Health Financia	al Systems	LUTHERAN HOSPITAL O	F INDIANA	In Lie	u of Form CMS	-2552-10
	required by law (42 USC 1395	S			FORM APPROVE	ED
payments made	since the beginning of the co	st reporting period being o	leemed overpayments	(42 USC 1395g).	OMB NO. 0938	3-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX C SUMMARY	OST REPORT CERTIFICATION	Provi der CCN: 1500	From 07/01/2015	Worksheet S Parts I-III Date/Time Pr 11/30/2016 5	
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically filed	cost report		Date: 11/30/2	016 Time:	5:24 pm
use only	2. [] Manually submitted co	st report				
	3. [0] If this is an amended 4. [F] Medicare Utilization.	report enter the number of Enter "F" for full or "L"	f times the provide for low.	r resubmitted this c	ost report	
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended		this Provider CCN 1	IO.NPR Date: 11.Contractor's Vendo 12.[0]If line 5, co number of tim	olumn 1 is 4:	

PART II - CERTIFICATION

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 07/01/2015 and ending 06/30/2016 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.

(Signed)

Officer or Administrator of Provider(s)

SR VICE PRESIDENT-REVENUE MANAGEMENT

Title

11/30/2016

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-265, 306	134, 712	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	-265, 306	134, 712	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

Number Number Type Certified T,	P P 3 5 6 7 8 8 9 10 11 12 13 14 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 11. 00 1
1.00 Street: 7950 WEST JEFFERSON BLVD	P P 3 P P 3 10 11 12 13 14 15 16 17 18 18 19 10 11 11 12 13 14 15 16 17 18 18 19 19 10 10 11 11 11 12 13 14 15 16 17 18 18 19 19 10 10 11 11 11 12 13 14 15 16 17 18 18 19 19 10 10 11 11 11 12 13 14 15 16 17 18 18 19 19 10 10 10 11 11 11 12 13 14 15 16 17 18 18 19 19 10 10 10 10 10 10 10 10	3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 11.
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Hospital and Hospital-Based Component I dentification: 3.00	P P 3	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00
3.00 Hospital	10 11 12 13 14 15 16 17 18	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00
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8.00 Swing Beds - NF 9.00 Hospi tal -Based SNF 10.00 Hospi tal -Based NF 11.00 Hospi tal -Based OLTC 12.00 Hospi tal -Based HHA 13.00 Separately Certi fi ed ASC 14.00 Hospi tal -Based Hospi ce 15.00 Hospi tal -Based Heal th Clinic - RHC 16.00 Hospi tal -Based Heal th Clinic - FQHC 17.00 Hospi tal -Based (CMHC) I 18.00 Renal Dialysis 19.00 Other From: 1.00	10 11 12 13 14 15 16 17 18	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
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11. 00 Hospi tal -Based OLTC 12. 00 Hospi tal -Based HHA 13. 00 Separately Certi fi ed ASC 14. 00 Hospi tal -Based Hospi ce 15. 00 Hospi tal -Based Heal th Clinic - RHC 16. 00 Hospi tal -Based Heal th Clinic - FOHC 17. 00 Hospi tal -Based (CMHC) I 18. 00 Renal Dialysis 19. 00 Other From: 20. 00 Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for disproportionate	11 12 13 14 15 16 17 17	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
12.00 Hospital -Based HHA 13.00 Separately Certified ASC 14.00 Hospital -Based Hospice 15.00 Hospital -Based Health Clinic - RHC 16.00 Hospital -Based Health Clinic - FQHC 17.00 Hospital -Based (CMHC) I 18.00 Renal Dialysis 19.00 Other From: 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate	12 13 14 15 16 17 17	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
13.00 Separately Certified ASC 14.00 Hospital -Based Hospice 15.00 Hospital -Based Health Clinic - RHC 16.00 Hospital -Based Health Clinic - FQHC 17.00 Hospital -Based (CMHC) I 18.00 Renal Dialysis 19.00 Other From: 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 21.00 Type of Control (see instructions) Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate	13 14 15 16 17 18	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
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15. 00 Hospital -Based Health Clinic - RHC 16. 00 Hospital -Based Health Clinic - FQHC 17. 00 Hospital -Based (CMHC) I 18. 00 Renal Dialysis 19. 00 Other From: 1. 00 20. 00 Cost Reporting Period (mm/dd/yyyy) 21. 00 Type of Control (see instructions) Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for disproportionate	15 16 17 18	15. 00 16. 00 17. 00 18. 00
16. 00 Hospital -Based Health Clinic - FQHC 17. 00 Hospital -Based (CMHC) I 18. 00 Renal Dialysis 19. 00 Other From: 1. 00 20. 00 Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for disproportionate Y	16 17 18 19	16. 00 17. 00 18. 00
17. 00 Hospital-Based (CMHC) I 18. 00 Renal Dialysis 19. 00 Other From: 1. 00 20. 00 Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for disproportionate Y	17 18 19	17. 00 18. 00
18.00 Renal Dialysis 19.00 Other From: 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Y	18	18. 00
19.00 Other Trom:	19	
20.00 Cost Reporting Period (mm/dd/yyyy) 21.00 Type of Control (see instructions) Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Y	To:	
20.00 Cost Reporting Period (mm/dd/yyyy) 21.00 Type of Control (see instructions) Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Y		
21.00 Type of Control (see instructions) Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Y	2.00	
Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Y	06/30/2016 20	20. 00
22.00 Does this facility qualify and is it currently receiving payments for disproportionate Y	21	21. 00
	N 22	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 §412.106(c)(2)(Pickle		
amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting Y	Y 22	22 A
	Y 22	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)		
22.02 Is this a newly merged hospital that requires final uncompensated care payments to be	N 22	22. 02
determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes		
or "N" for no, for the portion of the cost reporting period prior to October 1. Enter		
in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on		
or after October 1.		
22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N	N 22	22. 03
of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter		
in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period		
prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the		
cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with		
42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.		
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column	N 23	23. 00
1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the	11 23	20.00
method of identifying the days in this cost reporting period different from the method		
used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.		
In-State In-State Out-of Out-of Medical o	d Other	
Medicaid Medicaid State State HMO days		
paid days eligible Medicaid Medicaid	days	
unpaid paid days eligible		
days unpai d		
1.00 2.00 3.00 4.00 5.00	6.00	0.4 -
24.00 If this provider is an IPPS hospital, enter the 3,395 1,597 106 154 13,30	366 196 24	24. 00
in-state Medicaid paid days in column 1, in-state		
Medicaid eligible unpaid days in column 2,		
out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column		
4, Medicaid HMO paid and eligible but unpaid days in		
column 5, and other Medicaid days in column 6.	0 25	25 N
column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0	0 25	25. 00
column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 25	25. 00
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 column 1, the in-state Medicaid eligible unpaid days in column 2,	0 25	25. 00
column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 25	25. 0(
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 column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state	0 25	25. 0(

Health Financial Systems	LUTHERAN	HOSPI T	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMP					eriod:	Worksheet S-2			
				To			pared:		
		Y/N	I ME	Direct GME	I ME	Direct GME	20 pili		
		1.00	2. 00	3. 00	4. 00	5. 00			
61.06 Enter the amount of ACA §5503 averaged for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61. 06		
general surgery. (See 11	istractions)	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
			1. 00	2. 00	3. 00	4. 00			
61.10 Of the FTEs in line 61.05, speci specialty, if any, and the number for each new program. (see instruction column 1, the program name, enter program code, enter in column 3, unweighted count and enter in column 1, the program code in the count and enter in column 3, unweighted count.	er of FTE residents ructions) Enter in er in column 2, the the IME FTE				0. 00	0.00	61. 10		
61.20 Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program of 3, the IME FTE unweighted count	the number of FTE gram. (see the program name, code, enter in column				0. 00	0.00	61. 20		
4, direct GME FTE unweighted cou	ınt.								
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)									
62.00 Enter the number of FTE resident	0.00	62. 00							
your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)									
Teaching Hospitals that Claim Re 63.00 Has your facility trained reside	esidents in Nonprovide	er Sett	i ngs		aniada Entan	N	(2.00		
"Y" for yes or "N" for no in col	N	63. 00							
		Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
				1. 00	2. 00	3.00			
Section 5504 of the ACA Base Year period that begins on or after				This base year	is your cost r	reporting			
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1)	s yes, or your facilit nber of unweighted nor otations occurring in e number of unweighted our hospital. Enter in	ty train n-priman all non d non-pr n column	ned residents ry care nprovider rimary care n 3 the ratio	0. 00	0. 00	0. 000000	64. 00		
(Program Name		ogram Code	Unwei ghted	Unwei ghted	Ratio (col. 3/			
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))			
65.00 Enter in column 1, if line 63	1.00		2.00	3. 00 0. 00	4. 00	5. 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)				0.00	0.00	0.00000	85. 00		

Health Financial Systems LUTHERAN HOSPITAL OF I HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA P	INDIANA Provider CO	`N: 150017 Da	In eri od:		of Form CMS Vorksheet S	
THOST FAC AND HOST FAC HEACTH CARC COMMERCE TECHNITION DATA	Tovider co		om 07/01/2	015 F	Part I Date/Time P 11/30/2016	repared:
			V 1. 00		XI X 2. 00	5. 23 piii
95.00 If line 94 is "Y", enter the reduction percentage in the applicable 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "Napplicable column.		in the	0. 00 N		0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicabl Rural Providers	e column.		0. 00		0. 00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclus for outpatient services? (see instructions)	sive metho	d of payment	N			105. 00 106. 00
107.00 f this facility qualifies as a CAH, is it eligible for cost reimble training programs? Enter "Y" for yes or "N" for no in column 1. (syes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 ar reimbursed. If yes complete Wkst. D-2, Pt. II.	see instru	ctions) If				107. 00
108.00 s this a rural hospital qualifying for an exception to the CRNA 1 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108. 00
1	rsi cal (0ccupati onal 2.00	Speech 3. 00		Respirator 4.00	
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109. 00
110.00Did this hospital participate in the Rural Community Hospital Demo	netration	project (410	A Domo) for		1. 00 N	110. 00
the current cost reporting period? Enter "Y" for yes or "N" for no		project (410	A Dellio) For	\perp	IN	110.00
				1. 00	2.00 3.0	0
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" is yes, enter the method used (A, B, or E only) in column 2. If column 2 is ther "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) base Pub. 15-1, chapter 22, §2208. 1.	olumn 2 is Iong term	"E", enter i care (includ	n column es	N	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" for ye 117.00 s this facility legally-required to carry malpractice insurance? no.			N" for	N N		116. 00 117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? E claim-made. Enter 2 if the policy is occurrence.	Enter 1 if	the policy i	s	1		118. 00
		Premi ums	Losses		Insurance	
		1. 00	2.00	2.12	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		1, 246, 338		248		0 118. 01
118.02 Are mal practice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule li and 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 Harml §3121 and applicable amendments? (see instructions) Enter in colum "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no.	nn 1, "Y" es for the	for yes or Outpatient	N		N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable patients? Enter "Y" for yes or "N" for no.	e devices	charged to	Υ			121. 00
122.00 Does the cost report contain state health or similar taxes? Enter for no in column 1. If column 1 is "Y", enter in column 2 the Work where these taxes are included.			N			122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes	and "N" fo	or no. If	Y			125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the			11/05/200	08		126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 of this is a Medicare certified heart transplant center, enter the			02/16/19			127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 f this is a Medicare certified liver transplant center, enter the						128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the	certi fi ca	tion date in				129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter		fi cati on				130. 00
date in column 1 and termination date, if applicable, in column 2. 131.00 f this is a Medicare certified intestinal transplant center, enter	er the cer	ti fi cati on				131. 00
date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the in column 1 and termination date, if applicable, in column 2.		ation date				132. 00

OST THE THE HEALTH ONCE SOME EL	X IDENTIFICATION DATA	TAL OF INDIANA Provider C	CN: 150017	Peri od: From 07/01/2015 To 06/30/2016		-2 repared:
					117 307 2010). 20 piii
20,001,011,11,11		1 11 1:6:		1. 00	2. 00	100.0
33.00 If this is a Medicare certified ot in column 1 and termination date,			cation date			133. 0
34.00 If this is an organ procurement or and termination date, if applicable	ganization (OPO), enter		n column 1			134. 0
All Providers						
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. I	f yes, and home o	office costs	, Y	449008	140. 0
1.00		00	0113)	3.00		
If this facility is part of a chai home office and enter the home off					of the	
41. 00 Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: W			or's Number: 103	01	— 141. (
42.00 Street: 4000 MERIDIAN BLVD	PO Box:					142.0
43.00 City: FRANKLIN	State: T	N	Zi p Code	: 370	67	143. 0
					1.00	\dashv
44.00 Are provider based physicians' cos	sts included in Worksheet	A?			Y	144. 0
AE OOLE coots for march assistant	aimed on Micat A Liv. 7	1 one +h'	for	1.00	2. 00	145 (
45. 00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no in Clude Medicare utilization for no in column 2.	n column 1. If con n for this cost r	olumn 1 is reporting	Y		145. 0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	column 1. (See CMS Pub.			. N		146. 0
					1.00	
47.00 Was there a change in the statisti					N	147. (
48.00 Was there a change in the order of					N	148. (
49.00 Was there a change to the simplifi	ed cost finding method?	Part A	Part B	Title V	N Title XIX	149. (
					II LIC XIX	
		1.00	2.00	3.00	4. 00	
Does this facility contain a provi		n exemption from	the applica	ation of the low	er of costs	
or charges? Enter "Y" for yes or "		n exemption from nent for Part A a	the applica and Part B.	ation of the low (See 42 CFR §41	er of costs 3.13)	155
or charges? Enter "Y" for yes or " 55.00 Hospi tal		n exemption from nent for Part A a N	the applica and Part B. N	tion of the low (See 42 CFR §41 N	er of costs 3.13) N	
or charges? Enter "Y" for yes or " 55.00 Hospi tal 56.00 Subprovi der - IPF		n exemption from nent for Part A a	the applica and Part B.	ation of the low (See 42 CFR §41	er of costs 3.13)	156. (
or charges? Enter "Y" for yes or " 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF		n exemption from nent for Part A a N N	the applica and Part B. N N	(See 42 CFR §41 N	er of costs 3.13) N N	156. (157. (
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF		n exemption from nent for Part A a N N N N	the applica and Part B. N N N	ation of the low (See 42 CFR §41 N N N	er of costs 3.13) N N N	156. (157. (158. (159. (
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY		n exemption from nent for Part A a N N N	the applica and Part B. N N N N	ation of the low (See 42 CFR §41 N N N N	er of costs 3.13) N N N N N N	156. (157. (158. (159. (160. (
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY		n exemption from nent for Part A a N N N N	the applica and Part B. N N N	ation of the low (See 42 CFR §41 N N N	er of costs 3.13) N N N	156. 0 157. 0 158. 0 159. 0
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 67.00 Subprovi der - IRF 68.00 SUBPROVI DER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC		n exemption from nent for Part A a N N N N	the applica and Part B. N N N N	ation of the low (See 42 CFR §41 N N N N	er of costs 3.13) N N N N N N	156. (157. (158. (159. (160. (
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	'N" for no for each compo	n exemption from nent for Part A a N N N N N	the applica and Part B. N N N N N	ation of the low (See 42 CFR §41 N N N N N N	er of costs 3.13) N N N N N N 1.00	155. (156. (157. (158. (159. (160. (
or charges? Enter "Y" for yes or " 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multica	'N" for no for each compo	n exemption from nent for Part A a N N N N N	the applica and Part B. N N N N N	ation of the low (See 42 CFR §41 N N N N N N	er of costs 3.13) N N N N N N N	156. (157. (158. (159. (160. (161. (
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 67.00 Subprovi der - IRF 68.00 SUBPROVI DER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	ampus hospital that has o	n exemption from nent for Part A a N N N N N N N County	the application and Part B. N N N N N N Sees in difference and the sees in	erent CBSAs?	er of costs 3.13) N N N N N N N N N N FTE/Campus	156. 0 157. 0 158. 0 159. 0
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 67.00 Subprovi der - IRF 68.00 SUBPROVI DER 69.00 SNF 90.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has o	n exemption from nent for Part A a N N N N N N N N N N N N N N N N N N N	the application and Part B. N N N N N N Sees in difference and the sees in	ation of the low (See 42 CFR §41) N N N N N N	er of costs 3.13) N N N N N N N N N FTE/Campus 5.00	156. (157. (158. (159. (160. (161. (
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 67.00 Subprovi der - IRF 68.00 SUBPROVI DER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has o	n exemption from nent for Part A a N N N N N N N County	the application and Part B. N N N N N N Sees in difference and the sees in	erent CBSAs?	er of costs 3.13) N N N N N N N N N FTE/Campus 5.00	156. (157. (158. (159. (160. (161. (
or charges? Enter "Y" for yes or " 55.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 68.00 SUBPROVIDER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	ampus hospital that has on Name	n exemption from nent for Part A a N N N N N N 1 N N N N N N N N N N N N	the applicated Part B. N N N N N N Sees in diffe	erent CBSAS? P Code CBSA 3.00 4.00	er of costs 3.13) N N N N N N N N N FTE/Campus 5.00	156. (157. (158. (159. (160. (161. (
or charges? Enter "Y" for yes or " 55. 00 Hospital 66. 00 Subprovider - IPF 67. 00 Subprovider - IRF 68. 00 SUBPROVIDER 69. 00 SNF 60. 00 HOME HEALTH AGENCY 61. 00 CMHC Multicampus 65. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Ampus hospital that has on Name O O Incentive in the Americal formula of the second	n exemption from nent for Part A a N N N N N N N 1 N N N N N N N N N N N	the applicated Part B. N N N N N N Sees in difference State Zi 2.00 Reinvestmer	erent CBSAs? P Code CBSA 3.00 4.00	er of costs 3.13) N N N N N N N N S T.00 N FTE/Campus 5.00 0.0	156. (157. (158. (159. (160. (161. (

Health Financial Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA		Peri od: From 07/01/2015	Worksheet S-2 Part I	
			To 06/30/2016		nared:
			10 00/ 30/ 2010	11/30/2016 5:	
	Endi ng				
	2. 00				
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)		170. 00			
				1.00	
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst. S (see instructions)	N	171. 00			

	Financial Systems LUTHERAN HOSPIT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 150017	In Lie	u of Form CMS- Worksheet S-2			
O3PI I	AL AND HUSPITAL HEALTH CAKE KETMBUKSEMENT QUESTIUNNAFRE	Pi ovi der		From 07/01/2015 To 06/30/2016	Worksheet 5-2 Part I Date/Time Pre 11/30/2016 5:	epared:		
				Y/N	Date			
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO ro	enoneoe Ent	1.00	2. 00			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOT ALL NO LE	sponses. Ent	er arr dates in t	Tie			
	Provider Organization and Operation							
. 00	Has the provider changed ownership immediately prior to the			N		1.00		
	reporting period? If yes, enter the date of the change in c	column 2. (see	Y/N	Date	V/I			
			1.00	2.00	3. 00			
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. 00		
3. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the provice officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)			3.00				
			Y/N	Туре	Date			
	Financial Data and Reports		1.00	2. 00	3. 00			
4. 00 5. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.			4.00				
3.00	those on the filed financial statements? If yes, submit rec		N			3.00		
	, , , , , , , , , , , , , , , , , , , ,		!	Y/N	Legal Oper.			
				1. 00	2. 00			
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is N the legal operator of the program?							
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	Y N		7. 00 8. 00				
9. 00	Are costs claimed for Interns and Residents in an approved	Y		9. 00				
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		he current	N		10.00		
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. 00		
					Y/N 1. 00			
	Bad Debts				1.00			
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00		
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see in	structions.	N	14. 00		
15. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,			Y	15. 00		
		Y/N	t A Date	Par Y/N	<u>t в</u> Date			
		1.00	2.00	3.00	4. 00			
16. 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	Y	11/01/2016		11/01/2016	16. 00		
17. 00	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	N		N		17. 00		
7. 00	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)	IN		14		17.00		
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00		
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00		

	Financial Systems LUTHERAN HOSPITA FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 07/01/2015 To 06/30/2016	u of Form CMS- Worksheet S-2 Part II Date/Time Pre 11/30/2016 5:	2 epared:			
		Descrip	otion	Y/N	Y/N				
		0		1. 00	3. 00				
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00			
	Report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date				
		1.00	2. 00	3. 00	4. 00				
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00			
					1 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	OT CHILDRENS HO	SDI TAI S)		1. 00				
	Capi tal Related Cost	1 CHI EDICENS HO	JITTALJ)						
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 00			
23. 00	Have changes occurred in the Medicare depreciation expense of	due to appraisa	ls made du	ing the cost		23. 00			
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	d into during t	hie cost r	onarting pariod?		24. 00			
24.00	If yes, see instructions	eporting perrous		24.00					
25. 00	Have there been new capitalized leases entered into during t	? If yes, see		25. 00					
2/ 00	instructions.	6		24 00					
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	r yes, see		26. 00					
27. 00	Has the provider's capitalization policy changed during the	f yes, submit		27. 00					
	copy.								
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting								
26. 00	period? If yes, see instructions.	t reporting		28. 00					
29. 00	Did the provider have a funded depreciation account and/or b	Reserve Fund)		29. 00					
	treated as a funded depreciation account? If yes, see instru								
30. 00	Has existing debt been replaced prior to its scheduled matur instructions.		30.00						
31. 00	Has debt been recalled before scheduled maturity without iss		31.00						
	instructions.								
32. 00	Purchased Services Have changes or new agreements occurred in patient care serv	vi cos furni shod	through co	ontractual		32.00			
32.00	arrangements with suppliers of services? If yes, see instruc		till ough Co	onti actual		32.00			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl	lied pertaining	to competi	tive bidding? If		33.00			
	no, see instructions.								
34. 00	Provider-Based Physicians Are services furnished at the provider facility under an arr	rangement with	provi der-ba	ased physicians?		34.00			
0 1. 00	If yes, see instructions.	angement with	provider b	asca physicians.		01.00			
35. 00			s with the	provi der-based		35. 00			
	physicians during the cost reporting period? If yes, see ins	structions.		Y/N	Date				
				1. 00	2. 00				
	Home Office Costs								
	Were home office costs claimed on the cost report?		661	Y		36.00			
37. 00	If line 36 is yes, has a home office cost statement been pre- If yes, see instructions.	epared by the h	ome office	? Y		37. 00			
38. 00		ice different f	rom that o	f Y	12/31/2015	38.00			
	the provider? If yes, enter in column 2 the fiscal year end	of the home of	fi ce.						
39. 00		r chain compone	nts? If yes	s, Y		39. 00			
40. 00	see instructions. If line 36 is yes, did the provider render services to the h	nome office? I	f ves see	N		40.00			
10. 00	instructions.	Tome office.	, yes, see			10.00			
		1. 0				_			
	Cost Report Preparer Contact Information	2.	00						
		KUZI WA		TSI GA		41.00			
41. 00		NUZI WA							
41. 00	Enter the first name, last name and the title/position keld by the cost report preparer in columns 1, 2, and 3,	NOZI WA							
	Enter the first name, last name and the title/position keld by the cost report preparer in columns 1, 2, and 3, respectively.					40.00			
41. 00	Enter the first name, last name and the title/position keld by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	CHS				42.00			
	Enter the first name, last name and the title/position keld by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.			KUZI WA_TSI GA@CI	HS. NET	42.00			

Heal th	Financial Systems	LUTHERAN HOSPIT	AL OF	I NDI ANA				In Lie	u of Form CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN:	150017	Peri From To	n 07/01/2015	Worksheet S-2 Part II Date/Time Pro 11/30/2016 5:	pared:
				3.	00					
	Cost Report Preparer Contact Information									
	Enter the first name, last name and the t held by the cost report preparer in colum respectively.	•	MANA	GER						41. 00
	Enter the employer/company name of the copreparer.	st report								42. 00
43.00	Enter the telephone number and email addr report preparer in columns 1 and 2, respe									43. 00

| Peri od: | Worksheet S-3 | From 07/01/2015 | Part I | Date/Time Prepared: |

					''	00/30/2010	11/30/2016 5:	
				·			I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	'	Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		241	88, 206	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			241	88, 206	0. 00	0	7. 00
0.00	beds) (see instructions)	21.00		0		0.00	0	0.00
8.00	INTENSIVE CARE UNIT	31. 00		0		0.00	0	8. 00
8. 01	PEDIATRIC INTENSIVE CARE UNIT	31. 01		10	1	0.00	0	8. 01
8. 02	NEONATAL INTENSIVE CARE UNIT	31. 02		24	1	0.00	0	8. 02
8. 03 9. 00	CARDIO INTENSIVE CARE UNIT	31. 03		84		0. 00 0. 00	0	8. 03
10.00	CORONARY CARE UNIT	32. 00		24	8, 784	0.00	U	9. 00 10. 00
11. 00	BURN INTENSIVE CARE UNIT 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)	43.00		383	140, 178	0.00	0	14. 00
15. 00	CAH visits			303	140, 170	0.00	Ö	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		0	0		0	16. 00
17. 00	SUBPROVI DER – I RF	10.00		ū				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)			383				27.00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days				I			33. 00

Health Financial Systems LUTHERAN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150017

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 07/01/2015 | Part |
| To 06/30/2016 | Date/Time Prepared: | 11/30/2016 5: 23 pm

						11/30/2016 5:	23 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	·
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	22, 672	1, 269	64, 585			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)	19, 588	15, 886				2. 00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	22, 672	1, 269	64, 585			7. 00
8.00	INTENSIVE CARE UNIT	0	0	C)		8. 00
8. 01	PEDIATRIC INTENSIVE CARE UNIT	0	141	1, 171			8. 01
8. 02	NEONATAL INTENSIVE CARE UNIT	0	444	4, 339	1		8. 02
8.03	CARDIO INTENSIVE CARE UNIT	7, 221	578	21, 035			8. 03
9.00	CORONARY CARE UNIT	2, 829	139	7, 205			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		161	1, 845			13. 00
14. 00	Total (see instructions)	32, 722	2, 732	100, 180	6. 07	2, 122. 18	1
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVIDER - I PF	0	0	C	0.00	0.00	
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 SURGI CAL CENTER (D. P.)						23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	0	0	C			24. 00 24. 10
25. 00	CMHC - CMHC	٩	٩	C			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00					6. 07	2, 122. 18	
28. 00	Observation Bed Days		0	547		2, 122. 10	28.00
29. 00		0	ď	347			29.00
30. 00	· ·	٥		C			30.00
31. 00				C			31.00
32. 00		0	196	354			32.00
32. 00	Total ancillary labor & delivery room		170	334			32. 00
52.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	o	ļ				33. 00
		-1	'		1	1	

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150017 Peri

Peri od: Worksheet S-3 From 07/01/2015 Part I To 06/30/2016 Date/Time Prepared:

11/30/2016 5:23 pm Full Time Di scharges Equi val ents Title V Title XVIII Total All Component Nonpai d Title XIX Workers Pati ents 12.00 13.00 11.00 14.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 5, 905 3, 292 19, 801 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) 3, 385 2 00 0 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 ol 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 PEDIATRIC INTENSIVE CARE UNIT 8.01 8.01 8.02 NEONATAL INTENSIVE CARE UNIT 8.02 8.03 CARDIO INTENSIVE CARE UNIT 8.03 9.00 CORONARY CARE UNIT 9.00 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 13.00 13.00 14.00 Total (see instructions) 5, 905 3, 292 19,801 0.00 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 0.00 0 0 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 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 FEDERALLY QUALIFIED HEALTH CENTER 26, 25 26, 25 27 00 Total (sum of lines 14-26) 0 00 27 00 28. 00 Observation Bed Days 28.00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions)

33.00

LTCH non-covered days

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150017 | Period: From 07/01/2

					T	06/30/2016	Date/Time Pre 11/30/2016 5:	
		Worksheet A		Recl assi 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 ÷ col. 5)	
				Worksheet A-6)	3)	col . 4	COI . 3)	
	DADE LA WAGE DATA	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	111, 695, 608	0	111, 695, 608	4, 414, 138. 00	25. 30	1.00
2.00	instructions)		0		0	0.00	0.00	2 00
2.00	Non-physician anesthetist Part A		0	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	0	0.00	0.00	4. 00
4.00	Admi ni strati ve		0		0	0.00	0.00	4.00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00	1	
5. 00 6. 00	Physician-Part B Non-physician-Part B		0	0	0	0. 00 0. 00		
7. 00	Interns & residents (in an	21. 00	151	Ö	151	3. 00		
7 01	approved program) Contracted interns and		0		0	0.00	0.00	7 01
7. 01	residents (in an approved		Ü	J	U	0. 00	0. 00	7. 01
	programs)							
8. 00 9. 00	Home office personnel	44. 00	0	0	0	0. 00 0. 00		
10.00	Excluded area salaries (see		2, 219, 757	368, 477	2, 588, 234			
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		176, 779	0	176, 779	2, 781. 00	63. 57	11. 00
40.00	Care				0	0.00		40.00
12. 00	Contract labor: Top level management and other		0	0	0	0. 00	0.00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		620, 618	0	620, 618	4, 416. 12	140 52	13. 00
13.00	A - Administrative		020, 018		020, 018	4, 410. 12	140. 53	13.00
14. 00	Home office salaries &		0	0	0	0. 00	0. 00	14. 00
15. 00	wage-related costs Home office: Physician Part A		11, 280, 727	0	11, 280, 727	320, 619. 00	35, 18	15. 00
	- Admi ni strati ve				,,			
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 00
	WAGE-RELATED COSTS	L						
17. 00	Wage-related costs (core) (see instructions)		22, 057, 870	0	22, 057, 870			17. 00
18. 00	Wage-related costs (other)		0	0	0			18. 00
40.00	(see instructions)				500.004			40.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		532, 334 0	0	532, 334 0			19. 00 20. 00
20.00	A		0		9			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
00.04	Administrative		0		0			00.01
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0		0			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00
25. 00	Interns & residents (in an approved program)		23	0	23			25. 00
	OVERHEAD COSTS - DIRECT SALARIE	S						
26.00	Employee Benefits Department	4. 00	504, 908		504, 908			
27. 00 28. 00	Administrative & General Administrative & General under	5. 00	10, 921, 441 213		10, 342, 061 213			
	contract (see inst.)		2.0		2.0			
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	0 1, 599, 889	0	0 1, 599, 889	0. 00 68, 550. 00		
31. 00	Laundry & Linen Service	8. 00	1, 377, 887	0	1, 377, 887	0. 00		
32. 00	Housekeepi ng	9. 00	1, 440, 418	0	1, 440, 418		12. 12	32. 00
33. 00	Housekeeping under contract (see instructions)		0	0	0	0.00	0. 00	33. 00
34. 00	Di etary	10. 00	2, 740, 396	-1, 629, 229	1, 111, 167	74, 121. 11	14. 99	
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
36. 00	i nstructi ons) Cafeteri a	11. 00	0	1, 664, 832	1, 664, 832	128, 299. 89	12. 98	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	4, 659, 647 1, 404, 754					1
40. 00		15. 00	6, 005, 734		6, 005, 734	•		40. 00
	·	,						

Health Financial Systems	L	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150017	Peri od:	Worksheet S-3	
					From 07/01/2015		
				[To 06/30/2016		
						11/30/2016 5:	23 pm_
	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)	3)	col. 4		
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	1, 491, 313	845, 599	2, 336, 91	2 112, 277. 00	20. 81	41.00
Records Library							
42.00 Social Service	17. 00	0	2, 084, 299	2, 084, 29	70, 266. 00	29. 66	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 150017 Peri od: From 07/01/2015 To 06/30/2016 11/30/2016 5: 23 pm 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 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 111, 695, 670 111, 695, 670 4, 414, 151. 00 25. 30 1.00 instructions) 2.00 Excluded area salaries (see 2, 219, 757 368, 477 2, 588, 234 25. 59 2.00 101, 154. 00 instructions) 3.00 Subtotal salaries (line 1 109, 475, 913 -368, 477 109, 107, 436 4, 312, 997. 00 25.30 3.00 minus line 2) 4.00 Subtotal other wages & related 12, 078, 124 12, 078, 124 327, 816. 12 36.84 4.00 costs (see inst.) Subtotal wage-related costs 5.00 22, 057, 870 C 22, 057, 870 0.00 20. 22 5.00 (see inst.)

