 628, 657	0	93. 00

Health Financial Systems LUTHERAN HOSPITAL C	F INDIANA		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Pre	pared:
	Ti +1	e XVIII	Hospi tal	12/1/2014 9: 5 PPS	5 am
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x col.	
			onal goo	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			28, 759, 562		30. 00
31. 00 03100 NTENSIVE CARE UNIT			0		31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT			0		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT			0		31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT			23, 135, 978		31. 03
32. 00 03200 CORONARY CARE UNIT			8, 716, 117		32. 00
40. 00 04000 SUBPROVI DER - I PF			0		40. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 11103			
51.00 O5100 RECOVERY ROOM		0.00000		0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 28577		8, 544	52.00
53. 00 05300 ANESTHESI OLOGY		0. 01434			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13053			54.00
54. 01 05401 PET SCAN		0. 19002			
56. 00 05600 RADI 0I SOTOPE		0. 08805			56. 00
57. 00 05700 CT SCAN		0. 02882			57. 00
58. 00 05800 MRI		0.00000		0	58. 00
60. 00 06000 LABORATORY		0. 13580			60.00
65. 00 06500 RESPIRATORY THERAPY		0. 13781			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33271			
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67. 00 68. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 00000 0. 05732		0 565, 988	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 03732		102, 044	•
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0. 31287			70.00
72. 00 07100 MPL. DEV. CHARGED TO PATIENTS		0. 24992			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 13214			
74. 00 07400 RENAL DI ALYSI S		0. 33459			
76. 00 03140 CARDI O CATH LAB		0. 07684			
76. 01 03050 ENDOSCOPY		0. 16174			1
7. 02 03061 CARDI AC DELIAR		0.1017			

1, 008, 723

7, 585, 545

1, 434, 240

320, 746, 192

320, 746, 192

193, 560

211, 406

387, 972

868, 211

69, 592

Ω

42, 563, 212 200. 00

76.02

90.00

91.00

92.00

95.00

96. 00

201. 00

202. 00

0. 209578

2. 004402

0. 114456

0.048522

0.000000

03051 CARDI AC REHAB

09000 CLI NI C

09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net Charges (line 200 minus line 201)

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

76.02

90.00

91.00

92.00

95.00

200.00

201.00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Pre	
			10 00/30/2014	12/1/2014 9:5	5 am
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	5 044 570		
30. 00 03000 ADULTS & PEDI ATRI CS			5, 214, 570		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT			285, 726		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT			2, 029, 172		31. 02
31. 03 03101 CARDLO INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT			5, 140, 621		31. 03
32. 00 03200 CORONARY CARE UNI T 40. 00 04000 SUBPROVI DER - PF			1, 522, 103		40.00
43. 00 04300 NURSERY			119, 636		43.00
ANCI LLARY SERVI CE COST CENTERS			119,030		43.00
50. 00 05000 OPERATING ROOM		0. 11103	10, 662, 009	1, 183, 835	50.00
51. 00 05100 RECOVERY ROOM		0.00000		1, 103, 033	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 28577		107, 075	
53. 00 05300 ANESTHESI OLOGY		0. 01434		19, 625	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13053		328, 676	
54. 01 05401 PET SCAN		0. 19002		1, 592	
56. 00 05600 RADI 0I SOTOPE		0. 08805		22, 034	
57.00 05700 CT SCAN		0. 02882		57, 859	57.00
58. 00 05800 MRI		0.00000	00	0	58.00
60. 00 06000 LABORATORY		0. 13580	6, 948, 981	943, 679	60.00
65. 00 06500 RESPIRATORY THERAPY		0. 13781	13 4, 432, 822	610, 900	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33271	561, 905	186, 952	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67.00
68.00 06800 SPEECH PATHOLOGY		0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 05732		82, 156	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 31287		33, 499	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 24992		967, 122	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 13460		651, 091	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 13214		2, 361, 273	
74. 00 07400 RENAL DI ALYSI S		0. 33459		151, 596	
76. 00 03140 CARDIO CATH LAB		0. 07684		114, 360	
76. 01 03050 ENDOSCOPY		0. 16174			
76. 02 03051 CARDI AC REHAB		0. 20957	78 127, 769	26, 778	76. 02
OUTPATIENT SERVICE COST CENTERS		2 00440	12 28 493	57 111	1 00 0
			1/1 /N 493		

0. 114456

0.048522

0.000000

28, 493

85, 118

1, 668, 459

61, 601, 363

61, 601, 363

57, 111

190, 965

4, 130

0

8, 183, 576 200. 00

90. 00 91. 00

92.00

95.00

96. 00

201. 00

202. 00

90.00

91.00

92.00

95.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net Charges (line 200 minus line 201)