-368, 477

-368, 477

143, 243, 430

30, 400, 236

4, 640, 813. 12

1, 350, 166. 00

143, 611, 907

30, 768, 713

6.00

7.00

30 87

22.52

Total (sum of lines 3 thru 5)

Total overhead cost (see

instructions)

6.00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150017	Period: Worksheet S-3 From 07/01/2015 Part IV
		To 06/30/2016 Date/Time Prepared:

	To 06/30/2016	11/30/2016 5:	
		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 134, 673	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)	11, 843, 877	8.00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	145, 555	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	104, 301	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	9, 249	
13.00	Disability Insurance (If employee is owner or beneficiary)	53, 254	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	196, 067	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, 501, 425	17. 00
18. 00	Medicare Taxes - Employers Portion Only	1, 520, 494	18. 00
19. 00		0	19. 00
20. 00	State or Federal Unemployment Taxes	310, 433	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	ol	22. 00
23. 00	•	ő	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	22, 819, 328	
50	Part B - Other than Core Related Cost	,,	
25. 00	OTHER EMPLOYEE BENEFITS	-229, 100	25. 00
	'		

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA		In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der Co	CN: 150017 I	Peri od:	Worksheet S-3	
			From 07/01/2015	Part V	
		-	To 06/30/2016	Date/Time Prep	oared:
				11/30/2016 5: 2	23 pm
Cost Center Description			Contract Labor	Benefit Cost	
			1. 00	2. 00	
PART V - Contract Labor and Benefit Cost					
Hospital and Hospital-Based Component Iden	ti fi cati on:				
1.00 Total facility's contract labor and benefi	t cost		0	0	1.00
2.00 Hospi tal			o	ol	2.00

		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	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	Subprovi der - (0ther)	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

Heal th	Financial Systems LUTHERAN HOSPITAL OF I	NDI ANA		In Lie	u of Form CMS-2	2552-10
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovi der	CCN: 150017	Peri od:	Worksheet S-10	0
				From 07/01/2015 To 06/30/2016	Date/Time Pre	namad.
				10 00/30/2010	11/30/2016 5:	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by li	ne 202 column	1 8)	0. 137951	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				48, 280, 626	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		from Modicois	10	N	3.00
4. 00 5. 00	If line 3 is "yes", does line 2 include all DSH or supplemental pa If line 4 is "no", then enter DSH or supplemental payments from Me		ironi wedicard	11	0	4. 00 5. 00
6.00	Medicaid charges	eui cai u			362, 058, 499	6.00
7. 00	Medicaid cost (line 1 times line 6)				49, 946, 332	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (lir	ne 7 min	us sum of lir	nes 2 and 5: if	1, 665, 706	
	< zero then enter zero)				, ,	
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for e	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	9. 00
10. 00	Stand-alone SCHIP charges				0	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.00
12. 00	Difference between net revenue and costs for stand-alone SCHIP (li	ne 11 m	inus line 9;	if < zero then	0	12. 00
	<pre>enter zero) Other state or local government indigent care program (see instruction)</pre>	ations f	or oach line			
13. 00	Net revenue from state or local indigent care program (Not include				126, 920	13. 00
14. 00	Charges for patients covered under state or local indigent care pr			,	2, 413, 382	
00	10)	og. a (2, 110, 002	
15. 00	State or local indigent care program cost (line 1 times line 14)				332, 928	15. 00
16.00	Difference between net revenue and costs for state or local indige	ent care	program (lir	ne 15 minus line	206, 008	16. 00
	13; if < zero then enter zero)					
47.00	Uncompensated care (see instructions for each line)					47.00
17.00	Private grants, donations, or endowment income restricted to fundi				0	
18. 00 19. 00	Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, SCHIP and state and local i			o (our of lines	0 1, 871, 714	18. 00 19. 00
19.00	8, 12 and 16)	nai gent	care program	is (suil of fines	1, 8/1, /14	19.00
	jo, 12 and 10)		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20.00	Total initial obligation of patients approved for charity care (at		7, 803, 79	3, 039, 933	10, 843, 725	20. 00
	charges excluding non-reimbursable cost centers) for the entire fa		4 07/ 5		4 405 000	
21. 00	Cost of initial obligation of patients approved for charity care (times line 20)	(iine T	1, 076, 54	419, 362	1, 495, 903	21. 00
22. 00	Partial payment by patients approved for charity care		183, 52	183, 182	366, 702	22. 00
23. 00	Cost of charity care (line 21 minus line 22)		893, 02		1, 129, 201	
20.00	cost of chartty care (fine 21 millios fine 22)		070, 02	200, 100	1, 127, 201	20.00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient da	ays beyo	nd a Length o	of stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indigent care pro		-	-		
25. 00	00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0					
26. 00	Total bad debt expense for the entire hospital complex (see instru				30, 341, 826	
27. 00	Medicare bad debts for the entire hospital complex (see instruction		- 1: 07)		950, 030	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		,	. 20)	29, 391, 796	
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expens Cost of uncompensated care (line 23 column 3 plus line 29)	se (IIne	i times iine	: 20)	4, 054, 628 5, 183, 829	
	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			7, 055, 543	
51.00	Trotal and or mour sea and an compensated care cost (Time 17 plus Time	30)			1,000,040	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	CCN: 150017 F	Peri od:	Worksheet A	
					rom 07/01/2015 o 06/30/2016		pared:
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	11/30/2016 5: Recl assi fi ed	23 pm
	cost center bescription	Jai ai i cs	Other	+ col . 2)	ons (See A-6)	Trial Balance	
				·	,	(col. 3 +-	
						col . 4)	
	CENEDAL CEDVICE COCT CENTEDS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT		6, 764, 898	6, 764, 898	5, 064, 950	11, 829, 848	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		15, 014, 762	15, 014, 762		20, 585, 978	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	504, 908	1, 119, 300	1, 624, 208		15, 790, 338	
5. 01	00540 ADMI TTI NG	10, 921, 441	68, 107, 737	79, 029, 178		10, 754, 730	
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	1 500 000	0	12 241 226		45, 044, 360	
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 599, 889	10, 641, 440 1, 623, 535	12, 241, 329 1, 623, 535		12, 255, 042 1, 623, 550	
9. 00	00900 HOUSEKEEPING	1, 440, 418	1, 680, 189	3, 120, 607		3, 120, 607	1
10.00	01000 DI ETARY	2, 740, 396	3, 614, 421	6, 354, 817		2, 324, 103	1
11. 00	01100 CAFETERI A	0	0	C	., , . = -	4, 119, 728	
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 659, 647	793, 111	5, 452, 758		1, 713, 591	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 404, 754 6, 005, 734	45, 622, 437 32, 522, 554	47, 027, 191 38, 528, 288		5, 560, 985 7, 838, 715	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 491, 313	2, 308, 386	3, 799, 699		5, 245, 124	
17. 00	01700 SOCIAL SERVICE	0	0	C, , C		2, 010, 041	1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	151	2, 807, 896	2, 808, 047	-2, 807, 885	162	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	C	_, _, _, _,	2, 807, 885	
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PHARMACY RESIDENCY PROGRAM	190, 829 177, 506	99, 249 23, 380	290, 078 200, 886		288, 559 200, 886	1
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	177, 500	23, 360	200, 880	<u>, </u>	200, 880	23.01
30.00	03000 ADULTS & PEDIATRICS	18, 744, 170	4, 517, 595	23, 261, 765	-1, 796, 392	21, 465, 373	30.00
31.00	03100 INTENSIVE CARE UNIT	16, 192, 615	3, 724, 502	19, 917, 117	-19, 917, 117	0	31. 00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 141, 604	512, 503	2, 654, 107		1, 112, 576	
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	0	0	C	_, _, _, _,	2, 653, 502	
31. 03 32. 00	03101 CARDIO INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0	C	14, 070, 446 4, 733, 845	14, 070, 446 4, 733, 845	
40. 00	04000 SUBPROVI DER - I PF	0	0	(0 4, 733, 643	4, 733, 643	
43. 00	04300 NURSERY	0	58, 253	58, 253	265, 098		
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 053, 371	13, 953, 509	23, 006, 880		19, 542, 262	
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	3, 009, 230	804, 418 -1	3, 813, 648 -1		0 1, 480, 364	
53. 00	05300 ANESTHESI OLOGY	73, 472	2, 952, 713	3, 026, 185		2, 853, 808	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 293, 452	2, 794, 103	7, 087, 555		7, 016, 258	
54. 01	05401 PET SCAN	663, 536	116, 475	780, 011	-639, 090	140, 921	54. 01
56. 00	05600 RADI OI SOTOPE	490, 267	1, 617, 874	2, 108, 141		1, 515, 495	
57. 00 58. 00	05700 CT SCAN 05800 MRI	722, 439 422, 115	367, 288 25, 338	1, 089, 727 447, 453		1, 074, 453 0	
60.00	06000 LABORATORY	4, 399, 295	9, 968, 141	14, 367, 436		14, 020, 713	
65. 00	06500 RESPI RATORY THERAPY	3, 895, 431	1, 443, 717	5, 339, 148			
66.00	06600 PHYSI CAL THERAPY	2, 454, 439	580, 149	3, 034, 588			66. 00
	06700 OCCUPATI ONAL THERAPY	661, 824	51, 168	712, 992			67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	264, 392 4, 590, 334	24, 683 2, 846, 060	289, 075 7, 436, 394		0 2, 484, 933	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	4, 570, 554	2, 840, 000	7, 430, 374	1, 535, 914	1, 535, 914	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	Ō	Č	18, 693, 735	18, 693, 735	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	22, 894, 806	22, 894, 806	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	30, 264, 600	30, 264, 600	
74. 00 76. 00	07400 RENAL DI ALYSI S 03140 CARDI O CATH LAB	0	2, 337, 042	2, 337, 042	3, 374, 187	2, 337, 042 3, 374, 187	
76. 00	03050 ENDOSCOPY	455, 011	79, 588	534, 599		4, 807, 821	
76. 02	03950 CARDI AC REHAB	0	0	C ., c . ,		485, 099	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	2, 126, 405	887, 095	3, 013, 500		4, 177, 635	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 053, 798	2, 810, 568	6, 864, 366	-109, 015	6, 755, 351	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVI CES	1, 810, 407	4, 582, 324	6, 392, 731	-101, 076	6, 291, 655	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	1, 721, 684	1, 721, 684	-6, 624	1, 715, 060	96. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	0	0	C			
118.00	10600 HEART ACQUISITION SUBTOTALS (SUM OF LINES 1-117)	111, 654, 593	251, 520, 084	363, 174, 677	1,	449, 073 360, 931, 087	
110.00	NONREI MBURSABLE COST CENTERS	111,004,073	201, 020, 004	505, 174, 077	2, 243, 370	300, 731, 007	1.13.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	450, 559	450, 559	7, 250	457, 809	
	07950 CLOSED PSYCH UNIT	0	0	C	0		194. 00
	07951 MARKETI NG 07952 SENI OR CI RCLE	0 41, 015	0 35, 899	76, 914	2, 163, 164 386	2, 163, 164	194. 01 194. 02
	07952 SENTOR CIRCLE	41,015	35, 6 79	70, 714	72, 790		194. 02
200.00		111, 695, 608	252, 006, 542	363, 702, 150		363, 702, 150	
			'		'		

 Health Financial
 Systems
 LUTHERAN HOST

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 150017 | Peri od: From 07/01/201

Peri od: From 07/01/2015
To 06/30/2016 Date/Ti me Prepared: 11/30/2016 5: 23 pm

			11/30/2016 5:	23 piii
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
OFNEDAL CEDIU OF COOT OFNEDO	6. 00	7. 00		
GENERAL SERVICE COST CENTERS	4 002 415	1/ 012 2/2		1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP	4, 983, 415 951, 898			1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-79, 185			4. 00
5. 01 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	-337, 529			5. 01 5. 02
7.00 O0700 OPERATION OF PLANT	3, 195, 735 -64, 374			7. 00
8.00 O0800 LAUNDRY & LINEN SERVICE	20, 343			8.00
9. 00 00900 HOUSEKEEPI NG	20, 343			9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A	-2, 103, 043	,		11.00
				1
13. 00 01300 NURSI NG ADMI NI STRATI ON	-140			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0			14. 00
15. 00 01500 PHARMACY	4 255	7, 838, 715		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-6, 355			16.00
17. 00 01700 SOCIAL SERVICE	0			17. 00
21. 00 02100 1&R SERVI CES-SALARY & FRI NGES APPRV	0	1		21.00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0			22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0			23. 00
23. 01 02301 PHARMACY RESI DENCY PROGRAM	0	200, 886		23. 01
30. 00 O3000 ADULTS & PEDIATRICS	FOE 200	20.0(0.072		20.00
	-505, 300	1		30.00
31. 00 03100 INTENSIVE CARE UNIT 31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0 0			31.00
				1
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	0			31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	0	,		31. 03
32. 00 03200 CORONARY CARE UNIT	0			32.00
40. 00 04000 SUBPROVI DER - I PF	0	1		40.00
43. 00 04300 NURSERY	-8, 920	314, 431		43. 00
ANCILLARY SERVICE COST CENTERS	/2/ 270	10 015 004		
50. 00 05000 OPERATING ROOM	-626, 378			50.00
51. 00 05100 RECOVERY ROOM	0			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	.,,		52.00
53. 00 05300 ANESTHESI OLOGY	-2, 770, 392			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-4, 784			54.00
54. 01 05401 PET SCAN	0			54. 01
56. 00 05600 RADI OI SOTOPE	0			56.00
57. 00 05700 CT SCAN	0			57. 00
58. 00 05800 MRI	0	0		58. 00
60. 00 06000 LABORATORY	-202, 000	1		60.00
65. 00 06500 RESPIRATORY THERAPY	0	4, 665, 018		65. 00
66. 00 06600 PHYSI CAL THERAPY	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	1		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			73. 00
74. 00 07400 RENAL DI ALYSI S	0			74.00
76. 00 03140 CARDI O CATH LAB	-347, 944			76. 00
76. 01 03050 ENDOSCOPY	-73, 980			76. 01
76. 02 03950 CARDI AC REHAB	0	485, 099		76. 02
OUTPATIENT SERVICE COST CENTERS	100 55:	0.75.05		00.00
90. 00 09000 CLI NI C	-423, 581			90.00
91. 00 09100 EMERGENCY	-1, 090, 933	5, 664, 418		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES	-3, 089, 097			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	-1, 715, 060	0		96. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON	0			105. 00
106.00 10600 HEART ACQUISITION	0			106. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-4, 297, 604	356, 633, 483		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192. 00
194.00 07950 CLOSED PSYCH UNIT	0	- 1		194. 00
194. 01 07951 MARKETI NG	0	2, 163, 164		194. 01
194. 02 07952 SENI OR CI RCLE	0			194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	,		194. 03
200.00 TOTAL (SUM OF LINES 118-199)	-4, 297, 604	359, 404, 546		200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150017

					11/30/2016 5: 23 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	A - EMPLOYEE BENEFITS			44 470 740	4.00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14, 170, 748	1.00
2.00	OPERATION OF PLANT	7.00	0	563	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7, 250	3.00
4. 00	SENI OR CI RCLE	1 <u>94.</u> 02		386	4.00
	TOTALS		Ŋ	14, 178, 947	
1 00	B - OXYGEN MEDICAL SUPPLIES CHARGED TO	71 00	ol	040 221	1 00
1. 00	PATIENT	71. 00	U	940, 231	1.00
2.00	PATIENT	0.00	0	О	2.00
3.00		0.00	o	0	3.00
3.00	TOTALS — — — —			940, 231	3.00
	C - RENTAL AND LEASE		<u> </u>	740, 231	
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	O	5, 498, 746	1.00
2. 00	OTHER ADMINISTRATIVE AND	5. 02	0	53, 755	2.00
2.00	GENERAL	3. 02	٥	33, 733	2.00
3.00	OPERATION OF PLANT	7. 00	o	13, 150	3.00
4.00	LAUNDRY & LINEN SERVICE	8. 00	o	15	4. 00
5. 00		0.00	o	0	5. 00
6. 00		0. 00	0	Ö	6.00
7. 00		0.00	0	Ö	7.00
8. 00		0.00	Õ	Ö	8.00
9. 00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11. 00		0.00	o	0	11.00
11.00		0.00	ol Ol	0	11.00
12.00		0.00	Ö		12.00
		I .	U	0	
14.00		0.00	0	0	14. 00
15.00		0.00	0	0	15. 00
16. 00		0.00	0	0	16.00
17. 00		0. 00	0	0	17. 00
18. 00		0.00	0	0	18.00
19. 00		0. 00	0	0	19.00
20.00		0.00	0	0	20.00
21. 00		0.00	0	0	21.00
22.00		0.00	0	0	22. 00
23.00		0.00	0	0	23. 00
24.00		0.00	0	0	24. 00
25.00		0.00	O	0	25. 00
26.00		0.00	O	0	26. 00
	TOTALS			5, 565, 666	
	D - OTHER CAPITAL COSTS			·	
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	313, 953	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	O	4, 833, 569	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	72, 470	3.00
	TOTALS	 		5, 219, 992	
	E - MARKETING DEPARTMENT	<u> </u>		-, , ,	
1.00	MARKETI NG	194. 01	301, 022	1, 862, 142	1.00
	TOTALS	— — —-+	301, 022	1, 862, 142	
	F - CNO RECLASS		22., 022		
1.00	NURSI NG ADMINI STRATI ON	13.00	299, 523	Ω	1.00
55	TOTALS	— — 	299, 523	0	1.00
	G - MEDICAL SUPPLIES		_,,, 020	<u> </u>	
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	O	17, 753, 504	1.00
55	PATI ENT	, 1. 00	9	, , 55, 554	1.00
2.00	IMPL. DEV. CHARGED TO	72.00	o	22, 894, 806	2.00
_, 00	PATI ENTS	. 2. 33	9	, 5, ., 555	2.00
3.00	OPERATING ROOM	50.00	0	995, 461	3.00
2.00	TOTALS		 	41, 643, 771	3.00
	H - DRUGS / IVS		3	1	
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	30, 264, 600	1.00
50	TOTALS	— — / 3. 3 	— — ў	30, 264, 600	1.00
	I - A&G COSTS		٩	55, 251, 550	
1.00	OTHER ADMINISTRATIVE AND	5. 02	6, 356, 317	57, 808, 201	1.00
1.00	GENERAL	3.02	0, 330, 317	37, 000, 201	1.00
2.00	DI ETARY	10.00	35, 603	90, 553	2.00
	CENTRAL SERVICES & SUPPLY	14. 00	35, 603		3.00
3.00				1, 386, 925	
4. 00	OTHER NONREI MBURSABLE COST	194. 03	67, 455	5, 335	4.00
	TOTALS	+	6, 814, 913	59, 291, 014	
			0, 014, 913	υ γ , ∠ γ 1, ∪14	
1 00	J - RADI OLOGY COSTS	E4 00	1 071 110	14 (00	1.00
1.00	RADI OLOGY-DI AGNOSTI C	54.00	1, 071, 443	14, 600	1.00
2. 00	PET SCAN	54.01		10, 738	2.00
	TOTALS		1, 071, 443	25, 338	

					10 06/30/2016	11/30/2016 5:23 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4.00	5. 00		
	K - DIETARY					
1.00	CAFETERI A	11. 00	1, 664, 832	2, 454, 896		1. 00
	TOTALS		1, 664, 832	2, 454, 896		
	L - MISC DEPARTMENT		<u> </u>			
1.00	OTHER ADMINISTRATIVE AND	5. 02	479, 761	43, 655		1. 00
	GENERAL					
2.00	MEDICAL RECORDS & LIBRARY	16. 00	845, 599	652, 610		2. 00
3.00	SOCI AL SERVI CE	17. 00	2, 084, 299	О		3. 00
4.00	ENDOSCOPY	76. 01	2, 465, 538	1, 815, 338		4. 00
5.00	CARDI AC REHAB	76. 02	420, 031	65, 068		5. 00
6.00	PHYSI CAL THERAPY	66.00	926, 216	75, 851		6. 00
7.00	ELECTROENCEPHALOGRAPHY	70.00	990, 516	545, 398		7.00
8. 00	CARDIO CATH LAB	76.00	1, 389, 102	1, 985, 085		8.00
9. 00	OPERATING ROOM	50.00	88, 680	0		9.00
	TOTALS		9, 689, 742	5, 183, 005		
	M - ORGAN ACQUISITION	<u> </u>				
1.00	KI DNEY ACQUI SI TI ON	105.00	0	1, 143, 686		1. 00
2.00	HEART ACQUISITION	106, 00	o	449, 073		2.00
3. 00	CLINIC	90.00	678, 561	509, 936		3.00
	TOTALS		678, 561	2, 102, 695		
	N - ICU COSTS					
1.00	NEONATAL INTENSIVE CARE UNIT	31. 02	2, 141, 604	511, 898		1. 00
2.00	CARDIO INTENSIVE CARE UNIT	31. 03	11, 413, 656	2, 656, 790		2.00
3.00	CORONARY CARE UNIT	32.00	3, 845, 813	888, 032		3.00
	TOTALS		17, 401, 073	4, 056, 720		
	O - LABOR AND DELIVERY		, , , , , ,			
1.00	NURSERY	43.00	258, 555	6, 543		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 217, 296	263, 069		2.00
	TOTALS		1, 475, 851	269, 612		
	P - INTERNS AND RESIDENTS					
1.00	I&R SERVICES-OTHER PRGM	22. 00	0	2, 807, 885		1.00
	COSTS APPRV		7			
	TOTALS	†		2, 807, 885		
500.00	Grand Total: Increases		39, 396, 960	175, 866, 514		500.00

Health Financial Systems
RECLASSIFICATIONS LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Provider CCN: 150017

	Financial Systems		LUTHERAN HOSPIT				eu of Form CMS-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 150017	Peri od: From 07/01/2015	Worksheet A-6
						To 06/30/2016	Date/Time Prepared:
							11/30/2016 5: 23 pm
	Cost Center	Decreases Li ne #	Sal ary	Other	_ Wkst. A-7 Ref	1	
	6.00	7.00	8. 00	9. 00	10. 00	·_	
	A - EMPLOYEE BENEFITS					-	
1.00	OTHER ADMINISTRATIVE AND	5. 02	0	14, 177, 814	1	0	1. 00
2.00	GENERAL	15.00		14/			2.00
2. 00 3. 00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	14 <i>6</i> 987		0	2. 00 3. 00
4. 00	WEDI CAL RECORDS & ELBRART	0.00	0	707		0	4. 00
00	TOTALS — — — —		— — 	14, 178, 94		7	
	B - OXYGEN						
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	105, 984		0	1. 00
2.00	ANESTHESI OLOGY	53.00	0	172, 377		0	2.00
3. 00	RESPIRATORY THERAPY TOTALS		0	66 <u>1, 8</u> 70		0	3. 00
	C - RENTAL AND LEASE		U	940, 231			
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	82, 572	2 1	0	1. 00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	ō	4, 618		o	2. 00
3.00	ADMITTING	5. 01	0	5, 357	7	0	3.00
4.00	DI ETARY	10.00	0	37, 142	-1	0	4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00	0	7, 023		0	5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 490, 669		0	6.00
7. 00 8. 00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	424, 827 51, 797		0	7. 00 8. 00
9. 00	PARAMED ED PRGM-(SPECIFY)	23. 00	0	1, 519			9. 00
10. 00	ADULTS & PEDIATRICS	30.00	o	50, 929		0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	250		0	11. 00
12.00	PEDIATRIC INTENSIVE CARE	31. 01	0	605	5	0	12. 00
	UNIT						
13.00	OPERATING ROOM	50.00	0	684, 649		0	13. 00
14. 00 15. 00	RADI OLOGY-DI AGNOSTI C PET SCAN	54. 00 54. 01	0	1, 142, 090 500		0	14. 00 15. 00
16. 00	RADI OI SOTOPE	56.00	0	592, 646		0	16. 00
17. 00	CT SCAN	57. 00	Ö	15, 274			17. 00
18. 00	LABORATORY	60.00	Ö	346, 723		o	18. 00
19.00	RESPIRATORY THERAPY	65. 00	0	12, 260		0	19. 00
20.00	PHYSI CAL THERAPY	66. 00	0	298, 782		0	20. 00
21. 00	ELECTROCARDI OLOGY	69.00	0	66, 703		0	21. 00
22. 00	ENDOSCOPY	76. 01	0	7, 654		0	22. 00
23. 00 24. 00	CLINIC EMERGENCY	90. 00 91. 00	0	24, 362 109, 015		0	23. 00 24. 00
25. 00	AMBULANCE SERVICES	95. 00	Ö	101, 076		0	25. 00
26. 00	DURABLE MEDICAL EQUIP-RENTED	96.00	o	6, 624		0	26. 00
	TOTALS			5, 565, 666		7	
	D - OTHER CAPITAL COSTS						
1. 00	OTHER ADMINISTRATIVE AND	5. 02	0	5, 219, 992	1:	2	1. 00
2.00	GENERAL	0. 00	0	C	1:	3	2.00
3.00		0.00	o	() 1:		3. 00
0.00	TOTALS		— — 	5, 219, 992		7	0.00
	E - MARKETING DEPARTMENT		,		1		
1.00	ADMI TTI NG		301, 022	<u>1, 862, 1</u> 42		0	1. 00
	TOTALS		301, 022	1, 862, 142	2		
1. 00	F - CNO RECLASS OTHER ADMINISTRATIVE AND	5. 02	299, 523	(0	1.00
1.00	GENERAL	5. 02	299, 523	('		1.00
	TOTALS		299, 523			7	
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	41, 612, 016		0	1.00
2.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	15, 250		0	2. 00
3. 00	ELECTROCARDI OLOGY	<u>69.</u> 00	•	1 <u>6, 5</u> 05		<u>0</u>	3. 00
	TOTALS H - DRUGS / IVS		0	41, 643, 771			
1.00	PHARMACY	15. 00	ol	30, 264, 600		0	1. 00
	TOTALS		<u> </u>	30, 264, 600		7	
	I - A&G COSTS						
1.00	ADMI TTI NG	5. 01	6, 814, 913	59, 291, 014		0	1.00
2.00		0. 00	0	C		0	2. 00
3.00		0.00	0	(0	3.00
4. 00	TOTALS — — — —			<u></u> 0 59, 291, 014		0	4. 00
	J - RADI OLOGY COSTS		0, 014, 713	37, 271, 014	T		
1.00	PET SCAN	54. 01	649, 328	C		0	1. 00
2.00	MRI	<u>58.</u> 00	422, 115	2 <u>5, 3</u> 38		<u>o</u>	2. 00
	TOTALS	T	1, 071, 443	25, 338	3		

RECLASSI FI CATI ONS

500.00 Grand Total: Decreases

Provider CCN: 150017

Worksheet A-6 From 07/01/2015

Date/Time Prepared:

500.00

06/30/2016

11/30/2016 5: 23 pm Decreases Cost Center 0ther Wkst. A-7 Ref. Li ne # Sal ary 10.00 6.00 7.00 8.00 9.00 K - DIETARY 1.00 DI ETARY 10.00 1, 664, 832 2, 454, 896 0 1.00 TOTALS 1, 664, 832 2, 454, 896 - MISC DEPARTMENT 1.00 RECOVERY ROOM 51.00 3, 009, 230 804, 418 0 1.00 2.00 ELECTROCARDI OLOGY 69.00 2, 344, 637 2, 523, 616 0 2.00 67.00 0 3.00 OCCUPATIONAL THERAPY 661. 824 51, 168 3.00 264, 392 0 4.00 SPEECH PATHOLOGY 68.00 24, 683 4.00 5.00 NURSING ADMINISTRATION 13.00 3, 409, 659 622, 008 0 5.00 6.00 OPERATING ROOM 50.00 1, 082, 854 0 6.00 7.00 SOCIAL SERVICE 17.00 0 74, 258 0 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 9.00 TOTALS 9, 689, 742 5, 183, 005 M - ORGAN ACQUISITION OPERATING ROOM 50.00 1.00 678, 561 2, 102, 695 0 1.00 2.00 0.00 0 2.00 3.00 0.00 0 3.00 TOTALS 678, 561 2, 102, 695 N - ICU COSTS 1.00 INTENSIVE CARE UNIT 31.00 16, 192, 615 3, 724, 252 0 1.00 PEDIATRIC INTENSIVE CARE 31.01 1, 208, 458 0 2.00 332, 468 2.00 luni t 3.00 0.00 0 3.00 TOTALS 17, 401, 073 4, 056, 720 O - LABOR AND DELIVERY 1.00 ADULTS & PEDIATRICS 30.00 1, 475, 851 269, 612 0 1.00 2.00 0.00 0 2.00 TOTALS 1, 475, 851 269, 612 P - INTERNS AND RESIDENTS I &R SERVICES-SALARY & 21.00 1.00 2, 807, 885 0 1.00 FRI NGES APPRV 2, 807, 885 TOTALS

39, 396, 960

175, 866, 514

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150017 Peri od: Worksheet A-7 From 07/01/2015 Part I 06/30/2016 Date/Time Prepared: 11/30/2016 5: 23 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 9, 573, 476 526, 561 11, 069, 630 0 43, 344 2.00 Land Improvements 43, 344 2.00 147, 398, 003 0 3.00 144, 053 144, 053 25, 942 3.00 Buildings and Fixtures 0 4.00 Building Improvements 21, 577, 784 4, 662, 824 4, 662, 824 17, 604 4.00 5.00 Fixed Equipment 47, 657, 981 3, 046, 294 3, 046, 294 63, 259 5.00 0 6.00 Movable Equipment 141, 678, 156 10, 349, 843 10, 349, 843 6, 697, 767 6.00 0 7.00 HIT designated Assets 2, 905, 310 0 7.00 8.00 Subtotal (sum of lines 1-7) 381, 860, 340 18, 246, 358 18, 246, 358 7, 331, 133 8.00 9.00 Reconciling Items 0 9.00 18, 246, 358 Total (line 8 minus line 9) 381, 860, 340 10.00 0 18, 246, 358 7, 331, 133 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 9, 046, 915 0 1.00 2.00 Land Improvements 11, 112, 974 0 2. 00 . Buildings and Fixtures 3.00 147, 516, 114 0 3.00 0 4.00 Building Improvements 26, 223, 004 4.00 5.00 Fi xed Equipment 50, 641, 016 0 5.00

145, 330, 232

392, 775, 565

392, 775, 565

2, 905, 310

0

0

0

0

6.00 7. 00

8.00

9.00

10.00

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

6.00

7.00

8.00

Heal th	Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10			
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150017	Peri od:	Worksheet A-7		
					From 07/01/2015	Part II	nanad.	
					To 06/30/2016	Date/Time Prep 11/30/2016 5::	pareu: 23 nm	
			Sl	JMMARY OF CAP	I TAL	117 007 2010 011		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
					instructions)			
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			ind 2				
1.00	CAP REL COSTS-BLDG & FLXT	6, 764, 898	0)	0 0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	15, 014, 762	0)	0	0	2. 00	
3.00	3.00 Total (sum of lines 1-2) 21,779,660 0 0 0						3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description		Total (1) (sum	ו				
		Capi tal -Rel ate						
		d Costs (see	through 14)					
		instructions)	45.00	1				
	DART II. BECONOLILIATION OF ANOUNTS FROM WORK	14.00	15.00	1.0				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM						
1.00	CAP REL COSTS-BLDG & FLXT	0	6, 764, 898	1			1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	15, 014, 762	1			2.00	
3. 00	Total (sum of lines 1-2)	0	21, 779, 660	y .			3. 00	

Health Financial Systems	LUTHERAN HOSPIT	UTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet A-7 Part III Date/Time Prep 11/30/2016 5:2	pared:	
	COM	COMPUTATION OF RATIOS			OTHER CAPITAL	,	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
		Leases	for Ratio	instructions)			
			(col . 1 - col 2)	•			
	1. 00	2.00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS		2.00	0.00	1. 00	0.00		
1.00 CAP REL COSTS-BLDG & FLXT	193, 899, 007	0	193, 899, 00	7 0. 493664	0	1. 00	
2.00 CAP REL COSTS-MVBLE EQUIP	198, 876, 559					2.00	
3.00 Total (sum of lines 1-2)	392, 775, 566		392, 775, 56			3. 00	
	ALLOCA	ALLOCATION OF OTHER CAPITAL			F CAPITAL		
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
		Capi tal -Rel ate					
	4.00	d Costs	through 7)	0.00	10.00		
DART III DECONCLITATION OF CARLTAL COSTS	6. 00	7. 00	8. 00	9. 00	10. 00		
1.00 PART III - RECONCILIATION OF CAPITAL COSTS CAP REL COSTS-BLDG & FLXT	LENIERS		1	0 4, 949, 699	-82, 572	1. 00	
2.00 CAP REL COSTS-BEDG & TTXT				0 15, 071, 464		2. 00	
3.00 Total (sum of lines 1-2)				0 20, 021, 163	5, 416, 174	3. 00	
o. oo retair (sain or riffles 1 2)		1	JMMARY OF CAPI		3, 113, 171	0.00	
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
cost center bescription	Titterest	instructions)	,	Capi tal -Rel ate	` ' '		
		Tristractions)	Tristractions,	d Costs (see	through 14)		
				instructions)			
	11. 00	12.00	13. 00	14.00	15. 00		
PART III - RECONCILIATION OF CAPITAL COSTS							
1.00 CAP REL COSTS-BLDG & FLXT	6, 798, 614		· · ·		16, 813, 263	1. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP	895, 196			0	, ,	2. 00	
3.00 Total (sum of lines 1-2)	7, 693, 810	386, 423	4, 833, 56	9 0	38, 351, 139	3. 00	