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

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

	Financial Systems ATION OF ORGAN ACQUISITION COSTS AND CHARGES	FOR HOSPITALS			CCN: 150017	Peri od:	wof Form CMS-2 Worksheet D-4	
WHI CH	ARE CERTIFIED TRANSPLANT CENTERS		Со	mponent	CCN:	From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
				Ki	dney	Hospi tal	PPS	
	Cost Center Description	Worksheet D-1	Inpat		Per Diem Cost		Cost (col. 2 x	
		Line Numbers	Routine		(from Wkst.	Acqui si ti on	col. 3)	
		0	Char		D-1, Part II		4.00	
	DART I COMPUTATION OF ORCAN ACQUISITION CO	0 OCTS (INDATIENT	1. (2.00	3. 00	4. 00	
	PART I - COMPUTATION OF ORGAN ACQUISITION CO Computation of Inpatient Routine Service Co					CES)		
1.00	ADULTS & PEDI ATRI CS	38.00		45, 172	835. 9	98 25	20, 900	1.00
2.00	INTENSIVE CARE UNIT	43. 00	1	43, 172	0. 0		20, 700	2.00
2. 01	PEDIATRIC INTENSIVE CARE UNIT	43. 01	1	0	1, 887. <i>6</i>		Ö	2. 01
2. 02	NEONATAL INTENSIVE CARE UNIT	43. 02	1	0	1, 149. 8		Ö	2. 02
2. 03	CARDIO INTENSIVE CARE UNIT	43. 03	1	0	806. 9		0	2. 03
3.00	CORONARY CARE UNIT	44. 00		0	1, 131. 7	77 0	0	3. 00
4.00	BURN INTENSIVE CARE UNIT	45. 00		0	0.0	00	0	4. 00
5.00	SURGICAL INTENSIVE CARE UNIT	46. 00		0	0.0	00	0	5. 00
6.00	OTHER SPECIAL CARE (SPECIFY)	47. 00		0	0.0		0	6. 00
7.00	TOTAL (sum of lines 1-6)			45, 172		25	20, 900	7. 00
	Cost Center Description		Worksh		Ratio of	0rgan	0rgan	
			Line Nu	umbers	Cost/Charges		Acquisition Ancillary	
					(from Wkst. (C) Ancillary Charges	Costs	
			0		1.00	2. 00	3. 00	
	Computation of Ancillary Service Cost Applic	able to Organ A			1.00	2.00	3.00	
8. 00	OPERATI NG ROOM	ioner o de di gani i		50.00	0. 11103	1, 199, 092	133, 139	8.00
9.00	RECOVERY ROOM			51.00	0.00000		0	9. 00
10.00	DELIVERY ROOM & LABOR ROOM			52.00	0. 28577	74 0	0	10.00
11.00	ANESTHESI OLOGY			53.00	0. 01434	104, 025	1, 493	11. 00
12.00	RADI OLOGY-DI AGNOSTI C			54.00	0. 13053		32, 039	1
12. 01	PET SCAN			54. 01	0. 19002		0	12. 01
13.00	RADI OLOGY-THERAPEUTI C			55.00	0.00000		0	13.00
14.00	RADI OI SOTOPE			56.00	0. 08805		79, 924	14.00
15. 00 16. 00	CT SCAN MRI			57. 00 58. 00	0. 02882		17, 799 0	15. 00 16. 00
17. 00	CARDI AC CATHETERI ZATI ON			59.00	0. 00000 0. 00000		0	17. 00
18. 00	LABORATORY			60.00	0. 13580		181, 184	18. 00
19. 00	PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00	0. 00000		0	19. 00
20. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS			62. 00	0. 00000		Ö	20.00
21.00	BLOOD STORING, PROCESSING & TRANS.			63.00	0.00000		0	21.00
22.00	INTRAVENOUS THERAPY			64.00	0.00000	00	0	22. 00
23.00	RESPI RATORY THERAPY			65.00	0. 13781	134, 290	18, 507	23. 00
24. 00	PHYSI CAL THERAPY			66. 00	0. 33271		0	24. 00
25. 00	OCCUPATI ONAL THERAPY			67.00	0. 00000		0	25. 00
26. 00	SPEECH PATHOLOGY			68. 00	0.00000		0	26. 00
27. 00	ELECTROCARDI OLOGY			69.00	0. 05732		16, 790	1
	ELECTROENCEPHALOGRAPHY			70.00	0. 31287		72 701	
	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS			71. 00 72. 00	0. 24992 0. 13460		73, 791 842	
31. 00	DRUGS CHARGED TO PATIENTS			73.00	0. 13214		48, 885	1
32. 00	RENAL DIALYSIS			74. 00			0	32.00
33. 00	ASC (NON-DISTINCT PART)			75. 00	0. 00000		Ö	33.00
34. 00	CARDIO CATH LAB			76. 00	0. 07684		0	34. 00
34. 01	ENDOSCOPY			76. 01	0. 16174		5, 513	
34. 02	CARDI AC REHAB			76. 02	0. 20957		0	1
35.00	RURAL HEALTH CLINIC			88. 00	0. 00000	00	0	35. 00
36. 00	FEDERALLY QUALIFIED HEALTH CENTER			89. 00	0. 00000		0	36. 00
37. 00	CLINIC			90.00	2. 00440		156, 526	
38. 00	EMERGENCY			91.00	0. 11445		201	38. 00
39. 00	OBSERVATION BEDS (NON-DISTINCT PART			92.00	0. 04852	25, 555	1, 240	
40.00	OTHER OUTPATIENT SERVICE COST CENTER TOTAL (sum of lines 8-40)					5, 645, 936	767, 873	40.00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

	TAL OF INDIANA			eu of Form CMS-2	
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS	Provider Componen		Period: From 07/01/2013 Fo 06/30/2014	Worksheet D-4 Date/Time Pre	pared:
	K	i dney	Hospi tal	12/1/2014 9: 5 PPS	o alli
Cost Center Description	Worksheet D-2, Part I Line	Average Cost Per Day (from	0rgan	Organ Acqui si ti on	
	Numbers	Wkst. D-2, Part I, col.		Costs (col. 1 x col. 2)	
	0	4) 1.00	2. 00	3. 00	
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER T					
Computation of the Cost of Inpatient Services of Interns					1
42. 00 ADULTS & PEDIATRICS	2.00				
43. 00 INTENSIVE CARE UNIT	3.00	•			1
43. 01 PEDIATRIC INTENSIVE CARE UNIT	3. 0	•		1	
43. 02 NEONATAL INTENSIVE CARE UNIT	3. 02	•			
43. 03 CARDIO INTENSIVE CARE UNIT 44. 00 CORONARY CARE UNIT	3. 03	•		0	
45. 00 BURN INTENSIVE CARE UNIT	5.00	•			
46. 00 SURGI CAL INTENSI VE CARE UNI T	6. 00	1		0	
47. 00 OTHER SPECIAL CARE (SPECIFY)	7. 00			o o	
48.00 TOTAL (sum of lines 42 through 47)			25	0	
Cost Center Description	Worksheet D-2,	Organ Charges	Ratio of Cost	0rgan	
	Part I Line Numbers	(see instructions)	To Charges from Wkst.	Acquisition Costs (col. 1	
			D-2, Part I,	x col. 2)	
		1.00	col . 4	0.00	
Computation of the Cost of Outpatient Services of Interns	ond Dooi donts I	1.00	2. 00	3.00	
49.00 RURAL HEALTH CLINIC	21.00		0. 000000		49. 00
50. 00 FEDERALLY QUALIFIED HEALTH CENTER	22. 00			0	
51. 00 CLINIC	23. 00	•			
52. 00 EMERGENCY	24. 00	•		0	1
53.00 OBSERVATION BEDS (NON-DISTINCT PART	25. 00	25, 55	0. 000000	0	53.00
54.00 OTHER OUTPATIENT SERVICE COST CENTER	26. 00		0. 000000	0	54. 00
55.00 TOTAL (sum of lines 49 through 52)		105, 40		0	55. 00
	I Co	ost	Cha	rges	
Cost Contor Doscription					
Cost Center Description	Part A	Part B	Part A	Part B	
Cost Center Description PART III - SUMMARY OF COSTS AND CHARGES					
·	Part A	Part B 2.00	Part A	Part B 4.00	56. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient)	Part A 1.00	Part B 2.00	Part A 3.00	Part B 4.00	57. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient)	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions)	Part A 1.00	Part B 2.00	Part A 3.00 5,691,108	Part B 4.00	57. 00 58. 00 59. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 18.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions)	Part A 1.00 788, 773	Part B 2.00	Part A 3.00 5,691,108 0 0 2,451,721	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60)	Part A 1.00	Part B 2.00	Part A 3. 00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions)	Part A 1.00 788, 773	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Fr.00 F	Part A 1.00 788, 773	Part B 2.00	Part A 3. 00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958	Part B 2.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958 2, 248, 818	Part B 2.00	Part A 3. 00 5, 691, 108 0 2, 451, 721 0 8, 142, 829	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold	Part A 1.00 788, 773 ((2, 147, 18) (2, 935, 955 2, 248, 815 100, 676	Part B 2.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66)	Part A 1.00 788, 773 (2, 147, 183 (2, 935, 958 2, 248, 818	Part B 2.00 3 3 4 3 0.76595	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 11 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions)	Part A 1.00 788, 773 ((2, 147, 18) (2, 935, 955 2, 248, 815 100, 676	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ± line 62) Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) Organs Furnished Part B	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00	Part B 4.00 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Excised in Provider (1)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveric 2.00	Part B 4.00 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospitals (2)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 5.00 Li vi ng Rel ater 1.00	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) Organs Purchased from Non-Transplant Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 6.60 Li vi ng Rel atector 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 19 0 0 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching hospital (see intructions) Total (sum of lines 56 thru 60) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Acquisition of Medicare Usable Organs (see instructions) Acquisition of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) Medicare Cost/Charges (see instructions) Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS Organs Excised in Provider (1) Organs Purchased from Other Transplant Hospitals (2) Organs Purchased from OPOS Total (sum of lines 70 thru 73)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 6 1.00 1:00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 15 3 34	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 6 0.10 1.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 15 3 34	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 08. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 71. 00 Organs Purchased from OPOs 72. 00 Organs Purchased from OPOs 73. 00 Organs Transplanted 76. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 3 19 0 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to OPOs	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 5, 691, 108 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 8 19 0 0 15 3 34 3 15	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from Other Transplant Hospitals 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Sent Outside the U.S. (no revenue received)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3 0.76595 Li vi ng Rel ater 1.00	Part A 3.00 5, 691, 108 0 0 2, 451, 721 0 8, 142, 829 6, 237, 057 0 6, 237, 057 0 6, 237, 057 1 Cadaveri c 2.00 15 3 4 15 0 0 19 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 Revenue 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to OPOs 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold Outside the U.S. 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Used for Research	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 6.00 Li vi ng Rel ater 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 8 19 0 0 15 8 34 15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from Other Transplant Hospitals 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. 81. 00 Organs Sent Outside the U.S. (no revenue received)	Part A 1.00 788, 773 (2, 147, 182 (2, 935, 958 2, 248, 818 100, 674 2, 148, 136	Part B 2.00 3.00 4.30 0.76595 6.00 Li vi ng Rel ater 1.00	Part A 3.00 5,691,108 0 2,451,721 0 8,142,829 6,237,057 0 6,237,057 0 6,237,057 1 Cadaveric 2.00 3 19 0 0 15 3 34 5 0 0 0 17 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 80. 00 81. 00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