Provider CCN: 150017 | Period: | Worksheet A-8 | From 07/01/2015 | To 06/30/2016 | Date/Time Prepared:

				T	o 06/30/2016		
				Expense Classification on		11/30/2016 5: 2	23 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5.00	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		O	CAP KEE COSTS-WVDEE EQUIP			
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	О	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by	В	-896 640	CAP REL COSTS-BLDG & FIXT	1. 00	9	6. 00
	suppliers (chapter 8)	D					
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
0.00	21)		0		0.00		0.00
8. 00	Television and radio service (chapter 21)		U		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-11, 396, 278		0.00	0	9. 00 10. 00
	adj ustment					٠	
11. 00	Sale of scrap, waste, etc. (chapter 23)	В	-4, 784	RADI OLOGY-DI AGNOSTI C	54.00	0	11. 00
12. 00	Related organization	A-8-1	12, 283, 233			o	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-2, 103, 043	CAFETERI A	11. 00 0. 00	l	14. 00 15. 00
	and others		-				
16. 00	Sale of medical and surgical supplies to other than		U		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	pati ents		O				
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	o	19. 00
20. 00	Vending machines	В	-40, 532	OTHER ADMINISTRATIVE AND	5. 02	0	20. 00
21. 00	Income from imposition of		0	GENERAL	0.00	0	21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
05	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL	A	_1 \012 214	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
26.00	COSTS-BLDG & FIXT		-1,013,310	CAP REL CUSTS-BLDG & FIXT	1.00	9	20.00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	284, 836	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 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	Ō	 SPEECH PATHOLOGY	68. 00		31. 00
200	pathology costs in excess of		Ü		55.00		2 33
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
		·					

	Financial Systems	L	UTHERAN HOSPIT		In Lie	eu of Form CMS-1	
ADJUST	MENTS TO EXPENSES				rom 07/01/2015	Worksheet A-8	
				T	06/30/2016	Date/Time Pre 11/30/2016 5:	pared: 23 pm
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
33. 00	MI NORI TY I NTEREST	1. 00 A	2.00	3. 00 OTHER ADMINISTRATIVE AND	4. 00 5. 02	5. 00	33.00
33.00	MINORITY INTEREST	A		GENERAL	5.02		33.00
33. 01	SPECIAL EVENTS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		00.0.
33. 02	OTHER MISC REVENUES	В		OTHER ADMINISTRATIVE AND	5. 02	0	33. 02
33. 03	PATIENT PHONES WAGE COST	Δ.		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	0	33. 04
33. 05	PATIENT PHONES EXPENSE	A	· ·	ADMI TTI NG	5. 01	0	33. 05
33.06	SPECIAL EVENTS	A		AMBULANCE SERVICES	95.00		33. 06
33. 07	PATIENT TV - CABLE EXPENSE	A	· ·	OPERATION OF PLANT	7. 00		1 00.07
33. 08	PATIENT TV DEPRECIATION	A		CAP REL COSTS-MVBLE EQUI P	2. 00		
33. 09	MARKETI NG	A	5, 425	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	33. 09
33. 10	LEGAL FEES	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 10
00.44	DUNCLOLAN DEODULTING			GENERAL	F 00		00.44
33. 11	PHYSICIAN RECRUITING	A		OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	33. 11
33. 12	LOBBYING IN ASSOCIATION DUES	A		OTHER ADMINISTRATIVE AND	5. 02	О	33. 12
		_		GENERAL		_	
33. 13	CHARI TABLE CONTRI BUTI ONS	A	· ·	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	33. 13
33. 14	PENALTI ES	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 14
				GENERAL			
33. 15	SPECIAL EVENTS	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 15
33. 16	TRAINING REVENUES	В		GENERAL NURSING ADMINISTRATION	13. 00	0	33. 16
33. 17	VALET SERVICE	A		OTHER ADMINISTRATION	5. 02		
50. 17	THE SERVICE			GENERAL	5.02	Ĭ	33. 17
33. 18	INTERCOMPANY LEASE RECEIPTS	A	2, 383, 976	OTHER ADMINISTRATIVE AND	5. 02	0	33. 18
	I .	1		CENEDAL		I .	1

GENERAL

50.00

-4, 297, 604

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, 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 OFFICE COSTS

Provider CCN: 150017

Worksheet A-8-1

0

0

0

25, 074, 595

4.10

4. 16

4.19

4. 20

4 21

4. 22

4.23

5.00

33, 810

22, 949

264, 508

1, 538, 108

12, 791, 362

1, 420, 763

From 07/01/2015 06/30/2016 Date/Time Prepared: 11/30/2016 5:23 pm Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 3.00 4.00 5.00 1.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 DIRECT CAPITAL INTEREST 6, 733, 812 1.00 1. 00 CAP REL COSTS-BLDG & FIXT PASI CAPITAL - BLDG 2.00 94.757 0 2.00 3.00 2. 00 CAP REL COSTS-MVBLE EQUIP PASI CAPITAL - EQUIP 0 14,870 3.00 3.01 5. 02 OTHER ADMINISTRATIVE AND GEN FRANCHISE TAXES 860 844 3.01 3.02 5. 02 OTHER ADMINISTRATIVE AND GEN CORPORATE OVERHEAD ALLOCATIO 2, 461, 023 3.02 5. 02 OTHER ADMINISTRATIVE AND GEN SHARED SERVICE CENTER ALLOCA 3 03 1 208 378 Ω 3 03 5. 01 ADMITTING 4.00 PASI OPERATING 1, 409, 226 0 4.00 64, 802 4.01 1.00 CAP REL COSTS-BLDG & FIXT POOLED CAPITAL - BLDG 4.01 2. OO CAP REL COSTS-MVBLE EQUIP POOLED CAPITAL - EQUIP 895.196 4 02 Ω 4 02 5. 02 OTHER ADMINISTRATIVE AND GEN POOLED HOME OFFICE COSTS 10, 775, 436 4.03 4.03 4.04 5. 02 OTHER ADMINISTRATIVE AND GEN MALPRACTICE 1, 548, 586 1, 483, 189 4.04 2. 00 CAP REL COSTS-MVBLE EQUIP 4.05 CIG ASSETS 737,600 977, 467 4.05 8.00 LAUNDRY & LINEN SERVICE 156, 919 HIS - CAPITAL 4 06 4 06 4.07 8.00 LAUNDRY & LINEN SERVICE HLS - OPERATING 1, 434, 153 1, 570, 729 4.07 5. 02 OTHER ADMINISTRATIVE AND GEN MANAGEMENT FEES 2, 907, 838 4.08 4.08 4.09 5. 02 OTHER ADMINISTRATIVE AND GEN 401K FEES 8.947 4.09 5. 02 OTHER ADMINISTRATIVE AND GEN AUDIT FEES 101, 187 C

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

PPSI FEES

EBOS FEES

PASI COLLECTION FEES

PASI LIEN UNIT COLLECTION FE

mas m	been posted to norksheet 71,	cordinas i anaroi 2, the amoun	it dirowabic sii	our a be intarcated in cordini	or time 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 RELATE	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

	Comont under the Co Attini		
6.00	В	0. 00 COMMUNI TY HEALT 100. 00	6.00
7.00	В	0. 00 PASI 100. 00	7.00
8.00	Е	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.
- Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

5. 02 OTHER ADMINISTRATIVE AND GEN

5. 02 OTHER ADMINISTRATIVE AND GEN INTEREST EXPENSE

5. 01 ADMITTING

5. 01 ADMITTING

5. 01 ADMITTING

0.00

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2,

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

4.10

4.16

4.19

4.20

4.21

4.22

4.23

011102	000.0				To 06/30/2016	Date/Time Pre 11/30/2016 5:	pared: 23 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7.00					
			MENTS REQUIRED AS A RESULT OF TRANS	SACTIONS WITH RELATED C	ORGANI ZATI ONS OR	CLAIMED	
	HOME OFFICE CO						
1.00	6, 733, 812						1. 00
2.00	94, 757						2. 00
3.00	14, 870						3. 00
3. 01	16						3. 01
3. 02	-2, 461, 023						3. 02
3. 03	1, 208, 378						3. 03
4.00	1, 409, 226						4. 00
4. 01	64, 802						4. 01
4. 02	895, 196						4. 02
4.03	10, 775, 436						4. 03
4.04	65, 397						4. 04
4.05	-239, 867						4. 05
4.06	156, 919						4. 06
4. 07	-136, 576						4. 07
4.08	-2, 907, 838						4. 08
4.09	-8, 947						4. 09
4. 10	-101, 187						4. 10
4. 16	-33, 810						4. 16
4. 19	-1, 420, 763	0					4. 19
4. 20	0	9					4. 20
4. 21	-22, 949						4. 21
4. 22	-264, 508						4. 22
4. 23	-1, 538, 108						4. 23
5.00	12, 283, 233						5. 00
* TL-		1 1 (:_+:_+_\		I	/ 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		
Type of Business		
3.		
6. 00		
B. INTERRELATIONSHIP TO RELAT	ED 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	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		11	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.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150017

Peri od: From 07/01/2015 To 06/30/2016 Date/Ti me Prepared:

Description								10 00/ 30/ 2010	11/30/2016 5:	23 pm
1.00		Wkst. A Line #	Cost Center/Physician	Total	Profess	i onal	Provi der	RCE Amount	Physi ci an/Prov	
1.00			I denti fi er	Remuneration	Compor	nent	Component			
1.00										
CEMERAL 16.00 DELO AL RECORDS & LIBRARY 25, 473 3.00 30.00										
2.00	1. 00	5. 02		538, 171	5	34, 888	3, 283	171, 400	22	1. 00
3.00 33.00 ADULTS & PEDIATRICS 505, 300 505, 300 0 0 0 0 0 0 0 0 0										
A-0									•	
5.00									_	
6.00										
7.00 5.3.00 ANESTHESI OLOGY 2.770.392 2.770.392 0 0 0 7.00 9.00 9.00 9.00 0.00 0.00 0.00 0.00 9.00 9.00 9.00 0.00 0.00 0.00 0.00 10.00 91.00 MBREGENCY 1.000 33.1 0.909.33 0.009.33 0.009.33 0.000 0.00 10.00 95.00 AMBULANCE SERVICES 3.069.077 3.069.077 0.00 0.00 11.00 12.00 96.00 DURABLE MEDICAL EQUIP-RENTED 1.715, 060 0.00 0.00 0.10.00 12.00 76.01 ENDOSCOPY 1.73, 980 73, 980 73, 980 12.00 76.00 ENDOSCOPY 11.417, 200 11.384, 453 28, 756 10.00 2.00 8.00 9.00 12.00 13.00 10.00 1.00 2.00 8.00 9.00 12.00 13.00 10.00 1.00 1.00 1.00 1.00									1	
8.00 6.0 OLABORATORY 202,000 202,000 0 0 0 8.00 0 0 0 0 0 0 0 0 0	6. 00								0	
9,00	7. 00							0	0	7. 00
10.00 91.00 EMERGENCY 1,090,933 1,090,933 0 0 0 10.00 10.00 95.00 DURABLE MEDI CAL EQUIP-RENTED 1,715,060 1,715,060 0 0 0 12.00 10.00 96.00 DURABLE MEDI CAL EQUIP-RENTED 1,715,060 1,715,060 0 0 0 12.00 10.00 76.01 EMDOSCOPY 11,388,453 28,756 11,417,209 11,388,453 28,756 10.00 10.00 EMDOSCOPY 11,388,453 28,756 11,417,209 11,388,453 28,756 10.00 10.00 EMBOSCOPY 11,388,453 28,756 11,417,209 11,388,453 28,756 10.00 10.00 EMBOSCOPY 11,388,453 28,756 11,417,209 11,388,453 28,756 10.00 10.00 EMBOSCOPY 11,388,453 28,756 11,417,209 1								0	0	
11.00 95.00 AMBULANCE SERVICES 3, 089, 077 3, 089, 077 0 0 0 11.00 12.00 76.01 ENDOSCOPY 73, 980 73,	9.00			423, 581	4	23, 581	0	0	0	9. 00
1.00	10.00	91.00	EMERGENCY	1, 090, 933	1,0	90, 933	3 0	0	0	10.00
13.00 76.01 NDOSCOPY 73.980 73.980 0 0 0 0 13.00	11.00	95. 00	AMBULANCE SERVICES	3, 089, 077	3, 0	89, 077	7 0	0	0	11. 00
200.00	12.00	96. 00	DURABLE MEDICAL EQUIP-RENTED	1, 715, 060	1,7	15, 060	0	0	0	12. 00
WKST. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Unadjusted RCE Limit Unadjusted RCE	13.00	76. 01	ENDOSCOPY	73, 980		73, 980	0	0	0	13. 00
Identifier	200.00			11, 417, 209	11, 3	88, 453	28, 756		254	200.00
Identifier		Wkst. A Line #	Cost Center/Physician						Physician Cost	
1.00							Memberships &	Component		
1.00										
1.00										
CEMERAL		1. 00	2.00	8. 00	9. 0	0			14.00	
2.00	1.00	5. 02	OTHER ADMINISTRATIVE AND	1, 813		91	0	0	0	1. 00
30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 0 3.00										
4. 00	2.00			19, 118		956			0	
5.00	3.00					C	0	0	0	3. 00
6.00	4.00	76. 00	CARDIO CATH LAB	0		C	0	0	0	4. 00
7. 00	5.00	43.00	NURSERY	0		C	0	0	0	5. 00
8. 00 60. 00 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00	50.00	OPERATING ROOM	0		C	0	0	0	6. 00
9.00 90.00 CLINIC 0 0 0 0 0 0 0 0 0	7.00	53. 00	ANESTHESI OLOGY	0		C	0	0	0	7. 00
10. 00	8.00	60.00	LABORATORY	0		C	0	0	0	8. 00
11. 00	9.00	90.00	CLINIC	0		C	0	0	0	9. 00
12. 00	10.00	91.00	EMERGENCY	0		C	0	0	0	10. 00
13.00	11.00	95.00	AMBULANCE SERVICES	0		C	0	0	0	11. 00
13.00	12.00	96.00	DURABLE MEDICAL EQUIP-RENTED	0		C	ol o	l o	l 0	12.00
Number Cost Center/Physician Cost Center/Physician Identifier Provider Component Share of col. 14				0		C			0	
Wkst. A Line # Cost Center/Physician Identifier Component Share of col. Limit Disallowance Disallowance Limit Disallowance Disallowance Limit Disallowance Limit Disallowance				20, 931		1. 047	7	0	0	
Identifier Component Share of col		Wkst. A Line #	Cost Center/Physician	Provi der	Adjuste	d RCE	RCE	Adjustment		
1.00				Component			Di sal I owance			
1.00				Share of col.						
1. 00 5. 02 OTHER ADMI NI STRATI VE AND GENERAL 0 1,813 1,470 536,358 1. 00 2. 00 16. 00 MEDI CAL RECORDS & LI BRARY 0 19,118 6,355 6,355 2. 00 3. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 505,300 3. 00 4. 00 76. 00 CARDI 0 CATH LAB 0 0 0 347,944 4. 00 5. 00 43. 00 NURSERY 0 0 0 347,944 4. 00 6. 00 50. 00 OPERATI NG ROOM 0 0 0 8, 920 5. 00 6. 00 53. 00 ANESTHESI OLOGY 0 0 0 2, 770, 392 7. 00 8. 00 60. 00 LABORATORY 0 0 0 22, 700, 392 7. 00 9. 00 90. 00 CLI NI C 0 0 0 423, 581 9. 00 10. 00 91. 00 EMERGENCY 0 0 0 1, 090, 933 10. 00 12. 00 96. 00 DURABLE MEDI CAL EQUI P-RENTED 0 0				14						
Canal		1. 00	2.00	15. 00	16. (00	17. 00	18. 00		
2. 00 16. 00 MEDI CAL RECORDS & LI BRARY 0 19, 118 6, 355 6, 355 2. 00 3. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 505, 300 3. 00 4. 00 76. 00 CARDI 0 CATH LAB 0 0 0 347, 944 4. 00 5. 00 43. 00 NURSERY 0 0 0 8, 920 5. 00 6. 00 50. 00 OPERATI NG ROOM 0 0 0 626, 378 6. 00 7. 00 53. 00 ANESTHESI OLOGY 0 0 0 2, 770, 392 7. 00 8. 00 60. 00 LABORATORY 0 0 0 202, 000 8. 00 9. 00 90. 00 CLI NI C 0 0 0 423, 581 9. 00 11. 00 95. 00 AMBULANCE SERVI CES 0 0 0 1, 090, 933 10. 00 12. 00 96. 00 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 1, 715, 060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 0 73, 980 13. 00	1.00	5. 02		0		1, 813	1, 470	536, 358		1. 00
3. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 505, 300 3. 00 4. 00 76. 00 CARDI 0 CATH LAB 0 0 0 347, 944 4. 00 5. 00 43. 00 NURSERY 0 0 0 0 8, 920 5. 00 6. 00 50. 00 OPERATI NG ROOM 0 0 0 626, 378 6. 00 7. 00 53. 00 ANESTHESI OLOGY 0 0 0 2, 770, 392 7. 00 8. 00 60. 00 LABORATORY 0 0 0 0 22, 700 8. 00 90. 00 CLI NI C 0 0 0 423, 581 9. 00 90. 00 CLI NI C 0 0 0 423, 581 9. 00 11. 00 91. 00 EMERGENCY 0 0 0 0 1, 090, 933 10. 00 11. 00 95. 00 AMBULANCE SERVI CES 0 0 0 3, 089, 077 11. 00 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 0 73, 980 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 14. 00										
4. 00 76. 00 CARDI O CATH LAB 0 0 347, 944 4. 00 5. 00 43. 00 NURSERY 0 0 0 8, 920 5. 00 6. 00 50. 00 OPERATI NG ROOM 0 0 0 626, 378 6. 00 7. 00 53. 00 ANESTHESI OLOGY 0 0 0 2, 770, 392 7. 00 8. 00 60. 00 LABORATORY 0 0 0 202, 000 8. 00 9. 00 90. 00 CLI NI C 0 0 0 423, 581 9. 00 10. 00 91. 00 EMERGENCY 0 0 0 1, 090, 933 10. 00 11. 00 95. 00 AMBULANCE SERVI CES 0 0 0 3, 089, 077 11. 00 12. 00 96. 00 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 1, 715, 060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 0 73, 980 13. 00						19, 118	6, 355			
5. 00 43. 00 NURSERY 0 0 8,920 5. 00 6. 00 50. 00 OPERATI NG ROOM 0 0 0 626,378 6. 00 7. 00 53. 00 ANESTHESI OLOGY 0 0 0 2,770,392 7. 00 8. 00 60. 00 LABORATORY 0 0 0 202,000 8. 00 9. 00 90. 00 CLI NI C 0 0 0 423,581 9. 00 10. 00 91. 00 EMERGENCY 0 0 1,090,933 10. 00 11. 00 95. 00 AMBULANCE SERVI CES 0 0 3,089,077 11. 00 12. 00 96. 00 DURABLE MEDI CAL EQUI P-RENTED 0 0 1,715,060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 73,980 13. 00	3.00			0		C	0	505, 300		3. 00
6. 00	4.00	76. 00	CARDIO CATH LAB	0		C	0	347, 944		4. 00
7. 00	5.00	43.00	NURSERY	0		C	0	8, 920		5. 00
8. 00 60. 00 LABORATORY 0 0 202,000 8. 00 9. 00 90. 00 CLI NI C 0 0 423,581 9. 00 10. 00 91. 00 EMERGENCY 0 0 1,090,933 10. 00 11. 00 95. 00 AMBULANCE SERVI CES 0 0 3,089,077 11. 00 12. 00 96. 00 DURABLE MEDI CAL EQUI P-RENTED 0 0 1,715,060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 73,980 13. 00	6.00	50.00	OPERATING ROOM	0		C	0	626, 378		6. 00
8. 00 60. 00 LABORATORY 0 0 202,000 8. 00 9. 00 90. 00 CLI NI C 0 0 423,581 9. 00 10. 00 91. 00 EMERGENCY 0 0 1,090,933 10. 00 11. 00 95. 00 AMBULANCE SERVI CES 0 0 3,089,077 11. 00 12. 00 96. 00 DURABLE MEDI CAL EQUI P-RENTED 0 0 1,715,060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 73,980 13. 00	7.00	53.00	ANESTHESI OLOGY	0		C	0	2, 770, 392		7. 00
9. 00 90. 00 CLINIC 0 0 0 423, 581 9. 00 10. 00 91. 00 EMERGENCY 0 0 0 1, 090, 933 10. 00 11. 00 95. 00 AMBULANCE SERVICES 0 0 0 3, 089, 077 11. 00 12. 00 96. 00 DURABLE MEDICAL EQUIP-RENTED 0 0 0 1, 715, 060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 0 73, 980 13. 00	8.00			0		C	ol o			8. 00
10. 00 91. 00 EMERGENCY 0 0 1,090,933 10. 00 11. 00 95. 00 AMBULANCE SERVI CES 0 0 0 3,089,077 11. 00 12. 00 96. 00 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 1,715,060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 73,980 13. 00					1	C				
11. 00 95. 00 AMBULANCE SERVICES 0 0 0 3, 089, 077 11. 00 12. 00 96. 00 DURABLE MEDICAL EQUIP-RENTED 0 0 0 1, 715, 060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 73, 980 13. 00						r				
12. 00 96. 00 DURABLE MEDI CAL EQUI P-RENTED 0 0 1,715,060 12. 00 13. 00 76. 01 ENDOSCOPY 0 0 73,980 13. 00				•		r				
13. 00 76. 01 ENDOSCOPY 0 0 73, 980 13. 00					1	(
					1					
200.00		70.01					-		•	
	200.00	1	ı		I	_0, ,01	7,323	,070,270	1	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2015 | Part I | To 06/30/2016 | Date/Time Prepared: | 11/30/2016 5: 23 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS LUTHERAN HOSPITAL OF INDIANA Provider CCN: 150017

							11/30/2016 5:	23 pm
				CAPI TAL REL	LATED COSTS			
	Co	ost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	
	00	35 C G 2555. 1 p 1 6.1	for Cost	5250 a		BENEFITS	7.5 7.7.70	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	4. 00	5. 01	
	GENERAL	SERVI CE COST CENTERS	<u> </u>		2.00	00	0.01	
1.00		AP REL COSTS-BLDG & FIXT	16, 813, 263	16, 813, 263				1. 00
2.00		AP REL COSTS-MVBLE EQUIP	21, 537, 876	400 004	21, 537, 876	44 404 450		2.00
4. 00 5. 01	00400 EM	MPLOYEE BENEFITS DEPARTMENT	15, 711, 153 10, 417, 201	439, 081 365, 159		16, 191, 153 554, 143	11, 356, 544	4. 00 5. 01
5. 02		THER ADMINISTRATIVE AND GENERAL	48, 240, 095	709, 803		951, 827	11, 350, 544	5. 02
7. 00		PERATION OF PLANT	12, 190, 668	3, 628, 559		232, 969	0	7. 00
8.00		AUNDRY & LINEN SERVICE	1, 643, 893	21, 054		0	0	8. 00
9.00		DUSEKEEPI NG	3, 120, 607	70, 687		209, 748	0	9. 00
10. 00 11. 00	01000 DI 01100 CA		2, 324, 103 2, 016, 685	680, 285 0		161, 804 242, 426	0	10. 00 11. 00
13. 00		JRSI NG ADMI NI STRATI ON	1, 713, 451	160, 857	23, 714	225, 634	0	13. 00
14. 00		ENTRAL SERVICES & SUPPLY	5, 560, 985	293, 768		256, 327	0	14. 00
15. 00	01500 PH		7, 838, 715	168, 172		874, 531	0	15.00
16. 00 17. 00		EDICAL RECORDS & LIBRARY OCIAL SERVICE	5, 238, 769 2, 010, 041	179, 614 121, 001	33, 102 0	340, 292 303, 507	0	16. 00 17. 00
21. 00		&R SERVICES-SALARY & FRINGES APPRV	162	121,001		22	0	21. 00
22. 00		&R SERVICES-OTHER PRGM COSTS APPRV	2, 807, 885	0	0	0	0	22. 00
23. 00		ARAMED ED PRGM-(SPECIFY)	288, 559	67, 803		27, 788	0	23. 00
23. 01		HARMACY RESIDENCY PROGRAM NT ROUTINE SERVICE COST CENTERS	200, 886	0	0	25, 848	0	23. 01
30. 00		OULTS & PEDIATRICS	20, 960, 073	2, 414, 947	666, 792	2, 514, 548	522, 882	30. 00
31. 00		NTENSI VE CARE UNI T	0	0		0	0	
31. 01		EDIATRIC INTENSIVE CARE UNIT	1, 112, 576	128, 667	28, 698	135, 881	18, 696	
31. 02		EONATAL INTENSIVE CARE UNIT	2, 653, 502	259, 491	289, 989	311, 852	63, 824	
31. 03 32. 00		ARDIO INTENSIVE CARE UNIT DRONARY CARE UNIT	14, 070, 446 4, 733, 845	927, 210 361, 056		1, 662, 011 560, 012	322, 308 125, 101	31. 03 32. 00
40. 00		JBPROVI DER - I PF	4, 733, 043	0 0	0	0	0	40.00
43.00	04300 NU	JRSERY	314, 431	12, 801	1, 079	37, 650	7, 504	
		RY SERVICE COST CENTERS	10.015.004	0 470 000		4 000 400	1 070 (01	
50. 00 51. 00		PERATING ROOM ECOVERY ROOM	18, 915, 884 0	2, 479, 023 0		1, 232, 420	1, 973, 624 0	50. 00 51. 00
52. 00		ELIVERY ROOM & LABOR ROOM	1, 480, 364	0		177, 258	35, 327	52. 00
53. 00		NESTHESI OLOGY	83, 416	1, 876	402	10, 699	235, 861	53. 00
54.00		ADI OLOGY-DI AGNOSTI C	7, 011, 474	371, 536		781, 215	549, 134	
54. 01 56. 00	05401 PE	LI SCAN ADIOISOTOPE	140, 921 1, 515, 495	40, 443 94, 203		2, 069 71, 391	30, 367 156, 579	54. 01 56. 00
57. 00	05700 CT		1, 074, 453	46, 586		105, 199	461, 658	
58. 00	05800 MR		0	0		0	0	58. 00
60.00		ABORATORY	13, 818, 713	396, 294		640, 608	913, 954	
65. 00 66. 00		ESPI RATORY THERAPY HYSI CAL THERAPY	4, 665, 018 3, 737, 873	134, 693 285, 093		567, 237 492, 277	350, 628 98, 994	65. 00 66. 00
67. 00		CCUPATI ONAL THERAPY	3, 737, 673	285, 043		492, 277	98, 994	
68. 00		PEECH PATHOLOGY	0	0		0	0	
69. 00		LECTROCARDI OLOGY	2, 484, 933	337, 423		327, 009	348, 018	•
70. 00 71. 00		LECTROENCEPHALOGRAPHY EDICAL SUPPLIES CHARGED TO PATIENT	1, 535, 914 18, 693, 735	35, 262 0	295, 594 0	144, 235	45, 593 570, 975	70. 00 71. 00
71.00		MPL. DEV. CHARGED TO PATIENTS	22, 894, 806	0		0	1, 132, 657	•
73. 00	07300 DR	RUGS CHARGED TO PATIENTS	30, 264, 600	0	O	O	2, 040, 049	
74. 00		ENAL DIALYSIS	2, 337, 042	186, 155		0	43, 155	
76. 00 76. 01	03140 CA 03050 EN	ARDIO CATH LAB	3, 026, 243 4, 733, 841	151, 737 163, 085	859, 726 699, 945	202, 275 425, 279	434, 937 261, 099	76. 00 76. 01
76. 01		ARDI AC REHAB	485, 099	163, 065		61, 163	17, 557	76. 01
70.02		ENT SERVICE COST CENTERS	1007 077	<u> </u>	201707	0.7.00	177007	70.02
90. 00	09000 CL		3, 754, 054	479, 032		408, 448	18, 110	90. 00
91. 00 92. 00	09100 EM	MERGENCY BSERVATION BEDS (NON-DISTINCT PART	5, 664, 418	472, 960	431, 352	590, 298	516, 002	91. 00 92. 00
92.00		EIMBURSABLE COST CENTERS						92.00
95. 00		MBULANCE SERVICES	3, 202, 558	10, 832	310, 694	263, 624	32, 594	95. 00
96. 00		JRABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
105.00		PURPOSE COST CENTERS	1 142 (0)	(0 (52		ما	15 722	105 00
		DNEY ACQUISITION EART ACQUISITION	1, 143, 686 449, 073	60, 653 0		0	15, 733 13, 624	
118. 00	1 1	JBTOTALS (SUM OF LINES 1-117)	356, 633, 483	16, 756, 901	21, 360, 476	16, 131, 524	11, 356, 544	
	NONREI MB	BURSABLE COST CENTERS						
		FT, FLOWER, COFFEE SHOP & CANTEEN	0 457 900	56, 362		0		190.00
		HYSICIANS' PRIVATE OFFICES LOSED PSYCH UNIT	457, 809 0	0	· ·	0	0	192. 00 194. 00
	07951 MA		2, 163, 164	0		43, 834		194. 01
	· ·		·		<u> </u>			