Uool +h	Financial Systems	LITHEDAN HOSDIT	TAL OF INDIANA		المانما	u of Form CMC	2552 10
	Financial Systems I FATION OF ORGAN ACQUISITION COSTS AND CHARGES	_UTHERAN HOSPIT		CCN: 150017	Peri od:	u of Form CMS-2 Worksheet D-4	
	ARE CERTIFIED TRANSPLANT CENTERS	TOR HOSET TALS	Componen		From 07/01/2013 To 06/30/2014	Date/Time Pre	pared:
				leart	Hospi tal	12/1/2014 9: 5 PPS	5 am
	Cost Center Description	Worksheet D-1	Inpati ent	Per Diem Cost		Cost (col. 2 x	
		Line Numbers	Routine Organ		Acqui si ti on	col. 3)	
			Charges	D-1, Part II		,	
		0	1.00	2.00	3. 00	4. 00	
	PART I - COMPUTATION OF ORGAN ACQUISITION COS	STS (INPATIENT	ROUTINE AND AN	ICI LLARY SERVI	CES)		
	Computation of Inpatient Routine Service Cos						
1.00	ADULTS & PEDI ATRI CS	38. 00		1		0	
2.00	INTENSIVE CARE UNIT	43.00				0	
2. 01 2. 02	PEDIATRIC INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	43. 01 43. 02				0	
2. 02	CARDIO INTENSIVE CARE UNIT	43. 02		1		0	
3. 00	CORONARY CARE UNIT	44. 00				0	
4. 00	BURN INTENSIVE CARE UNIT	45. 00		0.0		0	
5. 00	SURGICAL INTENSIVE CARE UNIT	46. 00				0	
6.00	OTHER SPECIAL CARE (SPECIFY)	47.00		0.0	00	0	6.00
7.00	TOTAL (sum of lines 1-6)				0	0	7. 00
	Cost Center Description		Worksheet C	Ratio of	0rgan	0rgan	
			Line Numbers	Cost/Charges		Acquisition	
				(from Wkst. ('	Ancillary	
			0	1.00	Charges	Costs	
	Computation of Ancillary Service Cost Applica	abla ta Organ A	0	1.00	2. 00	3. 00	
8. 00	OPERATING ROOM	abre to organi P	50.00	0. 11103	13 0	0	8. 00
9. 00	RECOVERY ROOM		51.00			0	
10. 00	DELIVERY ROOM & LABOR ROOM		52.00			0	
11. 00	ANESTHESI OLOGY		53.00	1		0	
12.00	RADI OLOGY-DI AGNOSTI C		54.00			0	12. 00
12. 01	PET SCAN		54. 01	0. 19002	25 0	0	12. 01
13.00	RADI OLOGY-THERAPEUTI C		55.00	1		0	
14. 00	RADI OI SOTOPE		56.00	1		0	
15. 00	CT SCAN		57.00			0	
16.00	MRI		58. 00 59. 00			0	
17. 00 18. 00	CARDI AC CATHETERI ZATI ON LABORATORY		60.00	l .		0	
19. 00	PBP CLINICAL LAB SERVICES-PRGM ONLY		61.00	•		0	
20. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS		62.00	1		0	
21. 00	BLOOD STORING, PROCESSING & TRANS.		63.00			0	
22. 00	I NTRAVENOUS THERAPY		64.00	0. 00000	0 0	0	22. 00
23. 00	RESPI RATORY THERAPY		65.00	0. 13781	3 0	0	23. 00
24. 00	PHYSI CAL THERAPY		66.00	1		0	
25. 00	OCCUPATIONAL THERAPY		67.00	1		0	1
26. 00	SPEECH PATHOLOGY		68.00	1		0	1
27. 00 28. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY		69. 00 70. 00	1		0	
	MEDICAL SUPPLIES CHARGED TO PATIENT		70.00	1		0	
30.00	IMPL. DEV. CHARGED TO PATIENTS		71.00			0	
31. 00	DRUGS CHARGED TO PATIENTS		73.00			0	
32. 00	RENAL DIALYSIS		74.00			0	
33.00	ASC (NON-DISTINCT PART)		75.00	0. 00000	0 0	0	33. 00
34.00	CARDIO CATH LAB		76.00	0. 07684	3 0	0	34. 00
34. 01	ENDOSCOPY		76. 01	1		0	
34. 02	CARDI AC REHAB		76. 02	1		0	
35.00	RURAL HEALTH CLINIC		88.00	1		0	1
36.00	FEDERALLY QUALIFIED HEALTH CENTER		89.00	1		0	
37. 00 38. 00	CLINIC EMERGENCY		90.00	1		0	
39. 00	OBSERVATION BEDS (NON-DISTINCT PART		92.00	1		0	
40. 00	OTHER OUTPATIENT SERVICE COST CENTER		72.00	0.04002			40.00
	TOTAL (sum of lines 8-40)				0	0	41. 00
			•	•	•		