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016		
					11/30/2016 5:	23 pm
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	
	0	1.00	2. 00	4. 00	5. 01	
194. 02 07952 SENI OR CI RCLE	77, 300	0		0 5, 972	0	194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	72, 790	0		0 9, 823	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	359, 404, 546	16, 813, 263	21, 537, 87	16, 191, 153	11, 356, 544	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				T	0 06/30/2016	Date/Time Pre 11/30/2016 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	
	ENERAL SERVICE COST CENTERS D100 CAP REL COSTS-BLDG & FLXT						1 00
	D200 CAP REL COSTS-BLDG & FIXT					ı	1. 00 2. 00
	0400 EMPLOYEE BENEFITS DEPARTMENT					ı	4. 00
	D540 ADMITTING					ı	5. 01
	0560 OTHER ADMINISTRATIVE AND GENERAL	59, 894, 086				ı	5. 02
	0700 OPERATION OF PLANT	16, 521, 908				ı	7. 00
	D800 LAUNDRY & LINEN SERVICE D900 HOUSEKEEPING	1, 665, 345 3, 419, 665		35, 766 120, 082	2, 034, 135	4, 223, 588	8. 00 9. 00
	1000 DI ETARY	3, 269, 151	653, 742		0	248, 145	
	1100 CAFETERI A	2, 259, 111	451, 761	0	o	0	
13. 00 01	1300 NURSING ADMINISTRATION	2, 123, 656	l	273, 261	0	58, 675	13. 00
	1400 CENTRAL SERVICES & SUPPLY	6, 378, 974	1, 275, 623		2, 961	107, 156	
	1500 PHARMACY	9, 021, 025	1	285, 687	0	61, 343	
	1600 MEDICAL RECORDS & LIBRARY	5, 791, 777 2, 434, 549	1, 158, 199 486, 844		0	65, 517 44, 137	
	2100 I&R SERVICES-SALARY & FRINGES APPRV	2, 434, 344	l		0	44, 137	21.00
	2200 I &R SERVI CES-OTHER PRGM COSTS APPRV	2, 807, 885	l e	0	o	0	22. 00
23. 00 02	2300 PARAMED ED PRGM-(SPECIFY)	384, 627	76, 915	115, 183	2, 244	24, 732	23. 00
	2301 PHARMACY RESIDENCY PROGRAM	226, 734	45, 341	0	0	0	23. 01
	IPATIENT ROUTINE SERVICE COST CENTERS BOOO ADULTS & PEDIATRICS	27, 079, 242	E 41E 117	4 102 454	400 777	990, 990	30.00
	3100 INTENSIVE CARE UNIT	21,019,242	5, 415, 117	4, 102, 456 0	690, 777 0	880, 889 0	31.00
	2080 PEDIATRIC INTENSIVE CARE UNIT	1, 424, 518	284, 865	218, 577	21, 650	46, 933	
	2060 NEONATAL INTENSIVE CARE UNIT	3, 578, 658		440, 818	17, 100	94, 653	31. 02
	3101 CARDIO INTENSIVE CARE UNIT	17, 184, 528	3, 436, 442			338, 214	
	3200 CORONARY CARE UNIT	5, 812, 279	1, 162, 299		86, 418	131, 701	1
	1000 SUBPROVI DER - I PF 1300 NURSERY	272 445	74 402	0	0	0 4, 669	40.00
	ICI LLARY SERVI CE COST CENTERS	373, 465	74, 683	21, 746	U _I	4,009	43.00
	5000 OPERATING ROOM	27, 771, 184	5, 553, 487	4, 211, 307	369, 063	904, 265	50.00
	5100 RECOVERY ROOM	0	0	0	0	0	51.00
	5200 DELIVERY ROOM & LABOR ROOM	1, 692, 949	338, 544	0	0	0	52. 00
	ANESTHESI OLOGY	332, 254	66, 442		0	684	53. 00
	5400 RADI OLOGY-DI AGNOSTI C	10, 179, 530				135, 523	
	5401 PET SCAN 5600 RADI OI SOTOPE	525, 037 1, 875, 999			0	14, 752 34, 362	
	5700 CT SCAN	1, 796, 050	l		22, 595	16, 993	
	5800 MRI	0	0	0	0	0	58.00
60.00 06	5000 LABORATORY	16, 207, 922	3, 241, 147	673, 215	5, 436	144, 554	60.00
1	5500 RESPI RATORY THERAPY	5, 913, 868			,		1
1	6600 PHYSI CAL THERAPY	4, 710, 722	942, 017		0	103, 992	
	5700 OCCUPATIONAL THERAPY 5800 SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
	5900 ELECTROCARDI OLOGY	3, 855, 952	771, 086	573, 206	23, 253	123, 080	
	7000 ELECTROENCEPHALOGRAPHY	2, 056, 598	l		23, 233	12, 862	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 264, 710		0	Ō	0	
	7200 IMPL. DEV. CHARGED TO PATIENTS	24, 027, 463	4, 804, 844		0	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	32, 304, 649	1		0	0	73. 00
	7400 RENAL DIALYSIS	2, 750, 457	l			67, 903	74.00
	B140 CARDLO CATH LAB B050 ENDOSCOPY	4, 674, 918 6, 283, 249	l			55, 348 59, 488	
	3950 CARDI AC REHAB	589, 528			37, 152 0	0	76. 01
	ITPATIENT SERVICE COST CENTERS	007,020	1117070		٥١		70.02
	POOO CLI NI C	4, 697, 585	939, 390	813, 768	62, 550	174, 734	90. 00
	P100 EMERGENCY	7, 675, 030	1	803, 453	317, 757	172, 519	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
	THER REIMBURSABLE COST CENTERS PSOO AMBULANCE SERVICES	3, 820, 302	763, 957	18, 401	O	3, 951	95. 00
1	9600 DURABLE MEDICAL EQUIP-RENTED	3, 020, 302	l	10, 401		•	96.00
	PECIAL PURPOSE COST CENTERS	·		_	-1		
	D500 KIDNEY ACQUISITION	1, 220, 072	l	103, 035		22, 124	
	0600 HEART ACQUISITION	462, 697	l		۱		106.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) 	356, 340, 092	59, 281, 278	19, 730, 097	2, 034, 135	4, 203, 029	118.00
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	56, 362	11, 271	95, 747	ol	20, 559	190. 00
	2200 PHYSICIANS' PRIVATE OFFICES	630, 639	l		0		192. 00
194. 00 07	7950 CLOSED PSYCH UNIT	0	0	0	О	0	194. 00
	7951 MARKETI NG	2, 211, 568			0		194. 01
	7952 SENI OR CI RCLE	83, 272	l		0		194. 02
	7953 OTHER NONREIMBURSABLE COST CENTERS	82, 613	1	0	0		194. 03 200. 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	l	0	0		200.00
	1 -9				<u> </u>		1 30

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	
				rom 07/01/2015		
				Γo 06/30/2016		
					11/30/2016 5:	23 pm
Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE		
		AND GENERAL				
	5A. 01	5. 02	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118-201)	359, 404, 546	59, 894, 086	19, 825, 84	2, 034, 135	4, 223, 588	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			То	06/30/2016	Date/Time Prep 11/30/2016 5:2	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11. 00	13.00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 CAP REL COSTS-BLDG & FLXT						1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 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 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						8. 00 9. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	5, 326, 691					10.00
11. 00 01100 CAFETERI A	0, 320, 071	2, 710, 872				11. 00
13.00 01300 NURSING ADMINISTRATION	0	31, 977	2, 912, 243			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	83, 256	0	8, 347, 016		14.00
15. 00 01500 PHARMACY	0	119, 944	0	173, 702	11, 465, 662	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	85, 620	0	1, 910	0	16.00
17. 00 01700 SOCIAL SERVICE 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	53, 580	0	4, 056	0	17. 00 21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV		0	0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	o	4, 536	0	218	o	23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	0	4, 378	0	0	0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 054, 612	532, 781	794, 457	275, 718	0	30.00
31. 00 03100 INTENSIVE CARE UNIT 31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	37, 249	22, 571	0 42, 929	13, 221	0	31. 00 31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	37, 247	54, 865	98, 524	27, 666	0	31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	669, 177	293, 959	525, 085	180, 080	Ö	31. 03
32.00 03200 CORONARY CARE UNIT	229, 213	95, 184	176, 927	74, 711	0	32.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	0	6, 789	11, 895	6, 317	0	43.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM		251 400	200 242	1 021 777	0	EO 00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	0	251, 498	389, 363	1, 031, 777	0	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	31, 977	56, 002	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	o	4, 283	0	393	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	159, 074	246, 812	94, 173	0	54.00
54. 01 05401 PET SCAN	0	412	654	0	0	54. 01
56. 00 05600 RADI OI SOTOPE	0	11, 563	22, 555	4, 552	0	56.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	23, 285	33, 236	20, 714	0	57. 00 58. 00
60. 00 06000 LABORATORY		136, 916	0	483, 175	0	60.00
65. 00 06500 RESPI RATORY THERAPY	o	117, 803	0	57, 902	o	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	73, 359	0	10, 261	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 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	91, 044 27, 853	0	3, 617 52, 172	0	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		27, 653	0	2, 281, 219	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	o	2, 941, 866	o	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	11, 465, 662	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0	6, 167	0	74.00
76. 00 03140 CARDI O CATH LAB	0	32, 294		188, 283	0	76.00
76. 01 03050 ENDOSCOPY 76. 02 03950 CARDI AC REHAB	0	88, 967 15, 433	134, 360	179, 144	0	76. 01 76. 02
OUTPATIENT SERVICE COST CENTERS	<u> </u>	15, 455	<u> </u>	<u> </u>	U	70.02
90. 00 09000 CLINIC	0	74, 311	129, 043	58, 208	0	90.00
91. 00 09100 EMERGENCY	0	113, 124	186, 495	157, 600	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	1	57.004		47 (07		
95. 00 O9500 AMBULANCE SERVI CES 96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED	0 0	57, 831 0	0	17, 637	0	95. 00 96. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED SPECI AL PURPOSE COST CENTERS	UU	U	U_	<u> </u>	U	90.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	O	0	0	0		106. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 990, 251	2, 700, 467	2, 912, 243	8, 346, 459	11, 465, 662	118. 00
NONREI MBURSABLE COST CENTERS		_1		-1	-	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	2 224 440	0		0	•	190. 00 192. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES 194.00 07950 CLOSED PSYCH UNIT	2, 336, 440	0		0		192. 00 194. 00
194. 01 07951 MARKETI NG		7, 867	0	423		194. 00
194. 02 07952 SENI OR CI RCLE		1, 602	o	48		194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	O	936		86	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	LUTHERAN HOSPITA	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 07/01/2015 Fo 06/30/2016	Worksheet B Part I Date/Time Pre 11/30/2016 5:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI OI	CENTRAL N SERVI CES & SUPPLY	PHARMACY	
	10.00	11. 00	13. 00	14.00	15.00	
202.00 TOTAL (sum lines 118-201)	5, 326, 691	2, 710, 872	2, 912, 24	8, 347, 016	11, 465, 662	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150017

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2015 | Part | To 06/30/2016 | Date/Time Prepared: | 11/30/2016 5: 23 pm

Court Centure Description					INTERNS &	RESI DENTS	11/30/2016 5:	23 pm
SERBERAL SERVICE DOST CERTERS 10.00 17.00 21.00 22.00 23.00								
BIRBON SEPUICE COST CENTERS 10.00 17.00 27.00 22.00 22.00 23.00 24.00 25.0		Cost Center Description		SOCIAL SERVICE				
							PRGM	
1.00				17.00			23. 00	
2.00 00000 CAP REL COSTS-AVRILE EQUIP								
4.00 DOUGO LANDY E REMET IS DEPARMENT 5.01 DOSAG (THE AVAIR STEAT OF MARCH STATE		I I						
5.01 OSCHEJ AMM ITTIKO								
7. 00 00 00000 (AURINDAY & LINERS SERVICE 9 0 0 00 0000 (AURINDAY & LINERS SERVICE 9 0 0 00 0000 (AURINDAY & LINERS SERVICE 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
0.000 DUNION X & LINEN SERVICE 0.000 0.000 DETARY 1.100			RAL					
9.00 09000 NUSKECEP MS		1						
10.00 01000 DETARY								•
13.00 01300 MURSINEA RADIAL INTERNATION 11.00 10.00 CENTRAL SERVICES & SUPPLY 11.00 10.00 CENTRAL SERVICES & SUPPLY 11.00 10.00 CENTRAL SERVICES & SUPPLY 10.00 10.00 CENTRAL SERVICES & SUPPLY 10.00 10.00 CENTRAL SERVICES & SUPPLY 10.00 10.00 CENTRAL SERVICES & SUPPLY 10.00	10.00	01000 DI ETARY						
14.00 01400 CENTRAL SERVICES & SUPPLY								
15.00								
17.00 01700 SOCIAL SERVICE 0 3.228,719 17.00 221 220 221 220 221 220 221 220 221 220 2								
21.00			7, 408, 146					
22.00 0200 148 SERVICES-OTHER PROBL COSTS APPRV 0 0 0 3,369,386 02.00 0200			40004	3, 228, 719				
23.00 02300 PARAMED ED PROM. (SPECIFY) 0 0 608.45 23.00 23.01 23.01 PARAMEDY RESIDENCY PROGRAM 0 0 0 23.01 30.00		1	l l	0		3 369 386		
IMPATI ENT ROUTINE SERVICE COST CENTERS 341, 152 148, 677 25 386, 397 389, 553 30. 00 31. 00 3000 ADUITS & PEDIA PRICES 341, 152 148, 677 25 386, 397 389, 553 30. 00 31. 00 3000 ADUITS & PEDIA PRICE INTENSIVE CARE UNIT 1, 198 5, 316 1 15, 456 5, 531 31. 01 31. 02 3000 PEDIATRIC INTENSIVE CARE UNIT 12, 198 5, 316 1 15, 456 5, 531 31. 01 31. 02 3000 PEDIATRIC INTENSIVE CARE UNIT 12, 198 5, 316 1 15, 456 5, 531 31. 01 31. 02 3000 PEDIATRIC INTENSIVE CARE UNIT 210, 288 91. 646 0 293, 662 30, 598 31. 02 32. 00 32.00 30.200			0	_		0,007,000	608, 455	
0.000 0.0000 ADULTS & PEDIATRICS 341, 152 148, 677 25 366, 397 389, 553 30. 00 31.	23. 01		0	0				23. 01
31.00	20.00			140 477	25	204 207	200 552	20.00
10. 10. 2080 PEDIATRIC INTENSIVE CARE UNIT 12, 198 5, 316 1 15, 456 5, 531 31, 01 10. 2080 0.0 0.0 0.0 176, 874 31, 03 31. 01 20. 20. 0.0 0.0 0.0 176, 874 31, 03 31. 01 20. 0.3 20. 0.5			341, 132		1			
31.03 03101 CARDIO INTENSIVE CARE UNIT			12, 198		1	15, 456	-	
32.00 03200 COROMARY CARE UNIT 81,622 35,572 0 0 43,683 32.00		1	1		1	·		
40.00 04000 04000 04000 04000 0400 0400 0400 0400 0400 0400 0400 0400 0400 0400 0400 040000 040000 040000 040000 040000 040000 040000 040000 040000 0400000 0400000 040000000 0400000000					1	=		
43.00 04300 NURSERY A 896 2,134 0 0 12,241 43.00			01,022		1	=		
50.00 050000 0FERTIN OR ROOM		04300 NURSERY	4, 896	2, 134	0	0	12, 241	43. 00
51.00 05100 RECOVERY ROOM Color Colo	FO 00		1 207 (02	E/1 10E	1 40	011 000	0	F0 00
52.00 05200 05200 05200 05200 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05400 05600 05600 0500 05000 05000 05400 05600 05000 05000 05000 05600 05000 05000 05000 05000 05000 05000 05000 05500 05500 05000 05000 05500			1, 287, 083		1		-	
54.00 05400 RADI DLOGY-DI AGNOSTI C 358, 280 156, 142 0 0 0 54, 00		1 1	23, 049			0	-	
54.01					1	0	-	
56.00 05600 RADI DI SOTOPE 102,160 44,522 0 0 0 0 56.00 057.00 0570 CT SCAN 301,207 131,269 0 0 0 0 0 0 57.00 0570					1	0	-	
58.00 05800 MR			The state of the s		1	ő	-	
60.00 06000 LABORATORY 596, 306 259, 876 0 0 0 0 60.00			301, 207			O	-	
65.00 06500 RESPI RATORY THERAPY 228, 765 99, 698 2 30, 912 0 65.00		1	E04 204			0	-	
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 227, 063 98, 956 0 0 0 0 0 71.00 07000 ELECTROCRECEPHALGGRAPHY 29, 747 12, 964 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 372, 530 162, 352 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 738, 997 322, 062 0 0 0 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 329, 638 579, 646 0 0 0 0 74. 00 74.00 07400 RENAL DI ALYSI S 28, 156 12, 271 0 0 0 0 0 76.01 03050 ENDOSCOPY 170, 353 74, 241 0 0 0 0 76. 01 76.02 03950 CARDI AC REHAB 11, 455 4, 992 0 0 0 0 76. 01 76.02 03950 CARDI AC REHAB 11, 455 4, 992 0 0 0 0 76. 02 79.00 09000 CLINI C 11, 85 146, 721 0 0 0 0 0 79.00 09000 CHRREENCY 336, 663 146, 721 0 0 0 0 91. 00 79.00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09500 AMBURLANCE SERVI CES 21, 266 9, 268 0 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79.00 09500 DURABL			1		1	-	-	
68.00 06800 SPEECH PATHOLOGY		1	l		1	0	-	
69.00 06900 ELECTROCARDIOLOGY 227, 063 98, 956 0 0 0 69.00 70.00 07000 ELECTROCARDIOLOGY 29, 747 12, 964 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 372, 530 162, 352 0 0 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 738, 997 322, 062 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 329, 638 579, 646 0 0 0 0 74.00 74.00 07400 RENAL DI ALYSIS 28, 156 12, 271 0 0 0 0 0 74.00 76.01 03050 ENDOSCOPY 170, 353 74, 241 0 0 0 0 0 76.01 76.02 03950 CARDIO CATH LAB 283, 773 123, 671 8 123, 647 0 76.00 76.02 03950 CARDIO ACREMA 11, 455 4, 992 0 0 0 0 76.01 76.02 03950 CARDIO ACREMA 11, 455 4, 992 0 0 0 0 76.01 79.00 09100 EMERGENCY 336, 663 146, 721 0 0 0 0 0 79.00 09100 EMERGENCY 336, 663 146, 721 0 0 0 0 79.00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 79.00 09500 AMBULANCE SERVI CES 21, 266 9, 268 0 0 0 0 0 79.00 09500 DARBLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 70.00 09500 DARBLE MEDI CAL EQUI P-RENTED 0 0 0 0 70.00 09500 DARBLE MEDI CAL EQUI P-RENTED 0 0 0 0 70.00 09500 OLFART A CQUI SI TI ON 10, 265 4, 474 0 0 0 0 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.00 000 000 000 000 000 70.		1 1	0	0	_	0	-	
70.00 07000 ELECTROENCEPHALOGRAPHY 29,747 12,964 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 372,530 162,352 0 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 738,997 322,062 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,329,638 579,646 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSIS 28,156 12,271 0 0 0 0 74.00 76.00 03140 CARDI LAB 283,773 123,671 8 123,647 0 76.00 76.01 03050 ENDOSCOPY 170,353 74,241 0 0 0 0 76.01 76.02 03950 CARDI AC REHAB 11,455 4,992 0 0 0 0 76.02 79.00 09000 CLI NI C 11,816 5,149 96 1,452,855 0 90.00 91.00 09100 EMERGENCY 336,663 146,721 0 0 0 0 91.00 92.00 09200 DBERVAUTION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 07100 O9000 DURBLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96.00 O9000 DURBLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96.00 O9000 DURBLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 106.00 10500 KI DNEY ACQUI SITION 10,265 4,474 0 0 0 0 0 0 108.00 SUBTOTALS (SUM OF LINES 1-117) 7,408,146 3,228,719 211 3,214,827 608,455 18.00 100.00 190.00 190.00 191.00 192.00 192.00 194.00 0 0 0 0 0 0 0 194.00			227 063	09 056	1	0	-	
71. 00	70. 00	07000 ELECTROENCEPHALOGRAPHY	i i		1	o		70.00
73. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PA	ATI ENT 372, 530	162, 352	0	o	0	71. 00
74. 00						0	-	
76. 00					1	0		
76. 02 03950 CARDI AC REHAB 11, 455 4, 992 0 0 0 76. 02		03140 CARDIO CATH LAB	283, 773	123, 671	1	123, 647	-	
90. 00 09000 CLI NI C 11, 816 5, 149 96 1, 452, 855 0 90. 00 91. 00 09100 EMERGENCY 336, 663 146, 721 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 21, 266 9, 268 0 0 0 0 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 96. 00 SPECI AL PURPOSE COST CENTERS 0 0 0 0 0 105. 00 105.00 KI DNEY ACQUI SI TI ON 10, 265 4, 474 0 0 0 0 106. 00 HEART ACQUI SI TI ON 8, 889 3, 874 0 0 0 0 108. 00 SUBTOTALS (SUM OF LI NES 1-117) 7, 408, 146 3, 228, 719 211 3, 214, 827 608, 455 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 190. 00 192. 00 19200 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 194. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 194. 01 07951 MARKETI NG 0 0 0 0 0 0 194. 02 07952 SENI OR CI RCLE						0	-	
90. 00	76. 02		11, 455	4, 992	0	l 0	0	76.02
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0THER REI MBURSABLE COST CENTERS 21, 266 9, 268 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 10, 265 4, 474 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 8, 889 3, 874 0 0 0 0 106. 00 118. 00 SUBTOTALS (SUM OF LI NES 1-117) 7, 408, 146 3, 228, 719 211 3, 214, 827 608, 455 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 10 154, 559 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 0 0 0 0 0 194. 00 194. 02 07952 SENI OR CIRCLE 0 0 0 0 0 0 194. 00 194. 02 07952 SENI OR CIRCLE 0 0 0 0 0 0 194. 00 194. 02 07952 SENI OR CIRCLE 0 0 0 0 0 0 0 0 195. 00 0 0 0 0 0 0 0 0 0	90.00		11, 816	5, 149	96	1, 452, 855	0	90. 00
95. 00 09500 AMBULANCE SERVICES 21, 266 9, 268 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 SPECI AL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 10, 265 4, 474 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 8, 889 3, 874 0 0 0 0 106. 00 118. 00 SUBTOTALS (SUM OF LI NES 1-117) 7, 408, 146 3, 228, 719 211 3, 214, 827 608, 455 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 105. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 10 154, 559 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 0 0 0 0 0 194. 00 194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 194. 02				146, 721	0	0	0	
95. 00	92. 00		I PARI					92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 96. 00	95. 00		21, 266	9, 268	0	ol	0	95. 00
105. 00		09600 DURABLE MEDICAL EQUIP-RENTED	l l				0	
106. 00 10600 HEART ACQUISITION 8, 889 3, 874 0 0 0 0 106. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 7, 408, 146 3, 228, 719 211 3, 214, 827 608, 455 118. 00 NONREI MBURSABLE COST CENTERS	105.00		10.2/5	1 474	1 0	ام	0	105 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 7, 408, 146 3, 228, 719 211 3, 214, 827 608, 455 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 10 154, 559 0 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 10 154, 559 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 0 0 0 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 0 0 194. 02						0	0	105.00
190. 00					1	3, 214, 827		
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 10 154, 559 0 192.00 194.00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 0 194.00 194.01 07951 MARKETI NG 0 0 0 0 0 0 194.01 194.02 07952 SENI OR CI RCLE 0 0 0 0 0 0 194.02		NONREI MBURSABLE COST CENTERS						
194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 194. 00 194. 00 194. 01 07951 MARKETI NG 0 0 0 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 0 194. 02			ANILEN 0			154 550		
194. 01 07951 MARKETI NG 0 0 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 194. 02			0	0	0	154, 559		
194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 03	194. 01	1 07951 MARKETI NG	0	O	Ö	o	0	194. 01
194. U3 U/993 UTHEK NUNKETMBUKSABLE CUST CENTEKS U U U U U U 194. U3			0			0	0	194. 02
	194. 03	SIO1ADRIATER MONKELWROKZARTE COZI CEL	VIEKO 0	<u> </u>	<u>η</u> Ο	l 이	0	194. 03

Health Financial Systems	LUTHERAN HOSPITA	L OF INDIANA		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Pre 11/30/2016 5:	
			INTERNS	& RESIDENTS		

						11/30/2016 5:	23 pm
				INTERNS &	RESI DENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	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	C	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	7, 408, 146	3, 228, 719	221	3, 369, 386	608, 455	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150017

				To	06/30/2016	Date/Time Prepare 11/30/2016 5:23 p	
	Cost Center Description	PHARMACY	Subtotal	Intern &	Total	117 307 2010 3. 23 p	
		RESI DENCY PROGRAM		Residents Cost & Post			
		FROGRAM		Stepdown			
		00.01		Adjustments	04.00		
	GENERAL SERVICE COST CENTERS	23. 01	24. 00	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.	. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P					· · · · · · · · · · · · · · · · · · ·	. 00
4. 00 5. 01	OO4OO EMPLOYEE BENEFITS DEPARTMENT OO54O ADMITTING					· · · · · · · · · · · · · · · · · · ·	. 00 . 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL					l	. 02
7. 00	00700 OPERATION OF PLANT					l	. 00
8. 00 9. 00	OO800 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING					l	. 00
10.00	01000 DI ETARY					l	. 00
11. 00	01100 CAFETERI A					11.	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY					13.	
15. 00	01500 PHARMACY					14. 15.	
16. 00	01600 MEDICAL RECORDS & LIBRARY					16.	
17. 00	01700 SOCI AL SERVI CE					17.	
21. 00 22. 00	O2100 I &R SERVICES-SALARY & FRINGES APPRV O2200 I &R SERVICES-OTHER PRGM COSTS APPRV					21.	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)					23.	
23. 01	02301 PHARMACY RESIDENCY PROGRAM	276, 453				23.	01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	43, 091, 853	-386, 422	42, 705, 431	30	. 00
31. 00	03100 INTENSIVE CARE UNIT	0	43, 041, 833	-380, 422	42, 703, 431	31.	
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	O	2, 151, 015		2, 135, 558	31.	
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	0	5, 411, 987		5, 118, 306	31.	
31. 03 32. 00	03101 CARDIO INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	24, 856, 619 8, 542, 917	1	24, 856, 619 8, 542, 917	31.	
40. 00	04000 SUBPROVI DER - I PF	o	0,012,717		0	40.	
43.00	04300 NURSERY	0	518, 835	0	518, 835	43.	00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	43, 242, 770	-911, 958	42, 330, 812	50.	.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.	. 00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	2, 152, 566 628, 194		2, 152, 566 628, 194	52. 53.	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 106, 754		14, 106, 754	54.	
54. 01	05401 PET SCAN	o	743, 000		743, 000	54.	
56. 00 57. 00	05600	0	2, 630, 891 2, 783, 649		2, 630, 891 2, 783, 649	56. 57.	. 00
58. 00	05800 MRI	o	2, 703, 047	1	2, 703, 047	58.	
60.00	06000 LABORATORY	0	21, 748, 547	0	21, 748, 547	60.	00
65. 00	06500 RESPI RATORY THERAPY	0	7, 932, 318		7, 901, 404	65. 66.	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	6, 417, 397 0		6, 417, 397 0	67.	
68. 00	06800 SPEECH PATHOLOGY	O	0	0	0	68.	
	06900 ELECTROCARDI OLOGY	0	5, 767, 257		5, 767, 257	69.	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 663, 362 25, 933, 233		2, 663, 362 25, 933, 233	70. 71.	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	O	32, 835, 232		32, 835, 232	72.	
73.00	07300 DRUGS CHARGED TO PATIENTS	276, 453	52, 416, 186		52, 416, 186	73.	
74. 00 76. 00	07400 RENAL DI ALYSI S 03140 CARDI O CATH LAB	0	3, 731, 206 6, 755, 226		3, 731, 206 6, 631, 571	74.	.00
76. 01	03050 ENDOSCOPY	0	8, 560, 478		8, 560, 478	· · · · · · · · · · · · · · · · · · ·	
76. 02	03950 CARDI AC REHAB	0	739, 298	0	739, 298	76.	02
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	O	8, 419, 505	-1, 452, 951	6, 966, 554	90.	.00
91. 00	09100 EMERGENCY	0	11, 444, 161		11, 444, 161	91.	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0		92.	.00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	O	4, 712, 613	0	4, 712, 613	95.	.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	.,,,,,,		0	l	
105.00	SPECIAL PURPOSE COST CENTERS		1 (O2 OE1		1 (02 051	105	00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	1, 603, 951 567, 987		1, 603, 951 567, 987	105. 106.	
118. 00	SUBTOTALS (SUM OF LINES 1-117)	276, 453	353, 109, 007		349, 893, 969	118.	
100.00	NONREI MBURSABLE COST CENTERS		102 000		102 000	100	00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1920 PHYSICIANS' PRIVATE OFFICES		183, 939 3, 247, 759		183, 939 3, 093, 190	190. 192.	
194.00	07950 CLOSED PSYCH UNIT	O	0	0	0, 0,0, 1,0	194.	. 00
	07951 MARKETI NG	0	2, 662, 112		2, 662, 112	194.	
	07952 SENIOR CIRCLE 07953 OTHER NONREIMBURSABLE COST CENTERS	0	101, 574 100, 155		101, 574 100, 155	194. 194.	
	12 Table 11	, <u> </u>	.50, 100	·	.55, 155	1174.	

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2552-10	0
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od: From 07/01/2015	Worksheet B Part I	
				To 06/30/2016	Date/Time Prepared: 11/30/2016 5:23 pm	_
Cost Center Description	PHARMACY	Subtotal	Intern &	Total		
	RESI DENCY		Residents Cos	st		
	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)	276, 453	359, 404, 546	-3, 369, 60	356, 034, 939	202. 00)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150017

CAST CENTER DESCRIPTION Directly Assigned May Support Directly Assigned May Capital Directly Assigned May Capital Directly Assigned May Capital Directly Assigned May Directly					Ic	06/30/2016	Date/lime Pre 11/30/2016 5:	
Assigned files Capit State				CAPI TAL RE	LATED COSTS		1 1.7 007 2010 01	
Assigned files Capit State		Cost Conton Dogonintion	Di saativ	DIDC 0 FLVT	MVDLE FOLLID	Cubtatal	EMDL OVEE	
DEMARKS SHIPTICE COST CENTERS		cost center bescription		BLDG & FIXI	MARTE EGOLD	Subtotai		
DEFINED SPRING CONT CENTERS 1987 1.00 2.00 2A 4.00 1.00								
DEWINDLE SERVICE COST CENTERS 1.00 1.0								
1.00		CENEDAL SERVICE COST CENTERS	0	1.00	2.00	2A	4. 00	
2.00	1 00							1 00
0.00 0.004 ARM TITING 0.0 3.65, 159 20.0 0.11 318, 200 1.6, 270 5.01 7.00 0.								
5.02 ODS-00 (INTER ADMINISTRATI VE AND CENTERN 0 OTTO-00 (OTTO-00 CENTERN CENTER) O 3.62,859 4.07,712 4.096,712 4.096,713 6.097,71 6.097			0			·		
7.00 000000 000000 000000 000000 000000			0	1				1
8.00 0.0000 LAURDRY & LINEN SERVICE 0 21,054 398 21,452 0 8.00			0	1				
10.00 01000 DETARY 0 660, 285 102, 990 783, 744 4, 797 10.00 7.181 11.00 11.00 02, 62FEERIA 4 797 11.00 7.181 11.00 11.00 62FEERIA 4 797 11.00 7.181 11.00 11.00 62FEERIA 4 797 11.00 7.181 11.00 11.00 11.00 62FEERIA 4 797 11.00 7.181 11.00			0					
11.00 01100 CAFFTERIA		1 1	0					1
13.00 01300 NIRSH NG ADMINISTRATION 0 100, 857 23, 714 184, 571 6.699 13.00			0	1	1			1
14.00 01400 CENTRAL SERVICES & SUPPLY 0 203, 768 267, 804 561, 602 7, 509 14.00 150.0 01500 PARMACY 0 168, 172 139, 607 307, 779 25, 227 15.00 01600 PARMACY 0 179, 614 33, 102 212, 716 10.088 16.00 121.00 1 21.0			0	٧	_	-		
10.00 01-000 NEDICAL RECORDS & LIBRARY 0 179, 614 33, 102 212, 716 10, 088 16, 00 21. 00 210 01 02 03 04 05 04 05 05 05 05 05			0	1				
17.00 01700 SOZIAL SERVICE 0 121,001 0 121,001 8,98% 17,00 22,00 220,00			0					1
21.00		1 1	0					
22.00 0.200 LAR SERVICES-OTHER PROXI COSTS APPRV 0 0 0 0 0 0 0 0 0			0	1	1			
23.0		1 1	0	Ö		0		
INPATI ENT ROUTINE SERVICE COST CENTERS 0			0	1	1			
30.00 3000 ADULTS & PEDIATRICS 0 2,414,947 666,792 3,081,739 74,539 30,00 31.00 31.00 31.00 1000 INTENSIVE CARE UNIT 0 128,667 28,698 157,365 4.028 31.01 31.01 20200 DENORMATEL INTENSIVE CARE UNIT 0 259,499 289,999 549,480 9,245 31.02 31.03 31.01 CARDIO I INTENSIVE CARE UNIT 0 927,210 202,553 1,129,763 49,273 31.03 31.01 CARDIO I INTENSIVE CARE UNIT 0 927,210 202,553 1,129,763 49,273 31.03 31.03 31.01 CARDIO I INTENSIVE CARE UNIT 0 361,096 32,265 393,327 16,660 32.00 40.00 30.00 40.00 30.00 40.00 30.00 40.00 30.00 40.00 30.00 40.00 30.00 40.00 30.00 40.00 30.00 40.00 30.00 40.00	23. 01		0	0	0	0	766	23. 01
31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	30. 00		0	2, 414, 947	666, 792	3, 081, 739	74, 539	30.00
31.02 02000 NEOMATAL INTENSIVE CARE UNIT 0 259, 491 289, 989 549, 480 9, 245 31.02 31.02 31.03 03101 CARDIO INTENSIVE CARE UNIT 0 927, 210 2025 51.129, 763 49, 273 31.02 32.00 03200 CORDNARY CARE UNIT 0 361, 056 32, 265 393, 321 16, 602 32.00 043.00 04000 0400 00 0 0 0 0			0	1	1			
31 0.0 03101 CARDIO ANTENSIVE CARE UNIT 0 927, 210 202, 553 1, 129, 763 49, 273 31, 03 03 030 0300 000000			0	1				
32.00 03200 COROMARY CARE UNIT 0 361.056 32, 265 393.321 16,602 32.00		l l	0					
40. 00 04000 SUBPROVI DER - I PP			0	1	1			
ANCIL LLARY SERVICE COST CENTERS 50.00 5			0	0				1
50.00 05000 0FECATI NG ROOM 0 2,479,023 3,170,233 5,649,256 33,537 50.00 51.00 51.00 6	43.00		0	12, 801	1, 079	13, 880	1, 116	43. 00
51.00 05100 DELOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 51.00	50.00		1 0	2 470 022	2 170 222	5 640 256	26 527	50.00
52.00 05200 DELLUYERY ROOM & LABOR ROOM 0 0 0 5. 255 52.00			0	1				1
54. 00 05400 RADI OLOGY-DIAGNOSTIC 0 371, 536 1, 466, 171 1, 837, 707 23, 160 54. 00 54. 01 05401 PET SCAN 0 40, 443 311, 237 351, 860 61 54. 01 56. 00 05700 CT SCAN 0 46, 586 108, 154 154, 740 3, 119 57. 00 57. 00 05700 CT SCAN 0 46, 586 108, 154 154, 740 3, 119 57. 00 60. 00 05000 MRI 0 0 0 0 0 0 0 0 0 60. 00 06000 RESPIRATORY THERAPY 0 396, 294 438, 353 834, 647 18, 992 60. 00 60. 00 06000 RESPIRATORY THERAPY 0 134, 693 196, 292 330, 895 16, 817 65. 00 60. 00 06000 RESPIRATORY THERAPY 0 285, 093 96, 485 381, 578 14, 594 66. 00 60. 00 06000 SEPECH PATHOLOGY 0 0 0 0 0 0 60. 00 06000 SPECCH PATHOLOGY 0 337, 423 338, 859 695, 992 9, 695 690, 090 60. 00 06000 ELECTROCARDI OLLOGY 0 337, 423 338, 859 695, 992 9, 695 690, 090 60. 00 0700 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 0 70. 00 0700 IMPL. DEV. CHARGED TO PATIENT 0 0 163, 085 699, 945 863, 030 12, 608 70. 00 0700 IMPL. DEV. CHARGED TO PATIENT 0 0 163, 085 699, 945 863, 030 12, 608 70. 00 0700 IMPL. DEV. CHARGED TO PATIENT 0 0 163, 085 699, 945 863, 030 12, 608 70. 00 0700 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 70. 00 0700 0700 0700 0700 0700 0700 0700 70. 00 0700 0700 0700 0700 0700 0700 0700 0700 70. 00 0700 0700 0700 0700 0700 0700 0700 0700 70. 00 0700 0700 0700 0700 0700 0700 0700 0700 70. 00 0700 0700 0700 0700 0700 0700 0700 0700 70. 00 0700 0700 0700 0700 0700 0700 0700 0700 70. 00 0700 0700 0700 0700 0700 0700 0700 0			0	o		0		
54 01 05401 PET SCAN 0 40, 443 311, 237 351, 680 61 54 01			0	1	1			1
56 00 05000 RADIO I SOTOPE 0 94, 203 38, 331 132, 534 2, 116 56, 00 05700 CT SCAN 0 46, 586 108, 154 154, 740 3, 119 57, 00 58, 00 05800 MRI 0 0 0 0 0 0 0 0 58, 00 05800 MRI 0 0 0 0 0 0 0 0 58, 00 05800 MRI 0 0 0 0 0 0 0 0 58, 00 05800 MRI 0 0 0 0 0 0 0 0 58, 00 05800 MRI 0 0 0 0 0 0 0 0 58, 00 05800 RESPIRATORY HERAPY 0 336, 294 438, 353 384, 647 18, 992 60, 00 0 0 0 0 0 0 0 0			0	1	1			1
57. 00 05700 CT SCAN 0 05800 MRI 0 0 0 0 0 0 0 0 0		l l	0					
60.00 06000 LABORATORY 0 396, 294 438, 353 834, 647 18, 992 0.00		05700 CT SCAN	0	1	1	·		
65. 00 06500 RESPI RATORY THERAPY 0 134, 693 196, 292 330, 985 16, 817 65, 00 66. 00 06000 PHYSI CAL THERAPY 0 285, 093 96, 485 381, 578 14, 594 66, 00 67, 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0			0	0	_	-		
66.00 06600 PHYSI CAL THERAPY 0 285, 093 96, 485 381, 578 14, 594 66, 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68. 00 68. 00 06800 SPEECH PATHOLOGY 0 337, 423 358, 569 695, 992 9, 695 69. 00 07000 ELECTROCARDI OLOGY 0 337, 423 358, 569 695, 992 9, 695 69. 00 07000 ELECTROCARDI OLOGY 0 35, 262 295, 594 330, 856 4, 76 70. 00 71. 0		1 1	0	1	1	·		
67. 00 06700 06CUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 06900 SEECTROCARDI OLOGY 0 337, 423 358, 569 695, 992 9, 695 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 35, 262 295, 594 330, 856 4, 276 70. 00 71. 00 07100 MEDICAL 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 07400 ENLACIDAD IN LIVES 0 186, 155 184, 105 370, 260 0 74, 00 76. 01 03410 CARDI O CATH LAB 0 151, 737 859, 726 1, 011, 463 5, 997 76, 00 76. 02 03950 CARDI AC REHAB 0 0 0 25, 709 25, 709 1, 813 76. 02 03950 CARDI AC REHAB 0 0 0 25, 709 25, 709 1, 813 76. 02 03950 CARDI AC REHAB 0 0 472, 960 431, 352 904, 312 17, 500 91. 00 79. 00 09100 EMERGENCY 0 472, 960 431, 352 904, 312 17, 500 91. 00 79. 00 09200 OSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 0 0 0 79. 00 09500 AMBULANCE SERVI CES 0 0 10, 832 310, 694 321, 526 7, 816 95. 00 79. 00 09500 AMBULANCE SERVI CE ST CENTERS 0 0 0 0 0 0 79. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 79. 00 09500 OURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79. 00 00 00 0 0 0 79. 00 00 00 0 0 79. 00 00 00 0 0 79. 00 00 00 00 0 79. 00 00 00 0 0 79. 00 00 00 0 79. 00 00 00 00 0 79. 00 00 00 00 0 79. 00 00 00 00 00 79. 00 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00 00 00 79. 00 00			0					1
69. 00 06900 ELECTROCARDI OLOGY 0 337, 423 358, 569 695, 992 9, 695 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 35, 262 295, 594 330, 856 4, 276 70. 00 0 0 0 0 0 0 0 0			0	1	1			
70. 00 07000 ELECTROENCEPHALGGRAPHY 0 35, 262 295, 594 330, 856 4, 276 70. 00 71. 00 0 0 0 0 0 0 0 0 0		1 1	0	۱	1 "			
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71. 00 72. 00 07200 1MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 186, 155 184, 105 370, 260 0 74. 00 76. 00 03140 CARDI O CATH LAB 0 151, 737 859, 726 1, 011, 463 5, 997 76. 00 76. 01 03050 ENDOSCOPY 0 163, 085 699, 945 863, 030 12, 608 76. 01 76. 02 03950 CARDI AC REHAB 0 0 25, 709 25, 709 1, 813 76. 02 03950 CARDI AC REHAB 0 479, 032 37, 941 516, 973 12, 109 90. 00 79. 00 09000 CLI NIC 0 479, 032 37, 941 516, 973 12, 109 90. 00 79. 00 09000 DEBERGENCY 0 472, 960 431, 352 904, 312 17, 500 91. 00 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 79. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 96. 00 79. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 79. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 79. 00 09000 OBSERVATION 0 0 0 0 0 0 0 79. 00 09000 OBSERVATION 0 0 0 0 0 0 0 79. 00 09000		1 1	0					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 07400 RENAL DI ALYSI S 0 186, 155 184, 105 370, 260 0 74. 00 76. 00 03140 CARDIO CATH LAB 0 151, 737 859, 726 1, 011, 463 5, 997 76. 00 76. 01 03050 ENDOSCOPY 0 163, 085 699, 945 863, 030 12, 608 76. 01 76. 02 03950 CARDI AC REHAB 0 0 0 25, 709 25, 709 1, 813 76. 02 0017PATIENT SERVICE COST CENTERS 0 479, 032 37, 941 516, 973 12, 109 90. 00 91. 00 09000 CLI NI C 0 479, 032 37, 941 516, 973 12, 109 90. 00 92. 00 09000 OBSERVATI ON BEDS (NON-DISTINCT PART 0 472, 960 431, 352 904, 312 17, 500 91. 00 95. 00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 O9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 106. 00 10600 HEART ACQUI SI TI ON 0 60, 653 0 105. 00 108. 00 109000 HEART ACQUI SI TI ON 0 16, 756, 901 21, 360, 476 38, 117, 377 478, 232 190. 00 19000 PHYSI CI ANS' PRI VATE OFFI CES 0 0 172, 830 172, 830 0 192. 00 194. 00 07950 LOSED PSYCH UNIT 0 0 0 0 0 0 0 194. 00 107951 MARKETI NG 0 0 0 0 0 0 194. 00 107951 MARKETI NG 0 0 0 0 0 0 194. 01 07951 MARKETI NG 0 0 0 0 0 0 194. 01 07951 MARKETI NG 0 0 0 0 0 0 105. 02 07900 07900 07900 07900 0 0 0 194. 01 07951 MARKETI NG 0 0 0 0 0 106. 00 07900 07900 07900 07900 0 0 0 107. 00 0 0 0 0 0 0 108. 00 0 0 0 0 0 109. 00 0 0 0 0 109. 00 0 0 0 0 109. 00 0 0 0 109. 00 0 0 0 109. 00 0 0 0 109. 00 0 0 0 109. 00 0 0 0 109. 00 0 0 0 109. 00 0 0 0 109. 00 0 0 0 109. 00 0 0 109. 00 0 0 109. 00 0 0 109. 00 0 0 109. 00 0 0 109. 00 0 0 109. 00 0 0 109. 00 0 0 109. 00			Ö	0	273, 374	0		
74. 00 07400 RENAL DI ALYSI S 0 186, 155 184, 105 370, 260 0 74. 00 76. 00 03140 CARDI O CATH LAB 0 151, 737 859, 726 1, 011, 463 5, 997 76. 00 76. 01 03050 ENDOSCOPY 0 163, 085 699, 945 863, 030 12, 608 76. 01 76. 02	72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
76. 00			0	10/ 155	104 105	0		
76. 01 03050 ENDOSCOPY 0 163, 085 699, 945 863, 030 12, 608 76. 01 76. 02 03950 CARDI AC REHAB 0 0 0 25, 709 25, 709 1, 813 76. 02 90. 00 09000 CLI NI C 0 479, 032 37, 941 516, 973 12, 109 90. 00 91. 00 09100 EMERGENCY 0 472, 960 431, 352 904, 312 17, 500 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 95. 00 09500 AMBULANCE SERVI CES 0 10, 832 310, 694 321, 526 7, 816 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 96. 00 98. 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					
90. 00 09000 CLI NI C 0 479, 032 37, 941 516, 973 12, 109 90. 00 91. 00 91. 00 92. 00 09200 0BERGENCY 0 472, 960 431, 352 904, 312 17, 500 91. 00 92. 00 09200 0BERGENCY 0 472, 960 431, 352 904, 312 17, 500 91. 00 92. 00 00 00 00 00 00 00 00			0	1				1
90. 00		03950 CARDI AC REHAB	0	1	1			
91. 00	00.00			470.000	27.041	E14 070	10 100	00.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0			0					1
95. 00 09500 AMBULANCE SERVICES 0 10, 832 310, 694 321, 526 7, 816 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 96. 00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0		09200 OBSERVATION BEDS (NON-DISTINCT PART	<u> </u>		.51, 552			
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00		OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 60, 653 0 105.00 106.00					1			
105. 00	96.00		0		0	Ü	0	J 96. UU
106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 106. 00 118. 00 SUBTOTALS (SUM OF LI NES 1-117) 0 16, 756, 901 21, 360, 476 38, 117, 377 478, 232 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 56, 362 0 172, 830 172, 830 0 192. 00 194. 00 1950 CLOSED PSYCH UNI T 0 0 0 0 0 0 0 194. 00 194. 0107951 MARKETI NG 0 0 4, 570 4, 570 1, 300 194. 01		10500 KIDNEY ACQUISITION	0	60, 653	0	60, 653	0	105. 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 56, 362 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 172, 830 172, 830 0 192.00 194.00 0 0 0 0 0 194.00 194.01 194.01 194.01 195.01 194.01	106.00	0 10600 HEART ACQUISITION	0	0	0	0	0	106. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 56, 362 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 172, 830 172, 830 0 192. 00 194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 194. 00 194. 00 194. 01 194. 0	118.00	SUBTOTALS (SUM OF LINES 1-117)	0	16, 756, 901	21, 360, 476	38, 117, 377	478, 232	J118. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 172, 830 0 192.00 194.00 07950 CLOSED PSYCH UNI T 0 0 0 194.00 194.01 194.01 194.01 0 0 0 4, 570 4, 570 1, 300 194.01	190 00		n	56 362	n	56 362	n	190 00
194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 194. 00 194. 01 194. 01 194. 01 0 0 4, 570 4, 570 1, 300 194. 01			0	l .				
194. 01 07951 MARKETI NG 194. 02 07952 SENI OR CI RCLE 194. 02 07952 SENI OR CI RCLE 194. 02 07952 SENI OR CI RCLE 194. 02 07952 SENI OR CI RCLE	194.00	07950 CLOSED PSYCH UNIT	0	0	0	0	0	194. 00
174. 02 0/732 3LINI OK OI KOLE U U U U U 1// [194. 02	194.01	1 07951 MARKETI NG	0	0	1			
	194. 02	ZIO173Z SENIUK CIKCLE	1 0	1 0	ıı U	U	1//	1194. UZ

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 07/01/2015	Part II	
				To 06/30/2016	Date/Time Pre 11/30/2016 5:	pared: 23 pm
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	291	194. 03
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	16, 813, 263	21, 537, 87	38, 351, 139	480, 000	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150017

			1	0 06/30/2016	Date/lime Pre 11/30/2016 5:	
Cost Center Description	ADMITTI 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 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 ADMITTING	401 420					4.00
5. 02 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	401, 628 0					5. 01 5. 02
7.00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	59, 663				8. 00
9. 00 00900 HOUSEKEEPI NG	0	122, 513	1		246, 490	9. 00
10. 00 01000 DI ETARY	0	117, 121	273, 795	0	14, 482	10. 00
11. 00 01100 CAFETERI A	0	80, 935		0	0	11. 00
13. 00 O1300 NURSING ADMINISTRATION	0	76, 082	64, 740	0	3, 424	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	228, 533				14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0		67, 684 72, 289	0	3, 580 3, 824	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE				0	2, 576	
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRV	0	7	0,077	0	2,370	21. 00
22. 00 02200 Lar Services-Other Prom Costs Apprv	Ö	100, 595	Ö	0	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	13, 780	27, 289	99	1, 443	23. 00
23. 01 02301 PHARMACY RESIDENCY PROGRAM	0	8, 123	0	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	18, 453	1	971, 944		51, 409	
31. 00 03100 INTENSIVE CARE UNIT	0		0		0	31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT 31. 02 02060 NEONATAL INTENSIVE CARE UNIT	660 2, 252		51, 785 104, 437	954 753	2, 739 5, 524	1
31. 03 03101 CARDIO INTENSIVE CARE UNIT	11, 375		373, 174		19, 738	
32. 00 03200 CORONARY CARE UNIT	4, 415		145, 314		7, 686	
40. 00 04000 SUBPROVI DER - PF	0	0	0	0,000	0	40.00
43. 00 04300 NURSERY	265	13, 380	5, 152	0	273	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	69, 652	994, 930	997, 733	16, 255	52, 772	50. 00
51.00 05100 RECOVERY ROOM	0	1	0	0	0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 247	60, 652	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	8, 324				40	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 PET SCAN	19, 380 1, 072		149, 532 16, 277	4, 864	7, 909 861	54. 00 54. 01
56. 00 05600 RADI 01 SOTOPE	5, 526		1	0	2, 005	
57. 00 05700 CT SCAN	16, 293		18, 749		992	
58. 00 05800 MRI	0	0 ., 5 . 6	0	0	0	58. 00
60. 00 06000 LABORATORY	32, 255	580, 665	159, 496	239	8, 436	
65. 00 06500 RESPI RATORY THERAPY	12, 374	211, 870	54, 210	1, 005	2, 867	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 494	168, 766	114, 742	0	6, 069	
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	12, 282				7, 183	1
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 609 20, 151				751 0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 973		0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	72, 833		Ö	o O	Ö	73. 00
74. 00 07400 RENAL DIALYSIS	1, 523		74, 922	0	3, 963	1
76. 00 03140 CARDIO CATH LAB	15, 350	167, 484	61, 070	738	3, 230	76. 00
76. 01 03050 ENDOSCOPY	9, 215			1, 636		1
76. 02 03950 CARDI AC REHAB	620	21, 120	0	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS		140.004	100 701	0.755	10.100	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	639					1
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	18, 210	274, 966	190, 352	13, 995	10, 068	1
OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	1, 150	136, 866	4, 359	0	231	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0			96.00
SPECIAL PURPOSE COST CENTERS	<u>'</u>	<u>'</u>				
105. 00 10500 KIDNEY ACQUISITION	555	43, 710	24, 411	0	1, 291	105. 00
106. 00 10600 HEART ACQUI SI TI ON	481		0			106. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	401, 628	10, 620, 595	4, 674, 408	89, 589	245, 290	118. 00
NONREI MBURSABLE COST CENTERS	-		00.75	1		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1		0		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 194.00 07950 CLOSED PSYCH UNIT	0	22, 593		0		192. 00 194. 00
194. 00 07950 CLOSED PSYCH UNIT 194. 01 07951 MARKETING		79, 232				194. 00
194. 01 07951 MARKETTING 194. 02 07952 SENI OR CLIRCLE	0	2, 983	0	0		194. 01
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS	0	2, 960		n		194. 02
200.00 Cross Foot Adjustments		2, 700			Ĭ	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
· · · · ·				'		

Health Financial Systems	LUTHERAN HOSPI7	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2015		
				To 06/30/2016	Date/Time Pre 11/30/2016 5:	
Cost Center Description	ADMITTING	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)	401, 628	10, 730, 382	4, 697, 09	2 89, 589	246, 490	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150017

Peri od: Worksheet B From 07/01/2015 Part II To 06/30/2016 Date/Time Prepared:

11/30/2016 5:23 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** SERVICES & ADMI NI STRATI ON **SUPPLY** 10.00 11.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 ADMITTING 5.01 00560 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 1, 193, 439 10 00 01100 CAFETERI A 88, 122 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 0 1,039 336, 545 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 2,706 925, 117 14.00 15.00 01500 PHARMACY 0 3, 899 0 19, 251 751, 307 15.00 0 01600 MEDICAL RECORDS & LIBRARY 2, 783 0 16.00 16,00 212 0 01700 SOCIAL SERVICE 17.00 1,742 0 450 0 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 0 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV C 0 0 0 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) 147 0 23.00 24 0 23.00 23.01 02301 PHARMACY RESIDENCY PROGRAM 142 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 91, 830 30, 558 30.00 460, 333 17. 321 0 03100 INTENSIVE CARE UNIT 31.00 0 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 8, 346 734 4, 961 1, 465 0 31.01 31.02 02060 NEONATAL INTENSIVE CARE UNIT 1, 783 11, 385 3,066 0 31.02 03101 CARDIO INTENSIVE CARE UNIT 149.928 9 556 60 675 19 958 31 03 31 03 0 03200 CORONARY CARE UNIT 32.00 51, 355 3,094 20, 444 8, 280 0 32.00 40.00 04000 SUBPROVIDER - IPF 0 40.00 04300 NURSERY 43.00 0 221 1, 374 700 0 43.00 ANCILLARY SERVICE COST CENTERS 8, 175 50.00 05000 OPERATING ROOM 0 44, 992 114, 352 0 50.00 05100 RECOVERY ROOM 51.00 0 0 0 51.00 C 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 1,039 6.471 0 52 00 0 05300 ANESTHESI OLOGY 53.00 139 44 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0000000000000000000 5, 171 28, 520 0 54.00 54.00 10.437 54.01 05401 PET SCAN 0 54.01 13 76 56.00 05600 RADI OI SOTOPE 504 376 2,606 56 00 0 57.00 05700 CT SCAN 757 3,840 2, 296 0 57.00 05800 MRI 58.00 58.00 0 60.00 06000 LABORATORY 4, 451 0 53, 550 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 3.829 6, 417 0 65.00 1, 137 66.00 06600 PHYSI CAL THERAPY 2, 385 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 0 0 06900 ELECTROCARDI OLOGY 0 69.00 2.960 401 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 905 0 5, 782 0 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 252, 828 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 72.00 0 326, 066 0 72.00 751, 307 73.00 C 0 73.00 07400 RENAL DIALYSIS 684 74.00 74.00 0 03140 CARDIO CATH LAB 76.00 1,050 7, 384 20, 867 0 76.00 03050 ENDOSCOPY 15, 526 76.01 2, 892 19,854 0 76.01 76.02 03950 CARDI AC REHAB 502 0 76.02 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 2.416 14. 911 6. 451 90.00 0 0 91.00 09100 EMERGENCY 0 3,677 21, 550 17, 467 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 1,880 0 1, 955 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 96.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 105. 00 Ω 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 106, 00 118.00 751, 307 118. 00 SUBTOTALS (SUM OF LINES 1-117) 669, 962 87, 784 336, 545 925, 056 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190, 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 523, 477 C 194.00 07950 CLOSED PSYCH UNIT C 0 0 0 194.00 194. 01 07951 MARKETI NG 0 256 0 47 0 194. 01 194. 02 07952 SENI OR CIRCLE 0 0 5 0 194. 02 52 194.03 07953 OTHER NONREIMBURSABLE COST CENTERS 9 0 30 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 OI 201.00 Negative Cost Centers 0 0 0 0 201.00

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 07/01/2015		
				To 06/30/2016	Date/Time Pre	
					11/30/2016 5:	23 pm_
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI O	N SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
202.00 TOTAL (sum lines 118-201)	1, 193, 439	88, 122	336, 54	5 925, 117	751, 307	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150017

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: | 11/30/2016 5: 23 pm

			,	00/30/2010	11/30/2016 5:	
			INTERNS &	RESI DENTS		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
	16. 00	17. 00	APPRV 21.00	APPRV 22. 00	23. 00	
GENERAL SERVICE COST CENTERS	10.00	17.00	21.00	22.00	23.00	
1.00 O0100 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						5. 01 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 13. 00 01300 NURSI NG ADMINI STRATI ON						11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	509, 408	•				16.00
17. 00 01700 SOCIAL SERVICE 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0 0	270, 686 0	8			17. 00 21. 00
22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV			_	100, 595		22.00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)	Ö			.00,070	111, 886	1
23. 01 02301 PHARMACY RESIDENCY PROGRAM	0	0				23. 01
INPATIENT ROUTINE SERVICE COST CENTERS		10.407				
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	23, 475					30. 00 31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	839					31.00
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	2, 865		•			31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	14, 470					31. 03
32. 00 03200 CORONARY CARE UNIT	5, 617	2, 990	1			32.00
40. 00 04000 SUBPROVI DER - 1 PF 43. 00 04300 NURSERY	337	0 179				40. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	337	177				43.00
50. 00 05000 OPERATI NG ROOM	88, 608	47, 169				50.00
51. 00 05100 RECOVERY ROOM	0	0	1			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	1, 586					52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 589 24, 654					53. 00 54. 00
54. 01 05401 PET SCAN	1, 363					54. 01
56. 00 05600 RADI 01 SOTOPE	7, 030	3, 742				56. 00
57. 00 05700 CT SCAN	20, 727	11, 034				57. 00
58. 00 05800 MRI 60. 00 06000 LABORATORY	41, 033	21, 843				58. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY	15, 742					65.00
66. 00 06600 PHYSI CAL THERAPY	4, 444					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	15, 625 2, 047					69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 635					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	50, 852					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	91, 136					73. 00
74. 00 07400 RENAL DIALYSIS 76. 00 03140 CARDIO CATH LAB	1, 937					74. 00 76. 00
76. 00 03140 CARDIO CATH LAB	19, 527 11, 722					76.00
76. 02 03950 CARDI AC REHAB	788					76. 02
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	813					90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	23, 166	12, 332				91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS		L				72.00
95. 00 09500 AMBULANCE SERVICES	1, 463	779				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0					96. 00
SPECIAL PURPOSE COST CENTERS	701	071				105 00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION	706 612					105. 00 106. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	509, 408			О	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0					192.00
194. 00 07950 CLOSED_PSYCH_UNIT 194. 01 07951 MARKETING	0					194. 00 194. 01
194. 02 07952 SENI OR CIRCLE	0					194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0		<u> </u>	<u> </u>		194. 03

Health Financial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eri od:	Worksheet B	
				rom 07/01/2015 o 06/30/2016		nared:
				0 00/ 30/ 2010	11/30/2016 5:	23 pm
			INTERNS &	RESI DENTS		
Cost Center Description		SOCIAL SERVICE		SERVI CES-OTHER		
	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			8	100, 595	111, 886	200.00
201.00 Negative Cost Centers	C	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	509, 408	270, 686	8	100, 595	111, 886	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150017 Peri od: Worksheet B From 07/01/2015 Part II 06/30/2016 Date/Time Prepared: 11/30/2016 5:23 pm 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 00100 CAP REL COSTS-BLDG & FIXT 1.00 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 9,031 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 834, 662 0 5, 834, 662 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 285, 358 0 285, 358 31.01 02060 NEONATAL INTENSIVE CARE UNIT 0 820, 524 31 02 31 02 820, 524 03101 CARDIO INTENSIVE CARE UNIT 0 31. 03 2, 471, 184 2, 471, 184 31.03 03200 CORONARY CARE UNIT 0 32.00 871, 155 871, 155 32.00 04000 SUBPROVI DER - I PF 0 40.00 40.00 04300 NURSERY 0 <u>36, 8</u>77 36, 877 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 8, 120, 431 8, 120, 431 50 00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 77, 094 77, 094 52 00 52 00 53.00 05300 ANESTHESI OLOGY 40, 026 40,026 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 489, 150 0 54.00 2, 489, 150 54.00 05401 PET SCAN 0 390, 939 54.01 390, 939 54.01 05600 RADI OI SOTOPE 56.00 261, 563 261, 563 56.00 57.00 05700 CT SCAN 297, 887 0 297, 887 57.00 58.00 05800 MRI 0 58.00 1, 755, 607 0 1, 755, 607 60.00 06000 LABORATORY 60.00 65.00 06500 RESPIRATORY THERAPY 664, 496 664, 496 65.00 66.00 06600 PHYSI CAL THERAPY 699, 575 699, 575 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 C 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 1,027,426 1, 027, 426 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 435, 188 435, 188 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 002, 438 1,002,438 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 304, 769 1, 304, 769 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 120, 764 0 2, 120, 764 73.00 73.00 07400 RENAL DIALYSIS 0 552, 858 74.00 552, 858 74.00 03140 CARDIO CATH LAB 0 76.00 1, 324, 555 1, 324, 555 76.00 76.01 03050 ENDOSCOPY 1, 236, 936 0 1, 236, 936 76.01 03950 CARDI AC REHAB 50, 972 76.02 50, 972 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 928, 790 0 928, 790 90.00 09100 EMERGENCY 1, 507, 595 0 1, 507, 595 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 478, 025 0 478, 025 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105 00 131, 702 0 131, 702 106.00 10600 HEART ACQUISITION 17, 996 0 17, 996 106.00 SUBTOTALS (SUM OF LINES 1-117) 37, 236, 542 37, 236, 542 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 82, 265 0 82, 265 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 718, 900 718, 900 194.00 07950 CLOSED PSYCH UNIT C 0 0 194.00 194. 01 07951 MARKETI NG 0 85, 405 85.405 194 01 194. 02 07952 SENI OR CIRCLE 3, 217 3, 217 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 3.290 3, 290 194.03

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 07/01/2015	Part II	
				To 06/30/2016		pared:
					11/30/2016 5:	23 pm_
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	9, 031	221, 520		0 221, 520		200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	9, 031	38, 351, 139		0 38, 351, 139		202. 00