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

	UTHERAN HOSPITAL O				u of Form CMS-2	
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES WHICH ARE CERTIFIED TRANSPLANT CENTERS	FOR HOSPITALS	Provider Component	1	Period: From 07/01/2013 To 06/30/2014	Worksheet D-4 Date/Time Pre	pared:
		Н	eart	Hospi tal	12/1/2014 9: 5 PPS	o alli
Cost Center Description	Par	ssheet D-2, rt I Line Numbers	Average Cost Per Day (from Wkst. D-2, Part I, col.	0rgan	Organ Acquisition Costs (col. 1 x col. 2)	
			4)			
		0	1.00	2. 00	3. 00	
PART II - COMPUTATION OF ORGAN ACQUISITION CO						
Computation of the Cost of Inpatient Services	of Interns and Re					
42. 00 ADULTS & PEDIATRICS		2.00	0.00		0	
43. 00 INTENSIVE CARE UNIT		3.00	0. 00			
43. 01 PEDIATRIC INTENSIVE CARE UNIT		3. 01	0.00		0	43. 01
43. 02 NEONATAL INTENSIVE CARE UNIT		3. 02	0.00		0	43. 02
43. 03 CARDIO INTENSIVE CARE UNIT		3. 03	0.00		0	43. 03
44. 00 CORONARY CARE UNIT		4.00	0.00		0	44.00
45. 00 BURN INTENSIVE CARE UNIT		5. 00	0.00		0	45. 00
46. 00 SURGICAL INTENSIVE CARE UNIT		6.00	0.00		0	46.00
47. 00 OTHER SPECIAL CARE (SPECIFY)		7. 00	0.00	0	0	47. 00 48. 00
48.00 TOTAL (sum of lines 42 through 47) Cost Center Description	Mork	choot D 2	Organ Charges	Ratio of Cost	Organ	48.00
COST CENTER DESCRIPTION	Par	rt I Line Numbers	(see instructions)	To Charges from Wkst. D-2, Part I,	Acquisition Costs (col. 1 x col. 2)	
		0	1. 00	col . 4	2.00	
Computation of the Cost of Outpatient Service	oc of Intorns and D	O Dosidonts N		2.00	3. 00	
49. 00 RURAL HEALTH CLINIC	es of fifteeris and R	21.00	ot ili Approved	0. 000000		49. 00
50. 00 FEDERALLY QUALIFIED HEALTH CENTER		22. 00			0	50.00
51. 00 CLINIC		23. 00	Ò		Ö	51.00
52. 00 EMERGENCY		24. 00	Ò		Ö	52. 00
53. 00 OBSERVATION BEDS (NON-DISTINCT PART		25. 00	ì		Ö	53. 00
54. 00 OTHER OUTPATIENT SERVICE COST CENTER		26. 00	`	0.00000	Ö	54. 00
55.00 TOTAL (sum of lines 49 through 52)		20.00	ì		0	55. 00
				4		00.00
		Co	st	Chai	raes	
Cost Center Description	_	Co Part A	st Part B	Part A	rges Part B	
Cost Center Description						
PART III - SUMMARY OF COSTS AND CHARGES		Part A	Part B	Part A	Part B	
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I		Part A	Part B	Part A	Part B	56. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient)		Part A 1.00	Part B	Part A 3.00	Part B	57. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient) 1 Interns and Residents (outpatient)		Part A 1.00 0 0	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions)		Part A 1.00	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00 59. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he		Part A 1.00 0 0	Part B	Part A 3.00	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 For one of the summary of the summ		Part A 1.00 0 0 0 964,332 0	Part B	Part A 3.00 0 0 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) Total (sum of lines 56 thru 60)		Part A 1.00 0 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions)		Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions)	ospi tal (see	Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal	ospi tal (see	Part A 1.00 0 0 0 964,332 0	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 70 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62)	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions)	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) Revenue for Organs Sold	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 11 Interns and Residents (outpatient) 12 Interns and Residents (outpatient) 13 Interns and Residents (outpatient) 14 Interns and Residents (outpatient) 15 Interns and Residents (outpatient) 15 Interns and Residents (outpatient) 16 Interns and Residents (outpatient) 17 Interns and Residents (outpatient) 18 Interns and Residents (outpatient) 18 Interns and Residents (outpatient) 19 Interns and Residents (see instructions) 10 Interns and Residents (see instructions) 10 Interns and Residents (see instructions) 11 Interns and Residents (see instructions) 12 Interns and Residents (see instructions) 13 Interns and Residents (see instructions) 14 Interns and Residents (see instructions) 15 Interns and Residents (inpatient) 16 Interns and Residents (inpatient) 17 Interns and Residents (inpatient) 18 Interns and Residents (inpatient) 19 Interns and Residents (inpatient) 19 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 11 Interns and Residents (inpatient) 12 Interns and Residents (inpatient) 13 Interns and Residents (inpatient) 14 Interns and Residents (inpatient) 15 Interns and Residents (inpatient) 16 Interns and Residents (inpatient) 17 Interns and Residents (inpatient) 18 Interns and Residents (inpatient) 18 Interns and Residents (inpatient) 18 Interns and Residents (inpatient) 19 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 10 Interns and Residents (inpatient) 11 Interns and Residents (inpatient) 12 Interns and Residents (inpatient) 13 Interns and Residents (inpatient) 14 Interns and Residents (inpatient) 15 Interns and Residents (inpatient) 16 Interns and Residents (inpatient) 17 Intern	ospi tal (see	Part A 1.00 0 0 964, 332 0 964, 332	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 0 783,058 0 783,058	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching he intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see	ospital (see	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 0 783,058 0 783,058	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see Cost Center Description	ospital (see ole Organs	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B	Part A 3.00 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 1 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Total Usable Organs Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Total Usable Organs Cost and Charges (see instructions) PART IV - STATISTICS	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 1 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 57. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospic	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 57. 00 Interns and Residents (inpatient) Interns and Residents (outpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from OPOS 74. 00 Total (sum of lines 70 thru 73)	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1: 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 7 783,058 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00
PART III - SUMMARY OF COSTS AND CHARGES 75.00 Routine and Ancillary from Part I 1 Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 1 Interns and Residents (outpatient) 1 Direct Organ Acquisition (see instructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost of physicians' services in a teaching heintructions) 1 Cost Ogans (see instructions) 1 Cost Ogans (see instructions) 1 Cost Office (see instructions) 1 Cost Ogans (see instructions) 1 Cost Ogans Sold 1 Cost Ogans Sold 1 Cost Ogans Furnished Part B 1 Cost Center Description	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 1 Cadaveric 2.00	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Fr.	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Part III - Summary of Costs and Charges Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching he intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Acquisition of Medicare Usable Organs to Total Usal (line 63 + line 62) Medicare Usable Organs (see instructions) Revenue for Organs Sold Revenue for Organs Sold Organs Furnished Part B Met Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS Organs Purchased from Other Transplant Hospital Cost Center Organs From Organs Ital Cost Center Organs Organs Ital Total (sum of lines 70 thru 73) Organs Transplanted Total (sum of lines 70 thru 73) Organs Sold to Other Hospitals Organs Sold to Other Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching he intructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 0 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I 57. 00 Interns and Residents (inpatient) 58. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching he intructions) 61. 00 Total (sum of lines 56 thru 60) 70 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Transplanted 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals	ospital (see ole Organs nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospital 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Transplanted 76. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 78. 00 Organs Sold to Military or VA Hospitals 79. 00 Organs Sold to Military or VA Hospitals 0. Organs Sold Outside the U.S.	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 2 3 7 783,058 0 783,058 0 783,058 1 Cadaveric 2.00 6 0 0 1,0000000000000000000000000000	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 78. 00 79. 00 80. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 From Fart III - SUMMARY OF COSTS AND CHARGES Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) Cost of physicians' services in a teaching heintructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Action of Medicare Usable Organs to Total Usal (line 63 + line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Revenue for Organs Sold Roudicare Usable Organs Inne 66) Organs Furnished Part B Medicare Cost/Charges (see instructions) Revenue for Organs Sold Total (line 65 minus line 66) Organs Furnished Part B Medicare Cost/Charges (see instructions) Total (sum of lines from Other Transplant Hospital) Organs Purchased from Other Transplant Hospital Organs Purchased from OPOs Total (sum of lines 70 thru 73) Total (sum of lines 70 thru 73) Organs Sold to Other Hospitals Organs Sold to Other Hospitals Organs Sold to Transplant Hospitals Organs Sold to Transplant Hospitals Organs Sold to Military or VA Hospitals Organs Sold Outside the U.S. Organs Sold Outside the U.S. Organs Sold Outside the U.S. (no revenue received)	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 12 0.66666 Li vi ng Rel atec 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching heintructions) 61. 00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usal (line 63 + line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) PART IV - STATISTICS 70. 00 Organs Excised in Provider (1) 71. 00 Organs Purchased from Other Transplant Hospital 73. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 thru 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Transplant Hospitals 78. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U.S. (no revenue recomposition or the search or the	nstructions)	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1: 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 0 1,174,586 0 1,174,586 0 0 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching heintructions) 61.00 Total (sum of lines 56 thru 60) 70 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usal (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospital 73.00 Organs Purchased from Mon-Transplant Hospital 73.00 Organs Transplanted 76.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Other Hospitals 78.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Military or VA Hospitals 80.00 Organs Sold Outside the U.S. 81.00 Organs Sent Outside the U.S. (no revenue reco	ospital (see ole Organs nstructions) tals (2) s	Part A 1.00 0 0 964, 332 0 964, 332 642, 888 16, 944 625, 944	Part B 2.00 1. 0.66666 Li vi ng Rel ater 1.00	Part A 3.00 0 0 1,174,586 0 1,174,586 0 783,058 0 783,058 0 783,058 0 783,058 0 1,174,586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 77. 00 78. 00 79. 00 80. 00 81. 00