Cost Center Description		•	LUTHERAN HUSPIT		CCN 150017 D		Wassissian D. 1	
Cast Centur Description	COST	ALLUCATION - STATISTICAL BASIS		Provi der			Worksheet B-1	
CONTINUED TO CONTINUED							Date/Time Pre	
COUNTY C			CAPITAL REI	LATED COSTS			11/30/2016 5:	23 pm
Columb C			O/II T T/IE IXE	LATED COOTS				
CEREMAL SERVICE COST CENTERS 1.00		Cost Center Description					Reconciliation	
CENERAL SERVICE COST CENTERS 1.00 2.00 1.00 5.01 SA CQ			(SQUARE FEET)	(DOLLAR VALUE)				
CAMPAIN_SERVICE_COST_CENTERS CAMPAIN_SERVICE_COST_CENTERS						GES)		
ENERGY SERVICE COST CENTERS 1.00 2.00 4.90 5.01 54.02								
0.00 0.00 CAP REL COSTS-BLD & FIXT 717, 131 14, 237, 742 1.00 0.0			1.00	2.00		5. 01	5A. 02	
2.00 00200 QAP REL COSTS-MARLE EDUIP 14, 237, 742 2.00 4.00 00300 DAPP REL COSTS-MARLE EDUIP 14, 758 2.7, 600 111, 190, 700 5.01 00340 ARBITTIN (STRATIVE AND CENERAL 15, 577 13, 248 3, 805, 506 2, 536, 362, 93 6.00 00340 ARBITTIN (STRATIVE AND CENERAL 15, 577 13, 248 3, 805, 506 2, 536, 362, 93 7.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 12, 241 1, 40, 418 0 0 0 0 8.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND CENERAL 1, 290, 180 0 9.00 00700 DAPPEN ION OF THE STRATIVE AND								
4.00 00-000 DOLANDET EMPRET IS DEPARTMENT 18, 728 27, 050 111, 190, 700 5.00			717, 131	1				
0.000 O.0540 AMM ITT ING			10 720	1 ' '				
5.02 0.0500 OTHER AMMINISTRATIVE AND GENERAL 30,275 6,005,510 6,536,555 0 -99,894,080 5.02 7.00 0.0700 OPERATION OF PLANT 154,768 310,506 1,599,889 0.0 0 0.0			l ·	1	1			
0.0700 OPERATION OF PLANT			l ·	1				
9.00 0900 BUSEKERPING 3.015 12.311 1,40,418 0 9.00 11.0	7.00	00700 OPERATION OF PLANT	154, 768	310, 506			0	7. 00
10.00 01000 DIETARY 29,016				ł		0	_	
11.00 0 1100 (CAFETRIA) 0 0 1, 664, 832 0 0 1, 10.00 13.00 13.00 1300 (MINSIN SAMINISTRATION) 6.861 15,676 1 1,549,511 0 0 13.00 13.00 1300 (MINSIN SAMINISTRATION) 6.861 15,676 1 1,549,511 0 0 13.00 13			1	1			0	1
13.00 01300 MURSING ADMINISTRATION 6.861 15.676 1.545, 511 0 0 13.00				1			0	1
14.00 01400 CENTRAL SERVICES & SUPPLY 12.530 177, 093 1,760, 292 0 0 14.00 15.00 15.00 01500 MEDICAL RECORDS & LIBRARY 7, 173 92, 288 2, 336, 912 0 0 16.70 01700 01			_	1			0	1
16.00 01600 MEDICAL RECORDS & LIBRARY 7, 641 21, 882 2, 336, 912 0 0 16.00 0 0 17.00 0700 02100 187 SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 0 0 0 0			1	1			Ō	
17.00 01700 SOCIAL SERVICE 5.161 0 2.084,299 0 0 17.00 22.00 2200 18R SERVICES-SALARY & FRINGS APPRV 0 0 0 0 0 0 0 0 22.00 02200 18R SERVICES-SOTHER PROM COSTS APPRV 0 0 0 0 0 0 0 0 0			7, 173			0	0	15. 00
21.00 02100 LAR SERVICES-SALARY & FERINCES APPRV 0 0 0 0 0 0 0 0 0			1	1			0	ı
22.00 02200 RAR SERVICES-OTHER PROM COSTS APPRV 0 0 0 0 0 0 23.00 0320 PARAMED ED PROMICA-(SPECI FY) 79.872 315 190,879 0 0 23.00 0320 PARAMED ED PROMICA 79.00 0 0 0 0 0 0 0 0 0				l			0	1
23.00 02300 PARAMED ED PROM-CEPTED PTO 2, 892 315 190,829 0 0 23.00 10230 PARAMENY RESIDENCY PROGRAM 0 0 17.506 0 0 23.00 18.000 0300 ABULT S & PEDIA TRIC ST. 0 0 0 0 0 0 0 0 0					1		0	
23.01			2.892	315	1	_	_	
30 00 030000 ADULTS & PEDIATRIC S 103,004 440,787 17,268,139 116,792,874 0,30,00 31.00 31.00 03100 07.00 0 0 0 0 0 0 0 0 0								
31.00 03100 INTENSIVE CARE UNIT								
33.1.01 02080 PEDJATRIC INTENSIVE CARE UNIT 5, 488 18, 971 933, 141, 464 4, 176, 088 0 31.01 31.02 02060 NEOMATAL INTENSIVE CARE UNIT 11, 068 101, 699 2, 141, 464 4, 176, 088 0 31.03 31.03 03101 CARRIO I INTENSIVE CARE UNIT 19, 069 2, 141, 464 4, 176, 088 0 31.03 31.03 03101 CARRIO I INTENSIVE CARE UNIT 15, 400 21, 329 3, 845, 813 27, 943, 089 0 32, 040, 00 0 0000 040, 00 051, 00 051,			103, 004	440, 787	17, 268, 319	116, 792, 874		
33. 02 02060 NEONATAL INTENSIVE CARE UNIT 11,068 191,669 2,141,604 14,255,881 0 31.02 31.03 3301 CARDI O INTENSIVE CARE UNIT 39,548 313,899 11,411,666 71,991,933 0 31.02 32.00 03200 CORONARY CARE UNIT 15,400 21,329 3,845,813 27,943,089 0 32.00 04.00 05.0			D 5 400	0	022 144	4 17/ 000	_	
33. 03 03101 CARDI O INTENSIVE CARE UNIT				•				ı
32.00 03200 CORONARY CARE LINIT 15,400 21,329 3,845,813 27,943,089 0 32.00 040.00 04000 04000 040.00 04				•			_	
40.00 0.000 0.000 0.000 0.0				•				
ANCILLARY SERVICE COST CENTERS S. C. C. C. C. C. C. C	40.00	04000 SUBPROVI DER - I PF	0	l .	1		l	40. 00
50.00	43.00		546	713	258, 555	1, 676, 011	0	43. 00
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 51.00	EO 00		10E 727	2 005 702	0 442 400	440 024 215	1 0	
52.00 05200 05200 05210 VERY ROOM & LABOR ROOM 0 0 1,217,296 7,890,777 0 52.00				1	8, 463, 490	440, 836, 315		
53.00 05300 AMESTHESI OLOGY 80 266 73, 472 52, 682, 896 0 53.00			Ö		1. 217. 296	7, 890, 777	_	•
54. 01 054.01 PET SCAN 1, 725 205, 745 14, 208 6, 782, 872 0 54. 01 57. 00 05600 RADIOI SOTOPE 4, 018 25, 339 490, 267 34, 974, 164 0 56. 00 58. 00 05700 CT SCAN 1, 987 71, 496 722, 439 103, 117, 755 0 57. 00 58. 00 05800 MRI 0 0 0 0 0 0 0 58. 00 06000 LABORATORY 16, 903 289, 776 4, 399, 295 204, 144, 370 0 60. 00 60. 00 60000 LABORATORY 16, 903 289, 776 4, 399, 295 204, 144, 370 0 60. 00 66. 00 06000 PHYSI CAL THERAPY 12, 160 63, 782 3, 380, 655 22, 111, 639 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 12, 160 63, 782 3, 380, 655 22, 111, 639 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 69. 00 69. 00 07000 ELECTROENCEPHALOGRAPHY 1, 504 195, 404 990, 516 10, 183, 741 0 70. 00 67. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 127, 535, 088 0 71. 00 67. 00 07400 ENABLE OLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 73. 00 67. 00 07400 RANDI OLATH LAB 6, 472 568, 327 1, 389, 102 97, 149, 145 0 76. 01 67. 00 07400 RANDI OLATH LAB 6, 472 568, 327 1, 389, 102 97, 149, 145 0 76. 01 67. 00 07400 ENABLE MEDI CAL EMBE 0 0 0 0 0 0 0 67. 00 09000 DURBARE MEDI CAL EMBE 0 0 0 0 0 0 67. 00 09000 DURBARE MEDI CAL EMBE 0 0 0 0 0 0 67. 00 09000 DURBARE MEDI CAL EMBE 0 0 0 0 0 0 67. 00 09000 DURBARE MEDI CAL EMBE 0 0 0 0 0 0 67. 00 09000 00000 000000 00000 00000 00000 0000			80	266	1		l .	
56.00 05600 RABI OI SOTOPE 4, 018 25, 339 490, 267 34, 974, 164 0 56.00			1	1			l .	
57.00 05700 CT SCAN 1,976 71,496 722,439 103,117,755 0 57.00			1	1			l .	1
58. 00 05800 MR			1	1			l .	
60. 00 06000 LABORATORY 16, 903 289, 776 4, 399, 295 204, 144, 370 0 60. 00 65. 00 065000 RESPI RATORY THERAPY 5, 745 129, 760 3, 895, 431 78, 317, 522 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 12, 160 63, 782 3, 380, 655 22, 111, 639 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 69. 00 06000 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 504 195, 404 990, 516 10, 183, 741 0 70. 00 71. 00 07100 MEDIC ALL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 127, 535, 088 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 252, 994, 630 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 252, 994, 630 0 72. 00 74. 00 07400 REDNAL DI ALYSIS 7, 940 121, 704 0 9, 639, 209 0 74. 00 76. 00 03140 CARDII O CATH LAB 6, 472 568, 327 1, 389, 102 97, 149, 145 0 76. 00 76. 01 03500 ENDOSCOPY 6, 956 462, 703 2, 920, 549 58, 320, 109 0 76. 01 76. 02 03950 CARDII O CATH LAB 0 16, 795 420, 031 3, 921, 491 0 76. 00 79. 00 09000 EMERGENCY 20, 173 285, 148 4, 053, 798 115, 256, 102 0 91. 00 79. 00 09000 EMERGENCY 20, 173 285, 148 4, 053, 798 115, 256, 102 0 91. 00 79. 00 09500 DSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 70. 00 09000 CLIPTER RESPINIBABLE COST CENTERS 0 0 0 0 0 0 70. 00 09000 CLIPTER ACCURATES 0 0 0 0 0 0 0 70. 00 09000 CLIPTER SOUTH COST CENTERS 0 0 0 0 0 0 0 70. 00 09000 CLIPTER COST CENTERS 0 0 0 0 0 0 0 70. 00 09000 CLIPTER SOUTH COST CENTERS 0 0 0 0 0 0 0 70. 00 09000 CLIPTER SOUTH COST CENTERS 0 0 0 0 0 0 0 0 70.			1, 907	71,490	122, 439	103, 117, 755		
66.00 06600 PHYSICAL THERAPY 12, 160 63, 782 3, 380, 655 22, 111, 639 0 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 69. 00 06900 ELECTROCARDI OLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 69. 00 70. 00 07000 ELECTROENCEPHALLOGRAPHY 1, 504 195, 404 990, 516 10, 183, 741 0 70. 00 71. 00 07100 MEDIC AL SUPPLIES CHARGED TO PATIENTS 0 0 0 127, 535, 088 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 252, 994, 630 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 455, 395, 242 0 73. 00 74. 00 07400 RENAL DI ALYSIS 7, 940 121, 704 0 9, 639, 209 0 74. 00 76. 01 03050 ENDOSCOPY 6, 956 462, 703 2, 920, 549 58, 320, 109 0 76. 01 76. 02 03950 CARDI AC REHAB 0 16, 995 420, 031 3, 921, 491 0 76. 01 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 DIBRIESENCY 20, 173 285, 148 4, 053, 798 115, 256, 102 0 91. 00 79. 00 09000 DIBRIESENCY 20, 173 285, 148 4, 053, 798 115, 256, 102 0 91. 00 79. 00 09000 DIBRIESENCY 20, 174, 727 14, 120, 471 110, 781, 208 2, 536, 362, 933 -59, 894, 086 118. 00 79. 00 09000 01000 0100 0100 0100 01000			16, 903	289, 776	4, 399, 295	204, 144, 370	_	
67. 00 66700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 06800 SPECCH PATHOLOGY 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 69. 00 70. 00 07000 ELECTROCARDIOLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 69. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 1, 504 195, 404 990, 516 10, 183, 741 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 252, 994, 630 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 252, 994, 630 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 455, 395, 242 0 73. 00 74. 00 07400 RENAL DI ALYSI S 7, 940 121, 704 0 9, 639, 209 0 74. 00 76. 00 03140 CARDI O CATH LAB 6, 472 568, 327 1, 389, 102 97, 149, 145 0 76. 00 76. 01 03050 ENDOSCOPY 6, 956 462, 703 2, 920, 549 58, 320, 109 0 76. 01 76. 02 03950 CARDI AC REHAB 0 16, 995 420, 031 3, 921, 491 0 76. 02 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 79. 00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 70. 00 09000 CLI NI C 00 0 0 0 0 0 70. 00 09000 0100 0100 0100 0100 0100 0100 0100 70. 00 09000 0100 0100 0100 0100 0100 0100 0100 70. 00 0100 0100 0100 0100 0100 0100 0100 0100 0100 70. 00 09000 0100 0100 0100 0100 0100 0100 0100 0100 0100 0100 0100 0100 0100 01000 01000 01000 01000 01000 01000 01000 01000 01000 01000 0	65.00	06500 RESPI RATORY THERAPY	5, 745	129, 760	3, 895, 431	78, 317, 522	0	65. 00
68. 00			1	1	3, 380, 655	22, 111, 639		
69. 00 06900 ELECTROCARDI OLOGY 14, 392 237, 034 2, 245, 697 77, 734, 622 0 69. 00 700 00 00 00 ELECTROENCEPHALOGRAPHY 1, 504 195, 404 990, 516 10, 183, 741 0 70. 00 710 00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 127, 535, 088 0 71. 00 72. 00 720 01 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 252, 994, 630 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 455, 395, 242 0 73. 00 74. 00 7400 RENAL DI ALYSI S 7, 940 121, 704 0 9, 639, 209 0 74. 00 76. 00 03140 CARDI O CATH LAB 6, 472 568, 327 1, 389, 102 97, 149, 145 0 76. 01 03050 ENDOSCOPY 6, 956 462, 703 2, 920, 549 58, 320, 109 0 76. 01 03950 CARDI AC REHAB 0 16, 995 420, 031 3, 921, 491 0 76. 02 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 90. 00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART 09500 DABBLE REI MBURSABLE COST CENTERS 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 3, 514, 287 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 106. 00 10600 HEART ACQUI SI TI ON 0 10600 ELAR E SHOP & CANTEEN 110, NONREI MBURSABLE COST CENTERS 190. 00 100 00 0 0 190. 00 1			0	0	1	_	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 504 195, 404 990, 516 10, 183, 741 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 127, 535, 088 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 252, 994, 630 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 455, 395, 242 0 73. 00 74. 00 07400 RENAL DIALYSIS 7, 940 121, 704 0 9, 639, 209 0 74. 00 76. 01 03050 ENDOSCOPY 6, 956 462, 703 2, 920, 549 58, 320, 109 0 76. 01 76. 02 03950 CARDI AC REHAB 0 16, 995 420, 031 3, 921, 491 0 76. 02 00179ATIENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 91. 00 09100 EMERGENCY 20, 173 285, 148 4, 053, 798 115, 256, 102 0 91. 00 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS) 95. 00 09500 AMBULANCE SERVI CES 462 205, 386 1, 810, 407 7, 280, 243 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 97. 00 0000 CLI NI DROSCOPY CENTERS 95. 00 09500 AMBULANCE SERVI CES 462 205, 386 1, 810, 407 7, 280, 243 0 96. 00 97. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 3, 514, 287 0 105. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 2, 587 0 0 0 3, 043, 127 0 106. 00 106. 00 10500 KI DNEY ACQUI SI TI ON 2, 587 0 0 0 3, 043, 127 0 106. 00 106. 00 10500 KI DNEY ACQUI SI TI ON 2, 587 0 0 0 3, 043, 127 0 106. 00 108. 00 10900 GLERER SHOP & CANTEEN 2, 404 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			14 202	227 024	1	-	0	
71. 00				1				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 252, 994, 630 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 455, 395, 242 0 73. 00 74. 00 74. 00 74. 00 RENAL DI ALYSI S 7, 940 121, 704 0 9, 639, 209 0 74. 00 76. 00 03140 CARDI O CATH LAB 6, 472 568, 327 1, 389, 102 97, 149, 145 0 76. 00 76. 00 76. 01 03050 ENDOSCOPY 6, 956 462, 703 2, 920, 549 58, 320, 109 0 76. 01 76. 02 03950 CARDI AC REHAB 0 16, 995 420, 031 3, 921, 491 0 76. 02 0017471 ENT SERVI CE COST CENTERS 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 91. 00 99000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 91. 00 99200 DBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 90. 00 0 0 0 0 0 0 0 0			0	0	0			
74. 00			0	0	0			72. 00
76. 00			0	0	0			
76. 01 03050 ENDOSCOPY 6, 956 462, 703 2, 920, 549 58, 320, 109 0 76. 01 76. 02 03950 CARDI AC REHAB 0 16, 995 420, 031 3, 921, 491 0 76. 02 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09100 EMERGENCY 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 91. 00 09100 EMERGENCY 20, 173 285, 148 4, 053, 798 115, 256, 102 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 9600 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								
76. 02 03950 CARDI AC REHAB 0 16, 995 420, 031 3, 921, 491 0 76. 02 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 20, 432 25, 081 2, 804, 966 4, 045, 034 0 90. 00 91. 00 09100 EMERGENCY 20, 173 285, 148 4, 053, 798 115, 256, 102 0 91. 00 9200 0BSERVATI ON BEDS (NON-DI STI NCT PART 115, 256, 102 0 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 115, 256, 102 0 91. 00 09500 AMBULANCE SERVI CES 462 205, 386 1, 810, 407 7, 280, 243 0 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 9600 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 2, 587 0 0 3, 514, 287 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 3, 043, 127 0 106. 00 18. 00 SUBTOTALS (SUM OF LI NES 1-117) 714, 727 14, 120, 471 110, 781, 208 2, 536, 362, 933 -59, 894, 086 118. 00 NONREI MBURSABLE COST CENTERS								
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICES OUTPATIENT SER		I I	1	•				
91. 00 09100 EMERGENCY 20, 173 285, 148 4, 053, 798 115, 256, 102 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 07HER REI MBURSABLE COST CENTERS 462 205, 386 1, 810, 407 7, 280, 243 0 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0	70.02			107770	1207001	0/721/171		70.02
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	90.00		20, 432			4, 045, 034	0	90. 00
OTHER REI MBURSABLE COST CENTERS 462 205, 386 1, 810, 407 7, 280, 243 0 95.00			20, 173	285, 148	4, 053, 798	115, 256, 102	0	
95. 00	92. 00							92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 96. 00	05 00		162	205 206	1 010 407	7 200 242	1 0	05.00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 2,587 0 0 3,514,287 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 3,043,127 0 106.00 118.00 SUBTOTALS (SUM OF LI NES 1-117) 714,727 14,120,471 110,781,208 2,536,362,933 -59,894,086 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 2,404 0 0 0 0 0 190.00								
105. 00 10500 KI DNEY ACQUI SI TI ON 2, 587 0 0 3, 514, 287 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 3, 043, 127 0 106. 00 118. 00 SUBTOTALS (SUM OF LI NES 1-117) 714, 727 14, 120, 471 110, 781, 208 2, 536, 362, 933 -59, 894, 086 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 2, 404 0 0 0 0 190. 00	70.00			,	,			70.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 714, 727 14, 120, 471 110, 781, 208 2, 536, 362, 933 -59, 894, 086 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 2, 404 0 0 0 0 190. 00	105.0		2, 587	0	0	3, 514, 287	0	105. 00
NONREI MBURSABLE COST CENTERS 2,404 0 0 0 190.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 2,404 0 0 0 0 190.00			0	0	1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,404 0 0 0 190.00	118. 0		714, 727	14, 120, 471	110, 781, 208	2, 536, 362, 933	-59, 894, 086	118.00
	100 0		2 404		1			100 00
192. 00 1920 PHYSI CI ANS' PRI VATE OFFI CES 0 114, 250 0 0 192. 00		0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES		l		0		
194. 00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 194. 00			_			Ö		
194. 01 07951 MARKETI NG 0 3, 021 301, 022 0 0 194. 01			0	3, 021	301, 022			

Health Finan	cial Systems L	_UTHERAN HOSPIT	AL OF INDIA	ANA		In Lie	u of Form CMS-:	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi	der	CCN: 150017	Peri od:	Worksheet B-1	
						From 07/01/2015 To 06/30/2016	Date/Time Pre 11/30/2016 5:	
		CAPITAL REL	LATED COSTS					
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQU (DOLLAR VAI			(GROSS CHAR	Reconciliation	
					DEPARTMENT (GROSS SALARI ES)	GES)		
		1.00	2.00		4. 00	5. 01	5A. 02	
194. 02 07952	SENI OR CIRCLE	0		0	41, 01	15 0	0	194. 02
194. 03 07953	OTHER NONREIMBURSABLE COST CENTERS	0		0	67, 45	55 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)	16, 813, 263	21, 537,	, 876	16, 191, 15	11, 356, 544		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	23. 445177	1. 512	2731	0. 14561	0. 004477		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)				480, 00	401, 628		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part II)				0. 00431	0. 000158		205. 00

Provider CCN: 150017

Peri od: From 07/01/2015 To 06/30/2016 Date/Ti me Prepared:

				''	00/30/2010	11/30/2016 5:	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE		LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		AND GENERAL	(SQUARE FEET)	(POUNDS OF			
		(ACCUM. COST) 5.02	7. 00	LAUNDRY) 8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	3.02	7.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMITTING						5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	299, 510, 460					5. 02
7.00	00700 OPERATION OF PLANT	16, 521, 908	1	1			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 665, 345	B .		402 072		8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 419, 665 3, 269, 151	3, 015 29, 016	1	493, 872 29, 016	438, 870	9. 00 10. 00
11. 00	01100 CAFETERI A	2, 259, 111	29,010		29, 010	430, 670	11. 00
13. 00	01300 NURSING ADMINISTRATION	2, 123, 656			6, 861	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 378, 974		3, 640	12, 530	ő	14. 00
15. 00	01500 PHARMACY	9, 021, 025			7, 173	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	5, 791, 777	7, 661	0	7, 661	0	16. 00
17. 00	01700 SOCIAL SERVICE	2, 434, 549	5, 161	0	5, 161	0	17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	184		0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	2, 807, 885		0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	384, 627	2, 892		2, 892	0	23. 00
23. 01	02301 PHARMACY RESIDENCY PROGRAM	226, 734	0	0	0	0	23. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	27, 079, 242	103, 004	849, 306	103, 004	169, 281	30.00
31. 00	03100 INTENSIVE CARE UNIT	27,079,242	103,004	049, 300	103, 004	109, 201	31.00
31. 00	02080 PEDIATRIC INTENSIVE CARE UNIT	1, 424, 518	5, 488	26, 618	5, 488	3, 069	
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	3, 578, 658			11, 068	0,007	31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT	17, 184, 528			39, 548	55, 134	31. 03
32. 00	03200 CORONARY CARE UNIT	5, 812, 279			15, 400	18, 885	32. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
43.00	04300 NURSERY	373, 465	546	0	546	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	27, 771, 184			105, 737	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	_	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 692, 949		_	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	332, 254			80 15 947	0	53.00
54. 00	05401 PET SCAN	10, 179, 530 525, 037			15, 847 1, 725	0	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE	1, 875, 999		1	4, 018	0	56. 00
57. 00	05700 CT SCAN	1, 796, 050	1	1	1, 987	0	57. 00
58. 00	05800 MRI	0	0	0	0	ő	58. 00
60.00	06000 LABORATORY	16, 207, 922	16, 903	6, 684	16, 903	0	60.00
65.00	06500 RESPIRATORY THERAPY	5, 913, 868	5, 745	28, 045	5, 745	0	65.00
66. 00	06600 PHYSI CAL THERAPY	4, 710, 722	12, 160	0	12, 160	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	3, 855, 952			14, 392	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	2, 056, 598		0	1, 504	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 264, 710 24, 027, 463			0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	32, 304, 649			0	0	73.00
	07400 RENAL DIALYSIS	2, 750, 457		0	7, 940	0	74.00
	03140 CARDIO CATH LAB	4, 674, 918				ő	76. 00
	03050 ENDOSCOPY	6, 283, 249					76. 01
	03950 CARDI AC REHAB	589, 528	0	0	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	4, 697, 585			20, 432	0	90. 00
91. 00	09100 EMERGENCY	7, 675, 030	20, 173	390, 681	20, 173	0	91. 00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
05.00	OTHER REIMBURSABLE COST CENTERS	2 020 202	1/2	1 0	44.2	0	05.00
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	3, 820, 302		1	462 0	0	1
70.00	SPECIAL PURPOSE COST CENTERS			<u> </u>	0	0	70.00
105 00	10500 KIDNEY ACQUISITION	1, 220, 072	2, 587	1 0	2, 587	0	105. 00
	10600 HEART ACQUISITION	462, 697		Ŏ	2, 307		106. 00
118. 00		296, 446, 006		2, 500, 958	491, 468		
	NONREI MBURSABLE COST CENTERS			_/ =/ =/ == /	,	= 107 001	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	56, 362	2, 404	0	2, 404	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	630, 639	0	0	0	192, 501	
	07950 CLOSED PSYCH UNIT	0	1	0	0		194. 00
	07951 MARKETI NG	2, 211, 568		0	0		194. 01
	07952 SENI OR CI RCLE	83, 272		0	0		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	82, 613	0	0	0	0	194. 03
200. 00	Cross Foot Adjustments	1	l				200. 00

Н	leal th Financ	cial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-	2552-10
(COST ALLOCATI	ION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					_	rom 07/01/2015		
						0 06/30/2016	Date/Time Pre	
_							11/30/2016 5:	23 pm
		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	
2	201. 00	Negative Cost Centers						201. 00
2		Cost to be allocated (per Wkst. B,	59, 894, 086	19, 825, 844	2, 034, 135	4, 223, 588	5, 326, 691	202. 00

39. 828127

4, 697, 092

9. 435985

0. 813342 89, 589

0. 035822

8. 551989

246, 490

0. 499097

0. 199973

0. 035826

10, 730, 382

12. 137287 203. 00 1, 193, 439 204. 00

2. 719345 205. 00

Part I)

Part II)

11)

203.00

204.00

205.00

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

	Financial Systems	LUTHERAN HUSPI		0011 450047		eu of Form CMS-2	
COST	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2015	Worksheet B-1	
					To 06/30/2016		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	11/30/2016 5: MEDI CAL	23 pm
	cost center bescription	(FTE'S)	ADMI NI STRATI ON		(COSTED	RECORDS &	
		(1.12.0)	7.5	SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT NRS	(COSTED	ĺ	(GROSS CHAR	
			ING SALAR)	REQUIS.)		GES)	
	CENEDAL CEDALCE COCT CENTEDO	11.00	13. 00	14. 00	15. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT		1				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 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 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A	170, 910					11.00
13. 00	01300 NURSING ADMINISTRATION	2, 016	l .				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 249			5		14.00
15. 00	01500 PHARMACY	7, 562	1			l	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 398	1				1
17. 00	01700 SOCIAL SERVICE	3, 378	1	1,		0	17. 00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV		0		0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	286	1	•	5 0		23. 00
23. 00	02301 PHARMACY RESIDENCY PROGRAM	276	1		0 0	0	23. 00
20.0.	INPATIENT ROUTINE SERVICE COST CENTERS		,		<u> </u>		20.0.
30.00	03000 ADULTS & PEDIATRICS	33, 590	17, 268, 319	2, 145, 76	7 0	116, 792, 874	30. 00
31. 00	03100 INTENSIVE CARE UNIT	C	1		0 0	0	
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	1, 423				4, 176, 088	1
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	3, 459				14, 255, 881	
31. 03 32. 00	03101 CARDIO INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	18, 533 6, 001				71, 991, 933 27, 943, 089	1
40. 00	04000 SUBPROVI DER - I PF	0,001			0 0		1
43. 00	04300 NURSERY	428	-	•			ı
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	15, 856	8, 463, 490	8, 029, 76			1
51.00	05100 RECOVERY ROOM	0	0	•	0		1
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 016			0		1
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	10, 029	 	3, 05 732, 89		52, 682, 896 122, 656, 677	1
54. 01	05401 PET SCAN	26			0 0		1
56. 00	05600 RADI OI SOTOPE	729					1
57.00	05700 CT SCAN	1, 468	722, 439	161, 20	8 0	103, 117, 755	57. 00
58.00	05800 MRI	C	1		0	0	1
60.00	06000 LABORATORY	8, 632	1				1
65.00	06500 RESPI RATORY THERAPY	7, 427	1				1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	4, 625	0	79, 85	6 0	· · · · · -	1
68. 00	06800 SPEECH PATHOLOGY				0 0	0	1
69. 00	06900 ELECTROCARDI OLOGY	5, 740	o o	28, 14		77, 734, 622	1
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 756	0	406, 02	5 0	10, 183, 741	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0				
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	,,,		252, 994, 630	1
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0		0 30, 264, 600		1
74. 00 76. 00	03140 CARDIO CATH LAB	2, 036	1, 389, 102	47, 99 1, 465, 30		9, 639, 209 97, 149, 145	
76. 00	03050 ENDOSCOPY	5, 609	1			58, 320, 109	
76. 02	i i	973			o o	3, 921, 491	1
	OUTPATIENT SERVICE COST CENTERS		•				
90.00	09000 CLI NI C	4, 685				.,	90. 00
91.00	09100 EMERGENCY	7, 132	4, 053, 798	1, 226, 51	7 0	115, 256, 102	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	3, 646	0	137, 25	7 0	7, 280, 243	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	3,040	1		0 0		1
	SPECIAL PURPOSE COST CENTERS				-, -,		
	10500 KIDNEY ACQUISITION	C	0		0 0	3, 514, 287	105. 00
	10600 HEART ACQUISITION	C	0	1	0	-, ,	
118.00	,	170, 254	63, 302, 106	64, 955, 84	6 30, 264, 600	2, 536, 362, 933	118. 00
100.00	NONREI MBURSABLE COST CENTERS					^	100 00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1920 PHYSICIANS' PRIVATE OFFICES		0		0 0		190. 00 192. 00
	07950 CLOSED PSYCH UNIT						194. 00
	07951 MARKETI NG	496	o o	3, 29	1 0		194. 01
194. 02	07952 SENI OR CI RCLE	101	0	1		0	194. 02
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	59	0	66	6 0	0	194. 03

Heal th Fi	nancial Systems L	UTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 07/01/2015 To 06/30/2016	Date/Time Pre 11/30/2016 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	
			(DI RECT NRS	(COSTED		(GROSS CHAR	
			ING SALAR)	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, 710, 872	2, 912, 243	8, 347, 01	6 11, 465, 662	7, 408, 146	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 861401	0. 046005	0. 12849	4 0. 378847	0. 002921	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	88, 122	336, 545	925, 11	7 751, 307	509, 408	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 515605	0. 005316	0. 01424	1 0. 024825	0. 000201	205. 00

	Financial Systems	LUTHERAN HOSPITA			In Lie	u of Form CMS-:	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: com 07/01/2015	Worksheet B-1	
				To		Date/Time Pre	pared:
						11/30/2016 5:	23 pm
			INTERNS &	RESI DENTS			
		COOLAL CEDVI OF	CEDITION CALAD	CEDVI OEC OTUED	DADAMED ED	DUA DIMA OV	
	Cost Center Description	SOCI AL SERVI CE	SERVICES-SALAR Y & FRINGES	PRGM COSTS	PARAMED ED PRGM	PHARMACY RESI DENCY	
		(GROSS CHAR	APPRV	APPRV	(ASSI GNED	PROGRAM	
		GES)	(ASSI GNED	(ASSI GNED	TIME)	(ASSI GNED	
		023)	TIME)	TIME)	11 WL)	TIME)	
		17. 00	21. 00	22.00	23. 00	23. 01	
	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. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
7. 00 8. 00	00700 OPERATION OF PLANT						7. 00 8. 00
9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17.00	01700 SOCIAL SERVICE	2, 536, 362, 933					17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	10, 900				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0		10, 900			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0			102, 747		23. 00
23. 01	02301 PHARMACY RESIDENCY PROGRAM	0				10, 000	23. 01
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	444 700 074	4 050	1 050	/F 700		00.00
30.00	03000 ADULTS & PEDI ATRI CS	116, 792, 874	1, 250		65, 782	0	
31. 00 31. 01	03100 INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT	4 174 000	0 50		0 934	0	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	4, 176, 088 14, 255, 881	950		5, 167	0	31. 01
31. 02	03101 CARDIO INTENSIVE CARE UNIT	71, 991, 933	7 50	730	21, 428	0	1
32. 00	03200 CORONARY CARE UNIT	27, 943, 089	0	0	7, 369	0	1
40. 00	04000 SUBPROVI DER - I PF	27, 743, 007	0	Ö	7, 307	0	1
43. 00	04300 NURSERY	1, 676, 011	0		2, 067	0	1
	ANCILLARY SERVICE COST CENTERS	.,,	<u> </u>	-1	_,,		1
50.00	05000 OPERATI NG ROOM	440, 836, 315	2, 950	2, 950	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	О	o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 890, 777	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	52, 682, 896	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	122, 656, 677	0	0	0	0	
54. 01	05401 PET SCAN	6, 782, 872	0	0	0	0	
56. 00	05600 RADI OI SOTOPE	34, 974, 164	0	0	0	0	
57. 00	05700 CT SCAN	103, 117, 755	0	0	0	0	
58. 00	05800 MRI	0	0	0	O O	0	
65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	204, 144, 370 78, 317, 522	0 100		0	0	
66. 00	06600 PHYSI CAL THERAPY	22, 111, 639	0		0	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	22, 111, 037	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY		0	0	ol	0	
69. 00	06900 ELECTROCARDI OLOGY	77, 734, 622	0	Ö	ol	0	1
	07000 ELECTROENCEPHALOGRAPHY	10, 183, 741	0	0	o	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	127, 535, 088	0	О	o	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	252, 994, 630	0	0	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	455, 395, 242	0	0	0	10, 000	73. 00
74.00	07400 RENAL DIALYSIS	9, 639, 209	0	0	0	0	
	03140 CARDIO CATH LAB	97, 149, 145	400	400	0	0	
76. 01	03050 ENDOSCOPY	58, 320, 109	0	0	0	0	
76. 02	03950 CARDI AC REHAB	3, 921, 491	0	0	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS				ام		
90.00	1 1	4, 045, 034	4, 700		0	0	
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	115, 256, 102	Ü	0	0	0	91.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	7, 280, 243	0	0	0	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	7, 200, 243	0	ő	ő	0	
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u>°ı</u>		70.00
105.00	10500 KIDNEY ACQUISITION	3, 514, 287	0	0	O	0	105. 00
	10600 HEART ACQUISITION	3, 043, 127	0	Ō	ol		106.00
		2, 536, 362, 933	10, 400	10, 400	102, 747		118. 00
118.00	NONREI MBURSABLE COST CENTERS						
		_		0	0	0	190. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	U		-1		
190. 00 192. 00	19200 PHYSICIANS' PRIVATE OFFICES	0 0	500		o	0	192. 00
190. 00 192. 00 194. 00	19200 PHYSICIANS' PRIVATE OFFICES 07950 CLOSED PSYCH UNIT	0	0	500 0	0	0	192. 00 194. 00
190. 00 192. 00 194. 00	19200 PHYSICIANS' PRIVATE OFFICES	0 0	500 0 0	500 0	0 0 0	0	192. 00

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2015	Worksheet B-1	
					Date/Time Pre 11/30/2016 5:	
		INTERNS &	RESI DENTS			
Cost Center Description	SOCI AL SERVI CE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE	R PARAMED ED PRGM	PHARMACY RESI DENCY	
	(GROSS CHAR	APPRV	APPRV	(ASSI GNED	PROGRAM	