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not to be included in the count.
(2) Organs procured outside your center by a procurement team from your center are included in the count.

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Pre 12/1/2014 9:5	pared: 5 am
		Ti tl	e XVIII	Hospi tal	PPS	
			before 1/1	on/after 1/1	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS	0	1. 00	1. 01	2. 00	
1.00	DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges		12, 653, 05	i3		1. 01
4 00	occurring prior to October 1, 2013 (see instructions)					
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		39, 408, 52	!5		1. 02
1. 03	DRG for Federal specific operating payment for Model 4			0		1. 03
	BPCI (see instructions)					
2.00	Outlier payments for discharges. (see instructions)		3, 207, 04	8		2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0		2. 02
3.00	Managed Care Simulated Payments		29, 440, 32	23		3. 00
4. 00	Bed days available divided by number of days in the cost		383. 9			4. 00
	reporting period (see instructions)					
	Indirect Medical Education Adjustment			_1		
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before		10. 1	3		5. 00
	12/31/1996. (see instructions)					
6.00	FTE count for allopathic and osteopathic programs which		0.0	00		6. 00
	meet the criteria for an add-on to the cap for new					
7.00	programs in accordance with 42 CFR 413.79(e)			20		7 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.0	00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as		0.0	00		7. 01
	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
	cost report straddles July 1, 2011 then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated		0.0	00		8. 00
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12,					
	1998, page 26340 and Vol. 67 Federal Register, page 50069,					
0.01	August 1, 2002.			20		0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report		0.0	10		8. 01
	straddles July 1, 2011, see instructions.					
8.02	The amount of increase if the hospital was awarded FTE cap		0.0	00		8. 02
	slots from a closed teaching hospital under section 5506					
9. 00	of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		10. 1	2		9. 00
7.00	lines (8, 8,01 and 8,02) (see instructions)		10. 1	3		7.00
10.00	FTE count for allopathic and osteopathic programs in the		8. 1	4		10. 00
	current year from your records					
11. 00 12. 00	FTE count for residents in dental and podiatric programs.		0. 0 8. 1			11. 00 12. 00
13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		9. 5			13.00
14. 00	' '		9. 3			14. 00
	year ended on or after September 30, 1997, otherwise enter					
	zero.					
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program		9. C 0. C			15. 00 16. 00
17. 00	Adjusment for residents displaced by program or hospital		0.0			17. 00
	closure					
18. 00	Adjusted rolling average FTE count		9. 0			18. 00
19. 00	Current year resident to bed ratio (line 18 divided by		0. 02349	93		19. 00
20. 00	line 4). Prior year resident to bed ratio (see instructions)		0. 02453	30		20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0. 02349			21. 00
22. 00	IME payment adjustment (see instructions)		1, 039, 63			22. 00
	Indirect Medical Education Adjustment for the Add-on for Secti	on 422 of t				
23. 00	Number of additional allopathic and osteopathic IME FTE		0.0	00		23. 00
24. 00	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)		-1.9	00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter		0.0			25. 00
	the lower of line 23 or line 24 (see instructions)					
26. 00	Resident to bed ratio (divide line 25 by line 4)		0. 00000			26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 00000			27. 00
28. 00 29. 00	IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28)		1, 039, 63	0		28. 00 29. 00
£ 7. UU	Di sproporti onate Share Adjustment		1, 037, 03			27.00
30.00	Percentage of SSI recipient patient days to Medicare Part		3. 7	4		30.00
	A patient days (see instructions)					
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31		17. 8 21. <i>6</i>			31. 00 32. 00
JZ. UU	Jouin of Titles to alla St		J ∠1. C	· · (l	J JZ. UU

69, 837, 719

4, 777, 664

281.088

120, 052

78,034

60.00

61.00

62.00

63.00

64.00

65.00

instructions)

58)

Primary payer payments

Total amount payable for program

beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries

Allowable bad debts (see instructions)

Adjusted reimbursable bad debts (see

Coinsurance billed to program beneficiaries

60.00

61.00

62.00

63.00

64.00

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150017

						12/1/2014 9:5	55 am
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
				October 1		October 1	
		0		1.00	1. 01	2.00	
66. 00	Allowable bad debts for dual eligible	0		0		2.00	66. 00
67. 00	beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines			64, 857, 001			67. 00
68. 00	62 and 63) Credits received from manufacturers for			15, 200			68. 00
	replaced devices applicable to MS-DRG (see instructions)						
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96) (For SCH see			0			69. 00
70. 00	instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70. 00
70. 50	(SPECIFY) RURAL DEMONSTRATION PROJECT			0			70. 50
70. 92	Bundled Model 1 discount amount			٥			70. 92
	1						
70. 93	HVBP incentive payment (see instructions)			-44, 949			70. 93
70. 94	Hospital readmissions reduction adjustment (see instructions)			-69, 815			70. 94
70. 95	Recovery of accelerated depreciation			0			70. 95
70. 96	Low volume adjustment for federal fiscal		0	0			70. 96
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	prior to 10/1)						
70. 97	Low volume adjustment for federal fiscal		0	,			70. 97
70. 97			U	0			70.97
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			0			70. 98
71.00	Amount due provider (line 67 minus lines 68			64, 727, 037			71.00
	plus/minus lines 69 & 70)			.,,,			
71. 01	Sequestration adjustment (see instructions)			1, 294, 541			71. 01
	, , , , , , , , , , , , , , , , , , , ,						72.00
72. 00	Interim payments			62, 802, 157			
73. 00	Tentative settlement (for contractor use			0			73. 00
	onl y)						
74.00	Balance due provider (Program) line 71 minus			630, 339			74.00
	lines 71.01, 72 and 73						
75.00	Protested amounts (nonallowable cost report			3, 738, 092			75. 00
	items) in accordance with CMS Pub. 15-2,			, ,			
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR			l .	L	l .	1
90. 00	Operating outlier amount from Worksheet E,			0	I		90.00
90.00				U			90.00
	Part A line 2 (see instructions)						
91. 00	Capital outlier from Worksheet L, Part I,			0			91. 00
	line 2						
92.00	Operating outlier reconciliation adjustment			0			92. 00
	amount (see instructions)						
93.00	Capital outlier reconciliation adjustment			1 0			93. 00
70.00	amount (see instructions)			Ĭ			70.00
94. 00	The rate used to calculate the time value of			0.00			94.00
74. 00] 0.00			74.00
05.05	money (see instructions)			_			05.00
95. 00	Time value of money for operating expenses			0			95. 00
	(see instructions)						1
96.00	Time value of money for capital related			0			96. 00
	expenses (see instructions)						1
	·						

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pi	rovi der (CCN: 150017	Peri od: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 12/1/2014 9:55 am

			10 00/30/2014	12/1/2014 9:5	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			19, 874	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction		21, 153, 602	2. 00	
3.00	PPS payments		23, 579, 591	3. 00	
4.00	Outlier payment (see instructions)			134, 994	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 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 Worksheet D, Pa	rt IV, column 13, line	e 200	27, 335	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			19, 874	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12. 00	Ancillary service charges			150, 045	
13. 00	Organ acquisition charges (from Worksheet D-4, Part III, line 6	9, col. 4)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			150, 045	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for page 1975			0	
16. 00	Amounts that would have been realized from patients liable for	payment for services o	on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	17.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	if lime 10 evenede li	no 11) (ooo	150, 045	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds II	ne II) (See	130, 171	19. 00
20. 00		if line 11 exceeds li	no 10) (soo	0	20. 00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)				20.00
21. 00					21. 00
22. 00	Interns and residents (see instructions)	riisti deti olis)		19, 874 0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			23, 741, 920	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions))	4, 605, 520	26. 00
27. 00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the			19, 156, 274	
	see instructions)				
28. 00	Direct graduate medical education payments (from Worksheet E-4,	line 50)		93, 085	28. 00
29. 00	ESRD direct medical education costs (from Worksheet E-4, line 3	6)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			19, 249, 359	30. 00
31. 00	Primary payer payments			5, 988	
32. 00	Subtotal (line 30 minus line 31)			19, 243, 371	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)			
33. 00	Composite rate ESRD (from Worksheet I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			67, 261	
35. 00	Adjusted reimbursable bad debts (see instructions)			43, 720	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	
37. 00	Subtotal (see instructions)			19, 287, 091	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	d daylaga (aga i natny	n+: ono)	0	
39. 98	Partial or full credits received from manufacturers for replace	a devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			10 207 001	39. 99
40.00	Subtotal (see instructions)			19, 287, 091	40.00
40. 01	Sequestration adjustment (see instructions)			385, 742	
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			19, 051, 989 0	1
43.00	Balance due provider/program (see instructions)			-150, 640	
44. 00	Protested amounts (nonallowable cost report items) in accordance	a with CMS Dub 15_2	chanter 1	- 130, 040	
44.00	§115. 2	C WI III GWG FUD. 19-2,	спарты Т,		44.00
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			ő	
92. 00	The rate used to calculate the Time Value of Money			-	92. 00
93. 00	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)			0	
				•	•

| Peri od: | Worksheet E-1 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared: | 12/1/2014 9:55 am Health Financial Systems LUTHE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150017

					12/1/2014 9: 5	5 am
			e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		62, 464, 057		19, 051, 989	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	07/01/2013	60, 800		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	02/11/2014	704, 100		0	3. 02
3. 03		0271172011	0		o o	3. 03
3. 04			Ö		l ő	3. 04
3. 05			ĺ		l ő	3. 05
0.00	Provider to Program				J	0.00
3.50	ADJUSTMENTS TO PROGRAM	06/30/2014	426, 800		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		338, 100		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		62, 802, 157		19, 051, 989	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
Г 00	TO BE COMPLETED BY CONTRACTOR	I		1		г оо
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
5. 02	TEMMINE TO THORISEN		Ö		l ol	5. 02
5. 03			0		l ol	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		o	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	SETTLEMENT TO PROVIDER		630, 339		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		150, 640	6. 02
7. 00	Total Medicare program liability (see instructions)		63, 432, 496		18, 901, 349	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	INGINE OF COTTE ACTO	I		I	ı l	0.00

Heal th	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10	
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150017	Peri od:	Worksheet E-1		
			From 07/01/2013	Part II Date/Time Pre		
	To 06/30/2014					
	12/1/2014 9: 5 PPS	<u> </u>				
		Title XVIII	Hospi tal			
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00						
2.00						
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2		18, 262	3. 00		
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		92, 401	4.00	
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			1, 984, 598, 649	5. 00	
6.00	Total hospital charity care charges from Wkst S-10, column 3 l	ine 20		8, 063, 005	6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HIT technology	Worksheet S-2,	0	7. 00	
	Part I line 168					
8.00	Calculation of the HIT incentive payment (see instructions)			1, 442, 766	8. 00	
9.00	Sequestration adjustment amount (see instructions)			28, 855	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1, 413, 911	10. 00	
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)			1, 336, 152		
	Other Adjustment (specify)			0	31. 00	
22 00	Dalamas dua maggidam (lima O (am lima 10) minus lima 20 and li	no 21) (coo i notruction	- N	77 750	22 00	