				TIVIERNS &	KESI DEN 13			
		Cost Center Description	SOCIAL SERVICE			PARAMED ED	PHARMACY	
				Y & FRINGES	PRGM COSTS	PRGM	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	SENI OR CIRCLE	0	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,	3, 228, 719	221	3, 369, 386	608, 455	276, 453	202. 00
		Part I)						
203.00		Unit cost multiplier (Wkst. B, Part I)	0. 001273	0. 020275	309. 117982	5. 921876	27. 645300	203. 00
204.00		Cost to be allocated (per Wkst. B,	270, 686	8	100, 595	111, 886	9, 031	204. 00
		Part II)						
205.00		Unit cost multiplier (Wkst. B, Part	0. 000107	0. 000734	9. 228899	1. 088947	0. 903100	205. 00
		11)						
	•	•		,	,	· ·		

						11/30/2016 5:	23 pm
			Tit	le 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	42, 705, 431		42, 705, 431	0	42, 705, 431	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0	0	31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 135, 558		2, 135, 558	0	2, 135, 558	31. 01
	02060 NEONATAL INTENSIVE CARE UNIT	5, 118, 306		5, 118, 306		5, 118, 306	
31. 03	03101 CARDIO INTENSIVE CARE UNIT	24, 856, 619		24, 856, 619		24, 856, 619	
32. 00	03200 CORONARY CARE UNIT	8, 542, 917		8, 542, 917		8, 542, 917	
40. 00	04000 SUBPROVI DER - I PF	0,0,0,0	l .	1 0,012,111	0		1
43. 00	04300 NURSERY	518, 835		518, 835	0	1	
10. 00	ANCI LLARY SERVI CE COST CENTERS	010,000		010,000	· · · · · · · · ·	010,000	10.00
50. 00	05000 OPERATING ROOM	42, 330, 812		42, 330, 812	. 0	42, 330, 812	50.00
51. 00	05100 RECOVERY ROOM	0		12,000,012			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 152, 566		2, 152, 566	_	1	1
53. 00	05300 ANESTHESI OLOGY	628, 194		628, 194	0	628, 194	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	14, 106, 754		14, 106, 754		14, 106, 754	
54. 00	05401 PET SCAN	743, 000		743, 000			1
56. 00	05600 RADI OI SOTOPE	2, 630, 891		2, 630, 891			
57. 00	05700 CT SCAN						
		2, 783, 649		2, 783, 649		2, 783, 649	
58. 00	05800 MRI	21 740 547		21 740 547	0	01 740 547	58. 00
60.00	06000 LABORATORY	21, 748, 547		21, 748, 547		21, 748, 547	
65. 00	06500 RESPIRATORY THERAPY	7, 901, 404		7, 901, 404	0	7, 901, 404	
66. 00	06600 PHYSI CAL THERAPY	6, 417, 397		0 6, 417, 397	0	6, 417, 397	
67. 00	06700 OCCUPATI ONAL THERAPY	0		0	0	0	
68. 00	06800 SPEECH PATHOLOGY	0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 767, 257		5, 767, 257		5, 767, 257	
	07000 ELECTROENCEPHALOGRAPHY	2, 663, 362		2, 663, 362		_, -,,	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 933, 233		25, 933, 233		25, 933, 233	
	07200 I MPL. DEV. CHARGED TO PATIENTS	32, 835, 232		32, 835, 232		32, 835, 232	
	07300 DRUGS CHARGED TO PATIENTS	52, 416, 186		52, 416, 186		52, 416, 186	
	07400 RENAL DIALYSIS	3, 731, 206		3, 731, 206		3, 731, 206	
76. 00	03140 CARDIO CATH LAB	6, 631, 571		6, 631, 571		6, 631, 571	
76. 01	03050 ENDOSCOPY	8, 560, 478		8, 560, 478		8, 560, 478	
76. 02	03950 CARDI AC REHAB	739, 298		739, 298	0	739, 298	76. 02
	OUTPATIENT SERVICE COST CENTERS	-			_		
	09000 CLI NI C	6, 966, 554		6, 966, 554			
	09100 EMERGENCY	11, 444, 161		11, 444, 161	0	11, 444, 161	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	358, 657		358, 657		358, 657	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	4, 712, 613		4, 712, 613	0	4, 712, 613	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	96.00
	SPECIAL PURPOSE COST CENTERS						1
105.00	10500 KIDNEY ACQUISITION	1, 603, 951		1, 603, 951		1, 603, 951	105. 00
106.00	10600 HEART ACQUISITION	567, 987		567, 987		567, 987	
200.00		350, 252, 626		350, 252, 626			
201.00		358, 657		358, 657		358, 657	
202.00	l	349, 893, 969		349, 893, 969	0		
		•	•			•	

From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/30/2016 5: 23 pm Title XVIII Hospi tal **PPS** Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 100, 006, 979 100, 006, 979 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 4, 176, 088 4, 176, 088 31.01 31.02 02060 NEONATAL INTENSIVE CARE UNIT 14, 255, 881 14, 255, 881 31.02 71, 991, 933 03101 CARDIO INTENSIVE CARE UNIT 71, 991, 933 31 03 31 03 32.00 03200 CORONARY CARE UNIT 27, 943, 089 27, 943, 089 32.00 04000 SUBPROVIDER - IPF 40 00 40.00 04300 NURSERY 1, 676, 011 1, 676, 011 43.00 43.00 ANCILLARY SERVICE COST CENTERS 254, 531, 643 440, 836, 315 50.00 05000 OPERATING ROOM 186, 304, 672 0.096024 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 7, 804, 226 86, 551 7, 890, 777 0.272795 0.000000 52.00 52.00 53.00 05300 ANESTHESI OLOGY 31, 181, 880 21, 501, 016 52, 682, 896 0.011924 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 44, 884, 734 77, 771, 943 122, 656, 677 0.115010 0.000000 54.00 54.01 05401 PET SCAN 118, 698 6, 664, 174 6, 782, 872 0.109541 0.000000 54.01 05600 RADI OI SOTOPE 7.058.302 27, 915, 862 34, 974, 164 0.075224 56,00 0.000000 56,00 57.00 05700 CT SCAN 40, 521, 736 62, 596, 019 103, 117, 755 0.026995 0.000000 57.00 05800 MRI 0.000000 0.000000 58.00 58.00 06000 LABORATORY 124, 106, 087 80, 038, 283 204, 144, 370 0.106535 0.000000 60.00 60.00 3, 689, 293 78, 317, 522 65.00 06500 RESPIRATORY THERAPY 74, 628, 229 0.100889 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 13, 847, 790 8, 263, 849 22, 111, 639 0.290227 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 0.000000 0 000000 68 00 40, 569, 525 69.00 06900 ELECTROCARDI OLOGY 37, 165, 097 77, 734, 622 0.074192 0.000000 69.00 8, 845, 695 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 338, 046 10, 183, 741 0.261531 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 88, 738, 572 38, 796, 516 127, 535, 088 0.203342 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 167, 035, 789 85, 958, 841 252, 994, 630 72.00 0.129786 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 295, 747, 696 159, 647, 546 455, 395, 242 0.115100 0.000000 73.00 74.00 07400 RENAL DIALYSIS 9, 263, 849 375, 360 9, 639, 209 0.387086 0.000000 74.00 76 00 03140 CARDIO CATH LAB 47 247 001 49 902 144 97 149 145 0.068262 0.000000 76 00 03050 ENDOSCOPY 76.01 9, 256, 149 49, 063, 960 58, 320, 109 0.146784 0.000000 76.01 1, 145, 101 03950 CARDI AC REHAB 2, 776, 390 3, 921, 491 0.188525 0.000000 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90 00 4, 045, 034 90 00 262, 961 3.782.073 1 722249 0.000000 logodol ce enec 0.000000 91.00 09100 EMERGENCY 37, 121, 564 78, 134, 538 115, 256, 102 0.099293 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 3, 159, 769 16, 785, 895 0.021367 0.000000 92.00 92.00 13, 626, 126 OTHER REIMBURSABLE COST CENTERS 0 647315 0.000000 95 00 95.00 09500 AMBULANCE SERVICES 0 7, 280, 243 7, 280, 243 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0.000000 96.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 3.514.287 3, 514, 287 105.00 106.00 10600 HEART ACQUISITION 3.043.127 3.043.127 106. 00

1, 524, 403, 603 1, 011, 959, 330

1, 524, 403, 603 1, 011, 959, 330 2, 536, 362, 933

2, 536, 362, 933

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	LUTHERAN HOSPITAL OF INDIAN	IA	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi de	er CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/30/2016 5:23 pm

				11/30/2016 5: 23 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				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
40. 00 04000 SUBPROVI DER - I PF				40. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 096024			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 272795			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 011924			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 115010			54.00
54. 01 05401 PET SCAN	0. 109541			54. 01
56. 00 05600 RADI 0I SOTOPE	0. 075224			56.00
57. 00 05700 CT SCAN	0. 026995			57. 00
58. 00 05800 MRI	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 106535			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 100889			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 290227			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 074192			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 261531			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 203342			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 129786			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 115100			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 387086			74. 00
76. 00 03140 CARDIO CATH LAB	0. 068262			76.00
76. 01 03050 ENDOSCOPY	0. 146784			76. 01
76. 02 03950 CARDI AC REHAB	0. 188525			76. 02
OUTPATIENT SERVICE COST CENTERS	000020			7 0. 02
90. 00 09000 CLINIC	1. 722249			90.00
91. 00 09100 EMERGENCY	0. 099293			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 021367			92.00
OTHER REIMBURSABLE COST CENTERS	0. 02 1007			72. 00
95. 00 09500 AMBULANCE SERVICES	0. 647315			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
SPECIAL PURPOSE COST CENTERS				70.00
105. 00 10500 KIDNEY ACQUISITION				105. 00
106. 00 10600 HEART ACQUISITION				106.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
1000 1130 400 013)	1			1202.00

			T	0 06/30/2016	Date/Time Pre 11/30/2016 5:	pared:
		Ti t	le XIX	Hospi tal	PPS	23 piii
		1110	I G XI X	Costs	110	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost denter beserretten	(from Wkst. B,	Adj.	Total oosts	Di sal I owance	10141 00313	
	Part I, col.					
	26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	42, 705, 431		42, 705, 431	0	42, 705, 431	30.00
31.00 03100 INTENSIVE CARE UNIT	0		0	o	0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	2, 135, 558		2, 135, 558	o	2, 135, 558	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	5, 118, 306		5, 118, 306	o	5, 118, 306	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	24, 856, 619		24, 856, 619	О	24, 856, 619	
32. 00 03200 CORONARY CARE UNIT	8, 542, 917		8, 542, 917	o	8, 542, 917	32. 00
40. 00 04000 SUBPROVI DER - I PF	0		0	o	0	40.00
43. 00 04300 NURSERY	518, 835		518, 835	o	518, 835	43.00
ANCILLARY SERVICE COST CENTERS			<u> </u>			
50. 00 05000 OPERATING ROOM	42, 330, 812		42, 330, 812	0	42, 330, 812	50.00
51.00 05100 RECOVERY ROOM	0		0	o	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 152, 566		2, 152, 566	o	2, 152, 566	52. 00
53. 00 05300 ANESTHESI OLOGY	628, 194		628, 194	o	628, 194	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 106, 754		14, 106, 754	o	14, 106, 754	54.00
54. 01 05401 PET SCAN	743,000		743, 000	o	743, 000	54. 01
56. 00 05600 RADI OI SOTOPE	2, 630, 891		2, 630, 891	О	2, 630, 891	56. 00
57. 00 05700 CT SCAN	2, 783, 649		2, 783, 649	o	2, 783, 649	57. 00
58. 00 05800 MRI	0		0	0	0	58. 00
60. 00 06000 LABORATORY	21, 748, 547		21, 748, 547	o	21, 748, 547	60.00
65. 00 06500 RESPIRATORY THERAPY	7, 901, 404	0	7, 901, 404	О	7, 901, 404	65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 417, 397	0	6, 417, 397	o	6, 417, 397	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		o	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	5, 767, 257		5, 767, 257	o	5, 767, 257	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 663, 362		2, 663, 362	o	2, 663, 362	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 933, 233		25, 933, 233	o	25, 933, 233	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 835, 232		32, 835, 232	o	32, 835, 232	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	52, 416, 186		52, 416, 186	o	52, 416, 186	73. 00
74. 00 07400 RENAL DI ALYSI S	3, 731, 206		3, 731, 206	o	3, 731, 206	74. 00
76. 00 03140 CARDI O CATH LAB	6, 631, 571		6, 631, 571	o	6, 631, 571	76. 00
76. 01 03050 ENDOSCOPY	8, 560, 478		8, 560, 478	O	8, 560, 478	76. 01
76. 02 03950 CARDI AC REHAB	739, 298		739, 298	O	739, 298	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	6, 966, 554		6, 966, 554	0	6, 966, 554	90.00
91. 00 09100 EMERGENCY	11, 444, 161		11, 444, 161	o	11, 444, 161	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	358, 657		358, 657		358, 657	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	4, 712, 613		4, 712, 613	0	4, 712, 613	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	1, 603, 951		1, 603, 951		1, 603, 951	105. 00
106.00 10600 HEART ACQUI SI TI ON	567, 987		567, 987		567, 987	
200.00 Subtotal (see instructions)	350, 252, 626	0	350, 252, 626	0	350, 252, 626	200. 00
201.00 Less Observation Beds	358, 657		358, 657		358, 657	201. 00
202.00 Total (see instructions)	349, 893, 969	0	349, 893, 969	0	349, 893, 969	202. 00

From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/30/2016 5: 23 pm Title XIX Hospi tal **PPS** Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 100, 006, 979 100, 006, 979 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 02080 PEDIATRIC INTENSIVE CARE UNIT 31.01 4, 176, 088 4, 176, 088 31.01 31.02 02060 NEONATAL INTENSIVE CARE UNIT 14, 255, 881 14, 255, 881 31.02 71, 991, 933 03101 CARDIO INTENSIVE CARE UNIT 71, 991, 933 31 03 31 03 32.00 03200 CORONARY CARE UNIT 27, 943, 089 27, 943, 089 32.00 04000 SUBPROVIDER - IPF 40 00 40.00 04300 NURSERY 1, 676, 011 1, 676, 011 43.00 43.00 ANCILLARY SERVICE COST CENTERS 254, 531, 643 440, 836, 315 50.00 05000 OPERATING ROOM 186, 304, 672 0.096024 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 7, 804, 226 86, 551 7, 890, 777 0.272795 0.000000 52.00 52.00 53.00 05300 ANESTHESI OLOGY 31, 181, 880 21, 501, 016 52, 682, 896 0.011924 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 44, 884, 734 77, 771, 943 0.115010 0.000000 122, 656, 677 54.00 54.01 05401 PET SCAN 118, 698 6, 664, 174 6, 782, 872 0.109541 0.000000 54.01 05600 RADI OI SOTOPE 7.058.302 27, 915, 862 34, 974, 164 0.075224 56,00 0.000000 56,00 57.00 05700 CT SCAN 40, 521, 736 62, 596, 019 103, 117, 755 0.026995 0.000000 57.00 05800 MRI 0.000000 0.000000 58.00 58.00 06000 LABORATORY 124, 106, 087 80, 038, 283 204, 144, 370 0.106535 0.000000 60.00 60.00 3, 689, 293 78, 317, 522 65.00 06500 RESPIRATORY THERAPY 74, 628, 229 0.100889 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 13, 847, 790 8, 263, 849 22, 111, 639 0.290227 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 0.000000 0 000000 68 00 40, 569, 525 69.00 06900 ELECTROCARDI OLOGY 37, 165, 097 77, 734, 622 0.074192 0.000000 69.00 8, 845, 695 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 338, 046 10, 183, 741 0.261531 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 88, 738, 572 38, 796, 516 127, 535, 088 0.203342 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 167, 035, 789 85, 958, 841 252, 994, 630 72.00 0.129786 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 295, 747, 696 159, 647, 546 455, 395, 242 0.115100 0.000000 73.00 74.00 07400 RENAL DIALYSIS 9, 263, 849 375, 360 9, 639, 209 0.387086 0.000000 74.00 76 00 03140 CARDIO CATH LAB 47 247 001 49 902 144 97 149 145 0.068262 0.000000 76 00 03050 ENDOSCOPY 76.01 9, 256, 149 49, 063, 960 58, 320, 109 0.146784 0.000000 76.01 1, 145, 101 03950 CARDI AC REHAB 2, 776, 390 3, 921, 491 0.188525 0.000000 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90 00 4, 045, 034 90 00 262, 961 3.782.073 1 722249 0.000000 logodol ce enec 0.000000 91.00 09100 EMERGENCY 37, 121, 564 78, 134, 538 115, 256, 102 0.099293 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 3, 159, 769 16, 785, 895 0.021367 0.000000 92.00 92.00 13, 626, 126 OTHER REIMBURSABLE COST CENTERS 0 647315 0.000000 95 00 95.00 09500 AMBULANCE SERVICES 0 7, 280, 243 7, 280, 243 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0.000000 96.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 3.514.287 3, 514, 287 105.00 106.00 10600 HEART ACQUISITION 3.043.127 3.043.127 106. 00 200.00 Subtotal (see instructions) 1, 524, 403, 603 1, 011, 959, 330 2, 536, 362, 933 200.00

1, 524, 403, 603 1, 011, 959, 330 2, 536, 362, 933

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der C	CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/30/2016 5:23 pm

				11/30/2016 5: 23 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	1			30.00
31. 00 03100 I NTENSI VE CARE UNI T	1			31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	1			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
40. 00 04000 SUBPROVI DER - I PF				40. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 096024			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 272795			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 011924			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 115010			54. 00
54. 01 05401 PET SCAN	0. 109541			54. 01
56. 00 05600 RADI 0I SOTOPE	0. 075224			56. 00
57. 00 05700 CT SCAN	0. 026995			57. 00
58. 00 05800 MRI	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 106535			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 100889			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 290227			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 074192			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 261531			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 203342			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 129786			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 115100			73.00
74. 00 07400 RENAL DI ALYSI S	0. 387086			74. 00
76. 00 03140 CARDI O CATH LAB	0. 068262			76. 00
76. 01 03050 ENDOSCOPY	0. 146784			76. 01
76. 02 03950 CARDI AC REHAB	0. 188525			76. 02
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	1. 722249			90.00
91. 00 09100 EMERGENCY	0. 099293			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 021367			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES	0. 647315			95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KIDNEY ACQUISITION				105. 00
106. 00 10600 HEART ACQUISITION				106. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA	In Lieu	of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO COREDUCTIONS FOR MEDICALD ONLY	CHARGE RATIOS NET OF PI		From 07/01/2015	Worksheet C Part II Date/Time Prepared:

					To 06/30/2016	Date/Time Pre 11/30/2016 5:	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos	t Capi tal	Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	42, 330, 812					50. 00
	05100 RECOVERY ROOM	0	0	1	0	·	51.00
	05200 DELIVERY ROOM & LABOR ROOM	2, 152, 566				0	52. 00
	05300 ANESTHESI OLOGY	628, 194	· ·			0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	14, 106, 754				0	54. 00
	05401 PET SCAN	743, 000	· ·			0	54. 01
	05600 RADI 0I S0T0PE	2, 630, 891	261, 563			0	56. 00
	05700 CT SCAN	2, 783, 649	297, 887	2, 485, 76	2 0	0	57. 00
	05800 MRI	0	0		0	0	58. 00
	06000 LABORATORY	21, 748, 547	1, 755, 607	19, 992, 94	0	0	60.00
	06500 RESPI RATORY THERAPY	7, 901, 404	664, 496	7, 236, 90	8 0	0	65. 00
	06600 PHYSI CAL THERAPY	6, 417, 397	699, 575	5, 717, 82	2 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	5, 767, 257	1, 027, 426	4, 739, 83	1 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 663, 362	435, 188	2, 228, 17	4 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 933, 233	1, 002, 438	24, 930, 79	5 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	32, 835, 232	1, 304, 769	31, 530, 46	3 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	52, 416, 186	2, 120, 764	50, 295, 42	2 0	0	73. 00
74.00	07400 RENAL DIALYSIS	3, 731, 206	552, 858	3, 178, 34	8 0	0	74.00
76.00	03140 CARDIO CATH LAB	6, 631, 571	1, 324, 555	5, 307, 01	6 0	0	76. 00
76. 01	03050 ENDOSCOPY	8, 560, 478	1, 236, 936	7, 323, 54	2 0	0	76. 01
76. 02	03950 CARDI AC REHAB	739, 298	50, 972	688, 32	6 0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	6, 966, 554	928, 790	6, 037, 76	4 0	0	90.00
91.00	09100 EMERGENCY	11, 444, 161	1, 507, 595	9, 936, 56	6 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	358, 657	49, 002	309, 65	5 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	4, 712, 613	478, 025	4, 234, 58	8 0	0	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96. 00
	SPECIAL PURPOSE COST CENTERS						
105.00	10500 KIDNEY ACQUISITION	1, 603, 951	131, 702	1, 472, 24	9 0	0	105. 00
	10600 HEART ACQUISITION	567, 987					106. 00
200.00		266, 374, 960			6 0		200. 00
201.00		358, 657	49, 002	309, 65	5 0		201. 00
202. 00	Total (line 200 minus line 201)	266, 016, 303	26, 916, 782	239, 099, 52	1 0	0	202. 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARREDUCTIONS FOR MEDICALD ONLY	GGE RATIOS NET OF Provider	From 07/01/2015	Worksheet C Part II Date/Time Prepared:

				10 00, 00, 20.0	11/30/2016 5: 23 pm
		Ti t	le XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges			
	Capital and	(Worksheet C,	Cost to Charg	ge	
		Part I, column	Ratio (col.	6	
	Reduction	8)	/ col . 7)		
	6.00	7. 00	8. 00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	42, 330, 812	440, 836, 315	0. 09602	24	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 152, 566			95	52.00
53. 00 05300 ANESTHESI OLOGY	628, 194	52, 682, 896	0. 01192	24	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 106, 754				54.00
54. 01 05401 PET SCAN	743, 000	6, 782, 872			54. 01
56. 00 05600 RADI 0I SOTOPE	2, 630, 891	34, 974, 164	0. 07522	24	56. 00
57. 00 05700 CT SCAN	2, 783, 649	103, 117, 755	0. 02699	95	57. 00
58. 00 05800 MRI	0	0	0.00000	00	58. 00
60. 00 06000 LABORATORY	21, 748, 547	204, 144, 370	0. 10653	35	60.00
65. 00 06500 RESPIRATORY THERAPY	7, 901, 404	78, 317, 522	0. 10088	39	65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 417, 397	22, 111, 639	0. 29022	27	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	00	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000	00	68. 00
69. 00 06900 ELECTROCARDI OLOGY	5, 767, 257	77, 734, 622	0. 07419	92	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 663, 362	10, 183, 741	0. 26153	31	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 933, 233	127, 535, 088	0. 20334	12	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 835, 232	252, 994, 630	0. 12978	36	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	52, 416, 186	455, 395, 242	0. 11510	00	73.00
74.00 07400 RENAL DIALYSIS	3, 731, 206	9, 639, 209	0. 38708	36	74.00
76.00 03140 CARDIO CATH LAB	6, 631, 571	97, 149, 145	0.06826	52	76. 00
76. 01 03050 ENDOSCOPY	8, 560, 478	58, 320, 109	0. 14678	34	76. 01
76. 02 03950 CARDI AC REHAB	739, 298	3, 921, 491	0. 18852	25	76. 02
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	6, 966, 554	4, 045, 034	1. 72224	19	90.00
91. 00 09100 EMERGENCY	11, 444, 161	115, 256, 102	0. 09929	93	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	358, 657	16, 785, 895	0. 02136	57	92. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	4, 712, 613	7, 280, 243	0. 6473	15	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000	00	96.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	1, 603, 951	3, 514, 287	0. 45640)9	105. 00
106. 00 10600 HEART ACQUI SI TI ON	567, 987	3, 043, 127	0. 1866	16	106. 00
200.00 Subtotal (sum of lines 50 thru 199)	266, 374, 960	2, 316, 312, 952			200. 00
201.00 Less Observation Beds	358, 657		1		201. 00
202.00 Total (line 200 minus line 201)	266, 016, 303	2, 316, 312, 952			202. 00

Harlah Firancial Custom	LUTUEDAN HOCOLT	TAL OF INDIANA		1-11-	£ F CMC	2552 40
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	LUTHERAN HOSPIT COSTS			Period: From 07/01/2015 To 06/30/2016		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	5, 834, 662	l .	5, 834, 66	· ·	89. 58	
31.00 INTENSIVE CARE UNIT	0			0	0.00	
31.01 PEDIATRIC INTENSIVE CARE UNIT	285, 358		285, 35		243. 69	
31.02 NEONATAL INTENSIVE CARE UNIT	820, 524		820, 52			
31.03 CARDIO INTENSIVE CARE UNIT	2, 471, 184	l .	2, 471, 18			
32.00 CORONARY CARE UNIT	871, 155	l .	871, 15	5 7, 205		
40. 00 SUBPROVI DER - I PF	0		1	0	0. 00	
43. 00 NURSERY	36, 877		36, 87	,	19. 99	
200.00 Total (lines 30-199)	10, 319, 760		10, 319, 76	0 100, 727		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 ADULTS & PEDIATRICS	22, 672		8			30.00
31.00 INTENSIVE CARE UNIT	0	()			31. 00
31. 01 PEDIATRIC INTENSIVE CARE UNIT	0	C)			31. 01
31. 02 NEONATAL INTENSIVE CARE UNIT	0	C)			31. 02
31. 03 CARDIO INTENSIVE CARE UNIT	7, 221		1			31. 03
32.00 CORONARY CARE UNIT	2, 829		1			32. 00
40. 00 SUBPROVI DER - I PF	0	C				40.00
43. 00 NURSERY	0	C)			43.00
200.00 Total (lines 30-199)	32, 722	3, 221, 335)			200. 00

	LUTHERAN HOSPIT				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Pre 11/30/2016 5:2	pared: 23 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	8, 120, 431	440, 836, 315			1, 486, 734	
51.00 05100 RECOVERY ROOM	0	1	1 0.0000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	77, 094	7, 890, 777			386	52. 00
53. 00 05300 ANESTHESI OLOGY	40, 026	52, 682, 896			7, 209	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 489, 150	122, 656, 677	0. 02029	4 15, 432, 937	313, 196	54.00
54. 01 05401 PET SCAN	390, 939				559	54. 01
56. 00 05600 RADI 0I SOTOPE	261, 563	34, 974, 164	0.00747	9 2, 560, 333	19, 149	56. 00
57. 00 05700 CT SCAN	297, 887	103, 117, 755	0. 00288	9 12, 848, 926	37, 121	57. 00
58. 00 05800 MRI	0	0	0.00000	0 0	0	58. 00
60. 00 06000 LABORATORY	1, 755, 607			0 43, 084, 432	370, 526	60. 00
65. 00 06500 RESPI RATORY THERAPY	664, 496	78, 317, 522	0.00848	5 24, 744, 768	209, 959	65. 00
66. 00 06600 PHYSI CAL THERAPY	699, 575	22, 111, 639	0. 03163	8 5, 600, 805	177, 198	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 027, 426	77, 734, 622	0. 01321	7 12, 562, 200	166, 035	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	435, 188	10, 183, 741	0. 04273	4 413, 729	17, 680	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 002, 438	127, 535, 088	0. 00786	0 31, 488, 369	247, 499	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 304, 769	252, 994, 630	0. 00515	7 53, 850, 714	277, 708	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 120, 764	455, 395, 242	0. 00465	7 95, 656, 880	445, 474	73. 00
74. 00 07400 RENAL DIALYSIS	552, 858		•		286, 182	74. 00
76.00 03140 CARDIO CATH LAB	1, 324, 555					
76. 01 03050 ENDOSCOPY	1, 236, 936				73, 811	76. 01
76. 02 03950 CARDI AC REHAB	50, 972					
OUTPATIENT SERVICE COST CENTERS	•		•			
90 00 09000 CLINIC	928 790	4 045 034	0 22961	2 179 174	/1 1/1	an nn

928, 790

49, 002

0 0 26, 338, 061 2, 302, 475, 295

1, 507, 595

4, 045, 034

115, 256, 102 16, 785, 895

0. 229612

0.013080

0.002919

0.000000

179, 174

12, 413, 937 1, 560, 366

0 426, 313, 449

41, 141

162, 374 4, 555

0 4, 551, 119 200. 00

90.00

91.00

92.00

95.00

96. 00

76.02 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 INI	JDI ANA	In Lie	u of Form CMS-2552-10

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/30/2016 5:	
			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,	
					minus col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			,			
30. 00 03000 ADULTS & PEDIATRICS	C	389, 553	1	0	389, 553	
31.00 03100 INTENSIVE CARE UNIT	C	0	1	0	0	31. 00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	C	5, 531		0	5, 531	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	C	30, 598		0	30, 598	
31.03 03101 CARDIO INTENSIVE CARE UNIT	C	126, 894	1	0	126, 894	
32. 00 03200 CORONARY CARE UNIT	C	43, 638		0	43, 638	
40. 00 04000 SUBPROVI DER - I PF	C	0	1	0	0	40. 00
43. 00 04300 NURSERY	C	12, 241		0	12, 241	
200.00 Total (lines 30-199)	C	608, 455		0	608, 455	200. 00
Cost Center Description		Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS		1	1		ı	
30. 00 03000 ADULTS & PEDI ATRI CS	65, 132			135, 579		30. 00
31. 00 03100 I NTENSI VE CARE UNI T	C	0.00		0		31. 00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 171			0		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	4, 339			0		31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT	21, 035	l .			•	31. 03
32. 00 03200 CORONARY CARE UNIT	7, 205			17, 144		32. 00
40. 00 04000 SUBPROVI DER - 1 PF	C			0		40. 00
43. 00 04300 NURSERY	1, 845			0		43. 00
200.00 Total (lines 30-199)	100, 727	1	32, 72	196, 266		200. 00

Health Financial Systems	LUTHERAN HOSPITAL OF	INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/30/2016 5: 23 pm

				T	o 06/30/2016	Date/Time Pre 11/30/2016 5:	pared:
			Ti tl	e XVIII	Hospi tal	PPS	23 μιι
	Cost Center Description	Non Physician			All Other	Total Cost	
	·	Anestheti st	Ü		Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0	0	0	0	0	50.00
	5100 RECOVERY ROOM	0	0	0	0	0	51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05	5300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	5401 PET SCAN	0	0	0	0	0	54. 01
56. 00 05	5600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 05	5700 CT SCAN	0	0	0	0	0	57. 00
58. 00 05	5800 MRI	0	0	0	0	0	58. 00
60.00 06	6000 LABORATORY	0	0	0	0	0	60.00
65. 00 06	5500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06	6600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00 06	5700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68. 00 06	5800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06	5900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	o	0	276, 453	0	276, 453	73. 00
74. 00 07	7400 RENAL DIALYSIS	o	0	0	0	0	74.00
76. 00 03	3140 CARDIO CATH LAB	o	O	0	0	0	76. 00
76. 01 03	BO50 ENDOSCOPY	o	Ö	0	0	0	76. 01
76. 02 03	3950 CARDI AC REHAB	o	Ö	0	0	0	76. 02
OU	JTPATIENT SERVICE COST CENTERS						
90.00 09	9000 CLI NI C	0	C	0	0	0	90. 00
91.00 09	9100 EMERGENCY	o	Ö	0	0	0	91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART	o	Ö	3, 272	. 0	3, 272	92. 00
ОТ	THER REIMBURSABLE COST CENTERS						
95. 00 09	9500 AMBULANCE SERVICES						95. 00
96. 00 09	9600 DURABLE MEDICAL EQUIP-RENTED	O	0	0	0	0	96.00
200.00	Total (lines 50-199)	0	O	279, 725	0	279, 725	200. 00
		•		•	•	-	•