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

1, 336, 152 30. 00 0 31. 00 77, 759 32. 00

Heal th	Financial Systems LUTHERAN HOSPITAL O	F INDIANA		In lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS			Peri od: From 07/01/2013 To 06/30/2014	Worksheet E-4 Date/Time Prep 12/1/2014 9:55	pared:
-		Ti tl	e XVIII	Hospi tal	PPS	J alli
				•		
					1. 00	
4 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT				0.05	4 00
1. 00	Unweighted resident FTE count for allopathic and osteopathic pr	ograms for	cost reporti	ng perioas	8. 95	1. 00
2.00	ending on or before December 31, 1996. 2.00 Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					
3. 00	Amount of reduction to Direct GME cap under section 422 of MMA		., (55551	401.01.0)	0. 00 0. 00	2. 00 3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance w	ith 42 CFR	§413.79 (m).	(see	0. 00	3. 01
4 00	instructions for cost reporting periods straddling 7/1/2011)				0.00	4 00
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	steopatni c	programs due	to a Medicare	0. 00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instru	uctions for	cost reporti	na periods	0. 00	4. 01
	straddl i ng 7/1/2011)	.01.00	000t . opo. t.	ing point due	0.00	
4.02	ACA Section 5506 number of additional direct GME FTE cap slots	(see inst	ructions for	cost reporting	0.00	4. 02
	peri ods straddling 7/1/2011)				0.05	
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus	or minus	line 4 plus l	ines 4.01 and	8. 95	5. 00
6. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic pr	roorams for	the current	vear from vour	8. 14	6. 00
0.00	records (see instructions)	ograms ror	the current	year from your	0. 14	0.00
7. 00	· · · · · · · · · · · · · · · · · · ·				8. 14	7. 00
			Primary Care		Total	
	lw		1.00	2. 00	3. 00	0.00
8. 00	Weighted FTE count for physicians in an allopathic and osteopat program for the current year.	hi c	8. 1	4 0.00	8. 14	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwis	se	8. 1	4 0.00	8. 14	9. 00
	multiply line 8 times the result of line 5 divided by the amour					
	6.					
10.00	Weighted dental and podiatric resident FTE count for the currer	nt year		0.00		10. 00
11.00	Total weighted FTE count	V005 (000	8. 1			11.00
12. 00	Total weighted resident FTE count for the prior cost reporting instructions)	year (see	8. 9	0.00		12. 00
13. 00	Total weighted resident FTE count for the penultimate cost repo	orti ng	8. 9	0.00		13. 00
	year (see instructions)	Ü				
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided b	y 3).	8. <i>6</i>			14. 00
15.00	Adjustment for residents in initial years of new programs		0.0			15. 00
16. 00 17. 00	Adjustment for residents displaced by program or hospital closu Adjusted rolling average FTE count	ire	0. 0 8. 6			16. 00 17. 00
18. 00	Per resident amount		93, 854. 3			18.00
19. 00	Approved amount for resident costs		814, 65	· ·	814, 656	
			·			
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FTE	resi dent	cap slots rec	eived under 42	0. 00	20. 00
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruct	ione)			0.00	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instruc					22. 00
23. 00	Enter the locally adjustment national average per resident amou		structions)			23. 00
	Multiply line 22 time line 23				0	24. 00
25. 00	Total direct GME amount (sum of lines 19 and 24)		l	.1	814, 656	25. 00
			Inpatient Par	t Managed care		
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
26. 00	Inpatient Days (see instructions)		30, 28	18, 262		26. 00
27. 00	Total Inpatient Days (see instructions)		92, 40			27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 32771			28. 00
29. 00 30. 00	Program direct GME amount Reduction for direct GME payments for Medicare Advantage		266, 97	161, 008 22, 750		29. 00 30. 00
	Net Program direct GME amount			22, 750	405, 231	
	, ,		•			

	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10	
DI REC	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 150017	Peri od:	Worksheet E-4		
MEDI CA	AL EDUCATION COSTS		From 07/01/2013 To 06/30/2014	Date/Time Prep 12/1/2014 9:5		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32. 00	1	t. I, sum of col. 20 an	d 23, lines 74	0	32. 00	
	and 94)					
33. 00			74 and 94)	9, 098, 177	ı	
34. 00	3	e 32 ÷ line 33)		0. 000000	1	
	Medicare outpatient ESRD charges (see instructions)	0				
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII Part A Reasonable Cost	UNLY				
37. 00				68, 385, 629	27.00	
38.00	·			2, 774, 080		
	Cost of physicians' services in a teaching hospital (see instr	ructions)		2, 774, 080	1	
	Primary payer payments (see instructions)	uctions)		86, 077	1	
	Total Part A reasonable cost (sum of lines 37 through 39 minus	line 40)		71, 073, 632		
41.00	Part B Reasonable Cost	11116 40)		71,073,032	41.00	
42. 00				21, 200, 811	42.00	
43. 00	·			5, 988		
	Total Part B reasonable cost (line 42 minus line 43)			21, 194, 823		
	Total reasonable cost (sum of lines 41 and 44)			92, 268, 455	1	
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	41 ÷ line 45)		0. 770292	46. 00	
47.00	Ratio of Part B reasonable cost to total reasonable cost (line	44 ÷ line 45)		0. 229708	47. 00	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	ТВ				
	Total program GME payment (line 31)			405, 231	48. 00	
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		312, 146	49. 00	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		93, 085	50.00	

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

Provider CCN: 150017

| Peri od: | From 07/01/2013 | To 06/30/2014 | Worksheet G | Date/Time Prepared: | 12/1/2014 9:55 am

					12/1/2014 9:5	5 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund	0.00	4 00	
	CHIPDENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	-10, 013, 009			0	1.00
2. 00	Temporary investments	-10,013,009			0	2.00
3. 00	Notes receivable				0	3.00
4. 00	Accounts recei vabl e	99, 647, 317	1	, i	0	4. 00
5. 00	Other receivable	0		o o	Ō	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-20, 492, 586		0	0	6. 00
7.00	Inventory	12, 596, 484		o	0	7. 00
8.00	Prepai d expenses	2, 756, 010)	0	0	8. 00
9.00	Other current assets	2, 475, 545	6	0	0	9. 00
10. 00	Due from other funds	0) (0	10.00
11. 00	Total current assets (sum of lines 1-10)	86, 969, 761		0	0	11. 00
	FI XED ASSETS				_	
12.00	Land	14, 006, 167	1		-	12.00
13.00	Land improvements	3, 905, 311	1	-	0	13.00
14.00	Accumulated depreciation	-1, 052, 509	1		0	14.00
15. 00	Buildings	234, 764, 800	1	-	0	15. 00 16. 00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-31, 205, 041 19, 997, 319	1	-	0	17. 00
18. 00	Accumulated depreciation	-4, 556, 926		-	0	18.00
19. 00	Fi xed equipment	4, 036, 185	1	-	0	19.00
20. 00	Accumulated depreciation	-2, 238, 849	1		0	20.00
21. 00	Automobiles and trucks	1, 058, 149	1		0	21.00
22. 00	Accumulated depreciation	-816, 872	1	-	0	22.00
23. 00	Major movable equipment	62, 749, 391	1	-	0	23. 00
24. 00	Accumulated depreciation	-40, 796, 887		-	0	24.00
25. 00	Mi nor equipment depreciable	30, 903, 349		-	Ö	25. 00
26. 00	Accumulated depreciation	-22, 530, 173		-	ő	26.00
27. 00	HIT designated Assets	0		0	Ō	27. 00
28. 00	Accumulated depreciation	0		0	Ō	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		o	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	268, 223, 414		0	0	30.00
	OTHER ASSETS					
31.00	Investments	0) (0	0	31. 00
32.00	Deposits on Leases	0) (0	0	32. 00
33.00	Due from owners/officers	0) (0	0	33. 00
34.00	Other assets	9, 879, 985	i (0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	9, 879, 985	5	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	365, 073, 160)	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	11, 002, 626	1	-		37. 00
38. 00	Salaries, wages, and fees payable	11, 165, 777	1	-	0	38. 00
39. 00	Payroll taxes payable	1, 204, 556	1	0	0	39. 00
40. 00	Notes and Loans payable (short term)	16, 668		0	0	40.00
41.00	Deferred income	0)	0	0	41.00
42.00	Accel erated payments	0)			42.00
43.00	Due to other funds	-601, 984, 426	1	0	0	43.00
44. 00	Other current liabilities	6, 632, 076	1	1	-	
45. 00	Total current liabilities (sum of lines 37 thru 44)	-571, 962, 723	i (0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable				0	46. 00
47. 00	Notes payable	0		, i		47.00
48. 00	Unsecured Loans	-4			0	48. 00
49. 00	Other long term liabilities			-	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	_4		-		50.00
51. 00	Total liabilites (sum of lines 45 and 50)	-571, 962, 727		o o		51.00
01.00	CAPITAL ACCOUNTS	071,702,727		<u> </u>		01.00
52.00	General fund balance	937, 035, 887	,			52. 00
53. 00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			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	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion		1			
59. 00	Total fund balances (sum of lines 52 thru 58)	937, 035, 887		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	365, 073, 160) (0	0	60. 00
	[59]		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 LUTHERAN HOSPITAL OF INDIANA Peri od: From 07/01/2013 Provider CCN: 150017

					To	06/30/2014		epared: 55 am
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	1
		1.00	2.00	3.00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0 0 0 0	783, 211, 215 153, 824, 682 937, 035, 897 0 937, 035, 897		0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
	sheet (line 11 minus line 18)	5					1	17.00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0		0 0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 0 0 0 0		0			12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150017 Peri od: Worksheet G-2 From 07/01/2013 Parts I & II 06/30/2014 Date/Time Prepared: 12/1/2014 9:55 am Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 86, 536, 342 86, 536, 342 1.00 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 0 0 5.00 Swing bed - NF 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 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) 86, 536, 342 86, 536, 342 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 0 11.01 PEDIATRIC INTENSIVE CARE UNIT 2, 394, 923 2, 394, 923 11.01 NEONATAL INTENSIVE CARE UNIT 11.02 14, 166, 369 14, 166, 369 11 02 64, 441, 705 11.03 CARDIO INTENSIVE CARE UNIT 64, 441, 705 11.03 12.00 CORONARY CARE UNIT 24, 974, 258 24, 974, 258 12.00 13.00 BURN INTENSIVE CARE UNIT 13.00 14.00 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 105, 977, 255 105, 977, 255 16.00 Total intensive care type inpatient hospital services (sum of lines 16.00 11-15) 192. 513, 597 17.00 Total inpatient routine care services (sum of lines 10 and 16) 192, 513, 597 17.00 18.00 Ancillary services 974, 703, 308 706, 468, 261 1, 681, 171, 569 18.00 19.00 Outpatient services 30, 354, 065 80, 459, 418 110, 813, 483 19.00 RURAL HEALTH CLINIC 20.00 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 Λ 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 C 23.00 24.00 CMHC 24.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 25, 00 26.00 HOSPI CE 26.00 27.00 OTHER (SPECIFY) 27.00 28 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 1, 197, 570, 970 786, 927, 679 1, 984, 498, 649 28 00 line 1) PART II - OPERATING EXPENSES 29.00 29.00 Operating expenses (per Wkst. A, column 3, line 200) 372, 465, 795 30.00 ADD (SPECIFY) 0 30.00 0 31.00 31.00 0 32.00 32.00 33.00 0 33.00 0 34.00 34.00 0 35.00 35.00 36.00 Total additions (sum of lines 30-35) 36.00 37.00 DEDUCT (SPECIFY) 37.00 0 38.00 38.00 39.00 39.00 40.00 40.00

0

372, 465, 795

41.00

42.00

43.00

41.00

42.00

Total deductions (sum of lines 37-41)

to Wkst. G-3, line 4)

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer

Heal th	n Financial Systems LUTHERAN HOSPITAL C		In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 150017	Peri od:	Worksheet G-3	
			From 07/01/2013 To 06/30/2014	Date/Time Pre 12/1/2014 9:5	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1, 984, 498, 649	1, 00
2. 00	Less contractual allowances and discounts on patients' accounts			1, 467, 008, 280	
3. 00	Net patient revenues (line 1 minus line 2)	,		517, 490, 369	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		372, 465, 795	
5. 00	Net income from service to patients (line 3 minus line 4)	,		145, 024, 574	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	1 3			0	14.00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00		ın patients		0	
17. 00	3				17. 00
18. 00					18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	3			0	
21. 00	1			0	
22. 00	' '			0	22. 00
23. 00				0	23. 00
24. 00				8, 800, 108	
	Total other income (sum of lines 6-24)			8, 800, 108	
	Total (line 5 plus line 25)			153, 824, 682	
	OTHER EXPENSES (SPECIFY)			0	
28 00	Intal other expenses (sum of line 27 and subscripts)			Λ	28 00

153, 824, 682 29. 00

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)

CAL CITI	Financial Systems LUTHERAN HOSPITAL ATION OF CAPITAL PAYMENT	Provi der CCN: 150017	Peri od:	Worksheet L	2552-1
JALOUI	ATTON OF CALLIAL FAINLING	Trovider cen. 130017	From 07/01/2013 To 06/30/2014	Parts I-III Date/Time Pre 12/1/2014 9:5	
		Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			4, 126, 700	1.0
. 01	Model 4 BPCI Capital DRG other than outlier			0	1. C
2. 00	Capital DRG outlier payments			690, 393	2. 0
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
3. 00				253. 15	3.0
. 00	· · · · · · · · · · · · · · · · · · ·				4. 0
5. 00					5. 0
. 00					6. 0
. 00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	oatient days (Worksheet E	, part A line	3. 74	7. (
. 00	Percentage of Medicaid patient days to total days (see instru	ictions)		17. 87	8. (
. 00	Sum of lines 7 and 8	10113)		21. 61	9. (
0. 00	Allowable disproportionate share percentage (see instructions	5)		4. 48	
1. 00	Disproportionate share adjustment (line 10 times the sum of I			184, 876	
2. 00	, , ,			5, 043, 649	12.
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1. (
. 00	Program inpatient ancillary capital cost (see instructions)			0	2.
. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.
. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 5.
. 00	Tiotal Tripatrent program capital cost (Tine 3 x Tine 4)				ا ن
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
	Program inpatient capital costs (see instructions)			1.00	
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		1.00	2.
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2)	es (see instructions)		1.00 0 0	2. 3.
.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	res (see instructions)		1.00 0 0 0 0.00	2. 3. 4.
00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			1.00 0 0 0 0.00	2. 3. 4. 5.
. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	nstructions)	Line 6)	1.00 0 0 0 0.00 0.00	2. 3. 4. 5. 6.
00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	nstructions)	line 6)	1.00 0 0 0 0.00 0.00 0.00	2. 3. 4. 5. 6. 7.
00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	nstructions) v circumstances (line 2 x	line 6)	1.00 0 0 0 0.00 0 0.00 0.00	2. 3. 4. 5. 6. 7. 8.
00 00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	nstructions) v circumstances (line 2 x cable)	ŕ	1.00 0 0 0 0.00 0.00 0.00	2. 3. 4. 5. 6. 7. 8.
.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c	nstructions) / circumstances (line 2 x cable) capital payments (line 8	less line 9)	1.00 0 0 0.00 0.00 0.00	5.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to comparison of capital minimum payment level over comparison.	nstructions) v circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri	less line 9) or year	1.00 0 0 0.00 0.00 0.00 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payment level to capital payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital minimum payments (promparison of capital mini	estructions) v circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital payments (if line 12 is positive, enter	estructions) y circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri capital payment (from pri capital payment on this line	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over compari	estructions) y circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri capital payment (from pri capital payment on this line	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over compar	estructions) y circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri ryments (line 10 plus line the amount on this line capital payment for the f	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0 0 0 0	2. (3. (4. (5. (6. (7. (8. (9. (11. (12. (13. (
2.00 3.00 3.00 3.00 3.00 3.00 4.00 5.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over compari	estructions) y circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri ryments (line 10 plus line the amount on this line capital payment for the f	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.