Heal th	Financial Systems	_UTHERAN HOSPIT	ΔI NF	Ι ΝΟΙ ΔΝΔ		Inlie	u of Form CMS-2	2552_10
APPOR1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS					Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Pre 11/30/2016 5:	pared:
					e XVIII	Hospi tal	PPS	
	Cost Center Description	Cost (sum of col. 2, 3 and	(from	Wkst. C,	Ratio of Cost to Charges (col. 5 ÷ col 7)	Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	
		4) 6. 00		7. 00	8.00	7) 9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00		7.00	0.00	7. 00	10.00	
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 57. 00 58. 00 60. 00 65. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05401 PET SCAN 05600 RADIOISOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06500 RESPIRATORY THERAPY	0 0 0 0 0 0 0 0	5 12 3 10 20 7	0, 836, 315 07, 890, 777 2, 682, 896 2, 656, 677 6, 782, 872 4, 974, 164 3, 117, 755 0 4, 144, 370 8, 317, 522	0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000	0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000	80, 708, 642 0 39, 491 9, 485, 415 15, 432, 937 9, 694 2, 560, 333 12, 848, 926 0 43, 084, 432 24, 744, 768	51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 57. 00 58. 00 60. 00 65. 00
66. 00 67. 00 68. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0 0 0		2, 111, 639 0 0	0. 00000 0. 00000	0. 000000 0. 000000	5, 600, 805 0 0	67. 00 68. 00
69. 00 70. 00 71. 00 72. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS	0 0 0	1 12	7, 734, 622 0, 183, 741 7, 535, 088 2, 994, 630	0. 00000 0. 00000	0. 000000 0. 000000	12, 562, 200 413, 729 31, 488, 369 53, 850, 714	70. 00 71. 00
73. 00 74. 00 76. 00 76. 01	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03140 CARDIO CATH LAB 03050 ENDOSCOPY	276, 453 0 0	45 9	5, 395, 242 9, 639, 209 7, 149, 145 8, 320, 109	0. 00060 0. 00000 0. 00000	7 0. 000607 0. 000000 0. 000000	95, 656, 880 4, 989, 669 14, 178, 089 3, 480, 191	73. 00 74. 00 76. 00
76. 02	03950 CARDI AC REHAB	0		3, 921, 491				

0

0

0 0 279, 725 2, 302, 475, 295

3, 272

4, 045, 034

115, 256, 102 16, 785, 895 0.000000

0.000000

0.000195

0.000000

0.000000

0.000000

0. 000195

0.000000

179, 174

12, 413, 937 1, 560, 366 90.00

91.00

92.00

95.00

0 96. 00 426, 313, 449 200. 00

OUTPATIENT SERVICE COST CENTERS

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

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

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

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	From 07/01/2015	Worksheet D Part IV Date/Time Prepared:

					11/30/2016 5:	:23 pm_
		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	0	43, 100, 016	0			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	4, 342, 277	0)		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	16, 113, 240	0)		54.00
54. 01 05401 PET SCAN	0	1, 615, 052	0			54. 01
56. 00 05600 RADI OI SOTOPE	0	7, 561, 669	0)		56. 00
57. 00 05700 CT SCAN	0	13, 189, 139	0)		57. 00
58. 00 05800 MRI	O	0	0)		58. 00
60. 00 06000 LABORATORY	O	11, 346, 873	0)		60.00
65. 00 06500 RESPIRATORY THERAPY	O	687, 803	0)		65. 00
66. 00 06600 PHYSI CAL THERAPY	O	260, 706	0)		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	O	0	0)		67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	0)		68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	11, 937, 306	0)		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	ol	1, 828, 988	0)		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	15, 609, 566)		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	21, 886, 048)		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 064	28, 219, 320		1		73. 00
74. 00 07400 RENAL DIALYSIS	0	334, 579)		74. 00
76. 00 03140 CARDI O CATH LAB	o	16, 870, 905	1)		76. 00
76. 01 03050 ENDOSCOPY	o	11, 067, 770	1)		76, 01
76. 02 03950 CARDI AC REHAB	o	297, 223	1)		76. 02
OUTPATIENT SERVICE COST CENTERS		· · ·		I		
90. 00 09000 CLI NI C	0	632, 131	0)		90.00
91. 00 09100 EMERGENCY	o	12, 680, 452		y .		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	304	2, 054, 075				92. 00
OTHER REIMBURSABLE COST CENTERS		_, , ,				1
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0)		96. 00
200.00 Total (lines 50-199)	58, 368	221, 635, 138	17, 530			200. 00
1,111	1 27,000	,	,	1		1

Health Financial Systems		LUTHERAN HOSPITAL O	F INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provi der CCN: 150017	Period: From 07/01/2015	Worksheet D
					Date/Time Prepared:

					To 06/30/2016	Date/Time Pre 11/30/2016 5:	
			Ti tl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	0. 096024			0	4, 138, 636	1
51. 00	05100 RECOVERY ROOM	0. 000000			0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 272795			0	0	
53.00	05300 ANESTHESI OLOGY	0. 011924			0	51, 777	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 115010	16, 113, 240		0	1, 853, 184	54.00
54.01	05401 PET SCAN	0. 109541	1, 615, 052		0	176, 914	54. 01
56.00	05600 RADI 0I SOTOPE	0. 075224	7, 561, 669		0	568, 819	56. 00
57.00	05700 CT SCAN	0. 026995	13, 189, 139		0	356, 041	57. 00
58.00	05800 MRI	0. 000000	0		0	0	58. 00
60.00	06000 LABORATORY	0. 106535	11, 346, 873	16, 30	1 0	1, 208, 839	60.00
65.00	06500 RESPIRATORY THERAPY	0. 100889	687, 803		0 0	69, 392	65.00
66.00	06600 PHYSI CAL THERAPY	0. 290227	260, 706		0	75, 664	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	. 0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			0	0	1
69.00	06900 ELECTROCARDI OLOGY	0. 074192			0	885, 653	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 261531	1, 828, 988	•	0	478, 337	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 203342			0	3, 174, 080	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 129786			0	2, 840, 503	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 115100			0 177, 634	3, 248, 044	1
74. 00	07400 RENAL DIALYSIS	0. 387086			0,	129, 511	
76. 00	03140 CARDI O CATH LAB	0. 068262			0 0	1, 151, 642	1
	03050 ENDOSCOPY	0. 146784				1, 624, 572	
	03950 CARDI AC REHAB	0. 188525				56, 034	1
70.02	OUTPATIENT SERVICE COST CENTERS	0. 100020	277,220		<u> </u>	00,001	70.02
90.00	09000 CLI NI C	1. 722249	632, 131		0 0	1, 088, 687	90. 00
91. 00	09100 EMERGENCY	0. 099293		•			1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 021367					1
72.00	OTHER REIMBURSABLE COST CENTERS	0. 02 1007	2,001,070		<u> </u>	10,007	72.00
95. 00	09500 AMBULANCE SERVICES	0. 647315			0		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0	0	
200.00		3. 000000	221, 635, 138		-	_	1
201.00			221,033,130	1	0 177,034	24, 477, 270	201.00
201.00	Only Charges				٥		201.00
202.00	1 1 3 3		221, 635, 138	16, 30	1 177, 634	24, 479, 298	202 00
202.00	1 Sharges (11110 200 17 11110 201)	1	221,000,100	1 15,50	., 177,004	21, 177, 270	1232.00

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	Provider CCN: 150017	From 07/01/2015	Worksheet D Part V Date/Time Prepared:

						To 06/30/2016	Date/Time Pro 11/30/2016 5:	
				Ti tl e	e XVIII	Hospi tal	PPS	
	·	Cos	sts			<u> </u>		
	Cost Center Description	Cost	С	ost				
		Rei mbursed	Reim	bursed				
		Servi ces		ces Not				
		Subject To	Subj	ect To				
		Ded. & Coins.		Coins.				
		(see inst.)		inst.)				
		6. 00	7	. 00				
	ANCILLARY SERVICE COST CENTERS	_						
	05000 OPERATING ROOM	0		0				50.00
	05100 RECOVERY ROOM	0		0				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0		0				52. 00
53. 00	05300 ANESTHESI OLOGY	0		0				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0		0				54. 00
54. 01	05401 PET SCAN	0		0				54. 01
56. 00	05600 RADI 0I SOTOPE	0		0				56. 00
57. 00	05700 CT SCAN	0		0				57. 00
58. 00	05800 MRI	0		0				58. 00
60. 00	06000 LABORATORY	1, 737	7	o				60.00
65. 00	06500 RESPI RATORY THERAPY	0		o				65. 00
66. 00	06600 PHYSI CAL THERAPY	0		o				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		o				67. 00
68. 00	06800 SPEECH PATHOLOGY	0		o				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		o				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		o				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0				71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	ol	20, 446				73. 00
74. 00	07400 RENAL DIALYSIS	0		0				74. 00
76. 00	03140 CARDIO CATH LAB	0		0				76. 00
	03050 ENDOSCOPY	0		0				76. 01
76. 02	03950 CARDI AC REHAB	0		0				76. 02
Ī	OUTPATIENT SERVICE COST CENTERS		•					
90. 00	09000 CLI NI C	0		0				90.00
91. 00	09100 EMERGENCY	0		o				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0				92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>		,				
95. 00	09500 AMBULANCE SERVICES	0						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0				96. 00
200.00	Subtotal (see instructions)	1, 737	7	20, 446				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0	1					201.00
	Only Charges							
202. 00	Net Charges (line 200 +/- line 201)	1, 737	'	20, 446				202. 00

Health Financial Systems	LUTHERAN HOSPIT				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAL	PITAL COSTS	Provi der		Period: From 07/01/2015	Worksheet D Part I	
				To 06/30/2016		nared·
				10 00, 00, 2010	11/30/2016 5:	
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
INDATI ENT. DOUTING CERVI OF COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F 024 (/2		F 024 //	٥ (٦ ١٥٥	00.50	20.00
30. 00 ADULTS & PEDIATRICS	5, 834, 662	U	5, 834, 66	2 65, 132		
31. 00 INTENSIVE CARE UNIT	205 250		205 25	0 1 171	0.00	
31. 01 PEDIATRIC INTENSIVE CARE UNIT	285, 358		285, 35		243. 69	
31. 02 NEONATAL INTENSIVE CARE UNIT	820, 524		820, 52			
31. 03 CARDIO INTENSIVE CARE UNIT	2, 471, 184		2, 471, 18			
32. 00 CORONARY CARE UNIT	871, 155		871, 15	5 7, 205		
40. 00 SUBPROVI DER - I PF	0 077	0)	0	0.00	
43. 00 NURSERY	36, 877		36, 87	· ·		
200. 00 Total (lines 30-199)	10, 319, 760		10, 319, 76	0 100, 727		200. 00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		(COI. 5 X COI.				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	1, 269	113, 677	,			30.00
31. 00 INTENSIVE CARE UNIT	1,23,	110,077	1			31.00
31. 01 PEDIATRIC INTENSIVE CARE UNIT	141	34, 360	1			31. 01
31. 02 NEONATAL INTENSIVE CARE UNIT	444	83, 960	1			31. 02
31. 03 CARDIO INTENSIVE CARE UNIT	578	67, 903	1			31. 02
32 OO CORONARY CARE LINET	139					32 00

139

161

2, 732

16, 806 0

3, 218 319, 924

32.00 40.00

43.00

200.00

31. 02 NEONATAL INTENSIVE CARE UNI 31. 03 CARDIO INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 40. 00 SUBPROVIDER - IPF NURSERY 200. 00 Total (lines 30-199)

Health Financial Systems	LUTHERAN HOSPIT			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der		Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Pre 11/30/2016 5:	pared: 23 pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	8, 120, 431	440, 836, 315			70, 424	
51. 00 05100 RECOVERY ROOM	0		0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	77, 094		•		3, 858	52. 00
53. 00 05300 ANESTHESI OLOGY	40, 026		•			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 489, 150		0. 02029	864, 998	17, 554	54.00
54. 01 05401 PET SCAN	390, 939	6, 782, 872	0. 05763	66 0	0	54. 01
56. 00 05600 RADI OI SOTOPE	261, 563	34, 974, 164	0.00747	'9 125, 560	939	56. 00
57. 00 05700 CT SCAN	297, 887	103, 117, 755	0. 00288	951, 803	2, 750	57. 00
58. 00 05800 MRI	0	C	0.00000	0 0	0	58. 00
60. 00 06000 LABORATORY	1, 755, 607	204, 144, 370	0.00860	0 2, 919, 440	25, 107	60.00
65. 00 06500 RESPIRATORY THERAPY	664, 496	78, 317, 522	0. 00848	2, 939, 035	24, 938	65. 00
66. 00 06600 PHYSI CAL THERAPY	699, 575	22, 111, 639	0. 03163	88 265, 186	8, 390	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	0.00000	0 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	C	0.00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 027, 426	77, 734, 622	0. 01321	7 502, 148	6, 637	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	435, 188	10, 183, 741	0.04273	59, 137	2, 527	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 002, 438	127, 535, 088	0. 00786	0 1, 809, 618	14, 224	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 304, 769	252, 994, 630	0.00515	2, 184, 320	11, 265	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 120, 764	455, 395, 242	0. 00465	7, 060, 541	32, 881	73. 00
74 00 07400 PENAL DIALVSIS	552 959	0 620 200	0 05725	5 240 308	12 700	74 00

1, 324, 555

1, 236, 936 50, 972

928, 790

49, 002

0 0 26, 338, 061 2, 302, 475, 295

1, 507, 595

552, 858

9, 639, 209

97, 149, 145

58, 320, 109 3, 921, 491

4, 045, 034

115, 256, 102 16, 785, 895

240, 398

788, 496

189, 850 24, 162

678, 879 29, 443

26, 307, 555

13, 788

10, 750

4, 027

8, 880

314

70

86

0 96.00

259, 756 200. 00

74.00

76.00

76. 01

76. 02

90.00

91.00

92.00

95.00

0.057355

0.013634

0.021209

0. 012998

0. 229612

0.013080

0.002919

0.000000

07400 RENAL DIALYSIS

03950 CARDI AC REHAB

95. 00 09500 AMBULANCE SERVICES

OUTPATIENT SERVICE COST CENTERS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50-199)

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

76.00 03140 CARDIO CATH LAB

03050 ENDOSCOPY

09000 CLI NI C

91. 00 09100 EMERGENCY

74.00

76. 01

76.02

90.00

Health Financial Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF INDAEL ENT DOUBLING	CERVILOR OTHER PAGE TURNING COCTE	D ' 1 00N 450047	D : 1	W 1 1 1 D

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der	F	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part III Date/Time Pre 11/30/2016 5:	
			le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School		All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cost		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	389, 553	(0	389, 553	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	()	0	31. 00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	5, 531	()	5, 531	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	0	30, 598	()	30, 598	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	0	126, 894	()	126, 894	31. 03
32.00 03200 CORONARY CARE UNIT	0	43, 638	(43, 638	32.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	(0	0	40.00
43. 00 04300 NURSERY	0	12, 241)	12, 241	43.00
200.00 Total (lines 30-199)	0	608, 455	(608, 455	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	65, 132				1	30. 00
31.00 03100 INTENSIVE CARE UNIT	0			,	l	31. 00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 171					31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	4, 339					31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	21, 035					31. 03
32. 00 03200 CORONARY CARE UNIT	7, 205					32. 00
40. 00 04000 SUBPROVI DER - I PF	0			,		40. 00
43. 00 04300 NURSERY	1, 845					43. 00
200.00 Total (lines 30-199)	100, 727	l	2, 732	16, 779		200. 00

Health Financial Systems	LUTHERAN HOSPITAL OF	INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/30/2016 5:23 pm

			1	0 06/30/2016	11/30/2016 5:	
			le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	0	0	0	50. 00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
54. 01 05401 PET SCAN	0	0	0	0	0	54. 01
56. 00 05600 RADI 01 SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	276, 453	0	276, 453	73. 00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
76.00 03140 CARDIO CATH LAB	0	0	0	0	0	76. 00
76. 01 03050 ENDOSCOPY	0	0	0	0	0	76. 01
76. 02 03950 CARDI AC REHAB	0	0	0	0	0	76. 02
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	
91. 00 09100 EMERGENCY	0	0	0	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES					I	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
200.00 Total (lines 50-199)	0	0	276, 453	0	276, 453	200. 00

							6.5	
APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	LUTHERAN HOSPIT				Period: From 07/01/2015 To 06/30/2016	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 11/30/2016 5:	pared:
					le XIX	Hospi tal	PPS	
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	(from	Wkst. C,	Ratio of Cost to Charges (col. 5 ÷ col 7)	Ratio of Cost	Inpatient Program Charges	
		6.00		7. 00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00	1	7.00	0.00	7.00	101.00	
50.00	05000 OPERATI NG ROOM	0	44	0, 836, 315	0.00000	0.000000	3, 823, 025	50.00
51.00	05100 RECOVERY ROOM	0	ĺ	0	0. 00000	0. 000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	ĺ	7, 890, 777	0.00000	0. 000000	394, 872	52.00
53.00	05300 ANESTHESI OLOGY	0	5	2, 682, 896	0.00000	0. 000000	456, 340	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	12	2, 656, 677	0.00000	0. 000000	864, 998	54.00
54.01	05401 PET SCAN	0		6, 782, 872	0.00000	0. 000000	0	54. 01
56.00	05600 RADI OI SOTOPE	0	3	4, 974, 164	0.00000	0. 000000	125, 560	56.00
57.00	05700 CT SCAN	0	10	3, 117, 755	0.00000	0. 000000	951, 803	57. 00
58.00	05800 MRI	0		0	0.00000	0. 000000	0	58. 00
60.00	06000 LABORATORY	0	20	4, 144, 370	0.00000	0. 000000	2, 919, 440	60. 00
65.00	06500 RESPI RATORY THERAPY	0	7	8, 317, 522	0.00000		2, 939, 035	65. 00
66.00	06600 PHYSI CAL THERAPY	0	2	2, 111, 639	0.00000	0. 000000	265, 186	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0	0.00000	0. 000000	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0		0	0.00000	0. 000000	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	7	7, 734, 622	0.00000	0. 000000	502, 148	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1	0, 183, 741	0.00000	0. 000000	59, 137	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	12	7, 535, 088	0.00000	0. 000000	1, 809, 618	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	25	2, 994, 630	0.00000	0. 000000	2, 184, 320	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	276, 453	45	5, 395, 242	0.00060	7 0. 000607	7, 060, 541	73. 00
74.00	07400 RENAL DIALYSIS	0		9, 639, 209	0.00000	0. 000000	240, 398	74. 00
76. 00	03140 CARDIO CATH LAB	0		7, 149, 145			788, 496	
76. 01	03050 ENDOSCOPY	0		8, 320, 109	1		189, 850	76. 01
76. 02	03950 CARDI AC REHAB	0		3, 921, 491	0.00000	0. 000000	24, 162	76. 02

0

0

0 0 276, 453 2, 302, 475, 295

4, 045, 034

115, 256, 102 16, 785, 895

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

678, 879 29, 443

304

26, 307, 555 200. 00

90.00

91.00

92. 00

95.00

96.00 0

OUTPATIENT SERVICE COST CENTERS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50-199)

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

90.00

200.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

91. 00 09100 EMERGENCY

Health Financial Systems	LUTHERAN HOSPITAL OF I	I NDI ANA	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS P	rovider CCN: 150017	From 07/01/2015	Worksheet D Part IV Date/Time Prepared:

				10 00, 00, 2010	11/30/2016 5:	
		Ti 1	le XIX	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	0	(0		50.00
51.00 05100 RECOVERY ROOM	0	(0		51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	()	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0		54.00
54. 01 05401 PET SCAN	0	(0		54. 01
56. 00 05600 RADI 0I SOTOPE	0	()	0		56. 00
57. 00 05700 CT SCAN	0	()	0		57. 00
58. 00 05800 MRI	0	()	0		58. 00
60. 00 06000 LABORATORY	0	()	0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	(0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	(0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	(0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	(0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 286	(0		73. 00
74.00 07400 RENAL DIALYSIS	0	(0		74. 00
76.00 03140 CARDIO CATH LAB	0	(0		76. 00
76. 01 03050 ENDOSCOPY	0	(0		76. 01
76. 02 03950 CARDI AC REHAB	0	(0		76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	(0		90. 00
91. 00 09100 EMERGENCY	O	(0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(0		92.00
OTHER REIMBURSABLE COST CENTERS			•			
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	(0		96. 00
200.00 Total (lines 50-199)	4, 286	(0		200. 00
			•	•		

Health Financial Systems	LUTHERAN HOSPITAL OF	INDIANA	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150017	Peri od:	Worksheet D

From 07/01/2015 To 06/30/2016 Part V Date/Time Prepared: 11/30/2016 5:23 pm Title XIX Hospi tal 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 0.096024 1, 867, 335 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 4. 986 52 00 0 272795 0 52 00 0 05300 ANESTHESI OLOGY 53.00 0.011924 0 244, 279 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 115010 813, 489 0 54.00 54.01 05401 PET SCAN 0.109541 0 108.876 54.01 0 05600 RADI OI SOTOPE 0 56.00 0.075224 100, 363 0 56.00 57.00 05700 CT SCAN 0.026995 696, 980 0 57.00 05800 MRI 58.00 0.000000 0 58.00 06000 LABORATORY 1. 093. 580 0 106535 0 60 00 60 00 0 65.00 06500 RESPIRATORY THERAPY 0.100889 122, 460 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 290227 476, 109 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.074192 0 266, 763 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 261531 141, 365 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 203342 0 272, 470 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72 00 0.129786 626, 516 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.115100 3, 003, 057 0 73.00 07400 RENAL DIALYSIS 0.387086 0 74.00 74.00 7, 248 0 03140 CARDIO CATH LAB 76.00 0.068262 0 76, 207 0 76.00 03050 ENDOSCOPY Ω 76.01 0.146784 275, 825 Ω 76.01 03950 CARDI AC REHAB 0. 188525 680 0 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 1.722249 121, 482 0 0 0 91.00 09100 EMERGENCY 0.099293 0 1, 881, 677 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.021367 323, 330 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 647315 95.00 0 270, 625 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96.00 0 0 200.00 200.00 Subtotal (see instructions) 0 12, 795, 702 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 0 202.00 202.00 0 12, 795, 702 0

Health Financial Systems	LUTHERAN HOSPI TAL	OF INDIANA	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150017		Worksheet D
			From 07/01/2015	Part V

ALTONITONIMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	rrovider	CON. 130017	From 07/01/2015 To 06/30/2016	Part V Date/Time Pre 11/30/2016 5:	epared: 23 pm
		Ti t	le XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	179, 309	l	1			50.00
51.00 05100 RECOVERY ROOM	0	(51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 360					52. 00
53. 00 05300 ANESTHESI OLOGY	2, 913					53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	93, 559	()			54. 00
54. 01 05401 PET SCAN	11, 926)			54. 01
56. 00 05600 RADI 0I SOTOPE	7, 550)			56. 00
57.00 05700 CT SCAN	18, 815	()			57. 00
58. 00 05800 MRI	0	C				58. 00
60. 00 06000 LABORATORY	116, 505	C				60.00
65. 00 06500 RESPIRATORY THERAPY	12, 355	C				65. 00
66. 00 06600 PHYSI CAL THERAPY	138, 180	C				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	C				68. 00
69. 00 06900 ELECTROCARDI OLOGY	19, 792	C				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	36, 971	C				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	55, 405	C				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	81, 313	C				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	345, 652	C				73. 00
74.00 07400 RENAL DIALYSIS	2, 806	C				74. 00
76.00 03140 CARDIO CATH LAB	5, 202	(76. 00
76. 01 03050 ENDOSCOPY	40, 487	C				76. 01
76. 02 03950 CARDI AC REHAB	128	(76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	209, 222	C				90.00
91. 00 09100 EMERGENCY	186, 837	C				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 909	C				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	175, 180					95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C				96. 00
200.00 Subtotal (see instructions)	1, 748, 376	C				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	1, 748, 376	()			202. 00

Heal th	Financial Systems LUTHERAN HOSPITAL O	F INDIANA	In Lie	u of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 150017	Peri od:	Worksheet D-1		
			From 07/01/2015 To 06/30/2016	Date/Time Pre	pared:	
				11/30/2016 5:		
		Title XVIII	Hospi tal	PPS		
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days,			65, 132	1. 00	
2.00	Inpatient days (including private room days, excluding swing-be			65, 132	1	
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	i). If you have only pr	ivate room days,	0	3. 00	
4. 00	Semi-private room days (excluding swing-bed and observation bed	days)		64, 585	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0 1, 555	5. 00	
	reporting period	3 , 3				
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)	da) there were Danasahara	21 -6	0	7.00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 of the cost	0	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8.00	
	reporting period (if calendar year, enter 0 on this line)	,				
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	22, 672	9. 00	
40.00	newborn days)	Z: 1 !:			40.00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction)		oom days)	0	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		nom davs) after	0	11. 00	
11.00	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	0	12. 00			
40.00	through December 31 of the cost reporting period		40.00			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13. 00	
14. 00	Medically necessary private room days applicable to the Program			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	(come carring contrigues		0	15. 00	
16.00	Nursery days (title V or XIX only)			0	16. 00	
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00	
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00	
10.00	reporting period	arter becember 31 or	the cost	0.00	10.00	
19.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00	
	reporting period					
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0. 00	20. 00	
21. 00	Total general inpatient routine service cost (see instructions)			42, 705, 431	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December		ina period (line	0	22. 00	
	5 x line 17)		3			
23. 00] 3	1 of the cost reportin	g period (line 6	0	23. 00	
24.00	X line 18)	21 of the cost report:	na nominal (lina	0	24. 00	
24. 00	00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 7 x line 19)					
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00	
	x line 20)	, ,	`			
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		42, 705, 431	27. 00	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation had ch	arnes)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)	and observation bed Cil	ui ge <i>a)</i>	0	29. 00	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000		
32. 00	00 Average private room per diem charge (line 29 ÷ line 3)					

22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×1) x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7×1 line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26.00	Total swing-bed cost (see instructions)	ol	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	42, 705, 431	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
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	42, 705, 431	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	655. 68	
	Program general inpatient routine service cost (line 9 x line 38)	14, 865, 577	
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)	14, 865, 577	41. 00

13.01 PIDIATRIC INTERSIVE CARE UNIT 2,135,256 1,177 1,823.70 0 4,501 1,301 1,302 MODIFICAL INTERSIVE CARE UNIT 5,118,306 4,339 1,179 0 0 0 8,532,911 43 0 1,301 1,301 1,301 1,302 1,301 1,302 1,301 1,302 1,301 1,302 1,302 1,302 1,303 1,30			LUTHERAN HOSPITAL			In Lie	u of Form CMS-2	2552-10
10 06/38/2016 15 15 15 15 15 15 15	COMPUT	TATION OF INPATIENT OPERATING COST		Provi der	CCN: 150017 F		Worksheet D-1	
Cast Center Description								
Preparation Desput Despu				Title	e XVIII	Hospi tal		23 piii
1.00		Cost Center Description						
1.00			inpatient costiin	ipati ent Days				
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13.00 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	42. 00			0]	0.00	0	0	42.00
13.02 MCGNATAL INTERIST CARE UNIT 5,118,306 4,339 1,179.60 0 0 43.00	43.00			0	0.00	0	0	43. 00
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44.00 CORROMARY CARE UNIT								
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1.00		4						
	47.00							47.00
1701a Program inpatient costs (sum of I lines 4) through 48) (see Instructions) 76,274,200 49 00	10.00			1: 000)				40.00
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Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/lcF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 + line 2) Program routine service cost (line 9 x line 71) 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) 79.00 Ragegate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Program inpatient ancillary services (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 + line 2) 655.68	67. 00	1 ,	e costs through D	December 31 o	f the cost rep	orting period	0	67. 00
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71) Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 75 + line 2) Program capital-related costs (line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost per diem limitation Inpatient routine service cost per diem limitation Program inpatient routine service costs (see instructions) Program inpatient routine service costs (see instructions) Total Program inpatient noutine service (see instructions) Total Program inpatient noutine service (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 67. 00 Aguestal Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 67. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 67. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 67. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 67. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 68. 00 69. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 69. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	68 00	1 7	e costs after Dec	cember 31 of	the cost repor	ting period	0	68 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 71.00 72.00 72.00 73.00 74.00 75.00 Total Program routine service cost (line 9 x line 71) 75.00 76.00 76.00 76.00 76.00 77.00 76.00 77.00 77.00 78.0		(line 13 x line 20)			•	tring period		
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71) Redically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73) Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Reasonable inpatient routine service see instructions) Reasonable inpatient routine service costs (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 70.00 71.00 72.00 72.00 73.00 74.00 75.00 75.00 76.00 77.00 78.00 79.00 79.00 80.00	69. 00						0	69.00
Program routine service cost (line 9 x line 71) 72.00 Redically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) 78.00 Rayregate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost per diem limitation Inpatient routine service cost per diem limitation Reasonable inpatient routine service costs (see instructions) Reasonable inpatient ancillary services (see instructions) Rayrogram inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 72.00 73.00 74.00 75.00 76.00 77.00 80.0	70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID routi	ne service c	ost (line 37)			70. 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 78.00 Inpatient routine service cost per diem limitation 78.00 Inpatient routine service cost ilmitation 79.00 Inpatient routine service cost see instructions) 79.00 Reasonable inpatient routine service costs (see instructions) 79.00 Utilization review - physician compensation (see instructions) 79.00 Utilization review - physician compensation (see instructions) 79.00 Total Program inpatient operating costs (sum of lines 83 through 85) 70.00 Total observation bed days (see instructions) 70.00 Total observation bed days (see instructions) 70.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 70.00 Total observation bed days (see instructions)	71.00	, ,	•	ne 70 ÷ line	2)			71.00
Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Reasonable inpatient ancillary services (see instructions) Balon or total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Total observation bed days (see instructions)	72. 00 73. 00			line 14 x li	ne 35)			72.00
26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Program capital-related costs (line 9 x line 77) Roo Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Roo Program inpatient ancillary services (see instructions) Roo Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Roo Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 10. 00 10. 0	74. 00				,			74. 00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	75. 00	· ·	routine service o	costs (from W	orksheet B, Pa	rt II, column		75. 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 78.00 Total Program inpatient routine cost per diem (line 27 ÷ line 2) 78.00 Total Program inpatient routine cost per diem (line 27 ÷ line 2)	76. 00	1	ne 2)					76. 00
79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Program inpatient routine service costs (see instructions) 83. 00 Program inpatient ancillary services (see instructions) 84. 00 Utilization review - physician compensation (see instructions) 85. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87. 00 655. 68	77. 00	Program capital-related costs (line 9 x line	76)					77. 00
Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Inpatient routine service cost per diem limitation 81. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 88. 00 89. 00 80. 00 81. 00 81. 00 81. 00 81. 00 82. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00 86. 00 87. 00 88. 00 88. 00 89. 00 80. 00 8				wider record	c)			
Inpatient routine service cost per diem limitation 81.00	80.00	1				s line 79)		80.00
Reasonable inpatient routine service costs (see instructions) Reasonable inpatient routine services (see instructions) B1. 00 Program inpatient ancillary services (see instructions) B2. 00 Utilization review - physician compensation (see instructions) B2. 00 Total Program inpatient operating costs (sum of lines 83 through 85) B2. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST B2. 00 Total observation bed days (see instructions) B3. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) B3. 00 Section 1 Section 2 Section 3	81.00	Inpatient routine service cost per diem limi	tati on			•		81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	82.00	1 .	* .	ı				82.00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 85.00 Sec. 00 Se	84. 00	1						84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 655.68 88.00	85.00	Utilization review - physician compensation	(see instructions					85. 00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 547 87.00 655.68 88.00	86. 00			ough 85)				86. 00
	87. 00						547	87. 00
89.00 UDSERVATION DECICOST (LINE 87 X LINE 88) (See Instructions) 358,657 89.00	88.00			ine 2)				
	89. UU	opservation bed COST (line 8/ x line 88) (se	e instructions)				358, 657	89.00

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150017			Peri od:	Worksheet D-1	
				From 07/01/2015 To 06/30/2016		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 834, 662	42, 705, 431	0. 13662	5 358, 657	49, 002	90.00
91.00 Nursing School cost	0	42, 705, 431	0.00000	358, 657	0	91.00
92.00 Allied health cost	389, 553	42, 705, 431	0. 00912	2 358, 657	3, 272	92.00
93 00 All other Medical Education	1 0	42 705 431	0 00000	358 657	n .	93 00

Heal th	Financial Systems LUTHERAN HOSPITAL C	F INDIANA	In Lie	u of Form CMS-	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST	Provi der CCN: 150017	Peri od: From 07/01/2015	Worksheet D-1	
			To 06/30/2016	Date/Time Pre	pared:
-		T: +1 - VIV	11: +-1	11/30/2016 5: PPS	23 pm
	Cost Center Description	Title XIX	Hospi tal	PP3	
	oust deficer bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS			/F 400	4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			65, 132 65, 132	1
3.00	Private room days (excluding swing-bed and observation bed days		ivate room days	05, 132	1
0.00	do not complete this line.	y. It you have only pr	rvate room days,	Ŭ	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed			64, 585	1
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) after becember	31 OF THE COST	0	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eveluding	swing bod and	1, 269	9. 00
7.00	newborn days)	the rrogram (excruding	swifig-bed and	1, 207	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00
	through December 31 of the cost reporting period (see instructi	0	11. 00		
11. 00	1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	0	12. 00		
12.00	through December 31 of the cost reporting period	Ü	12.00		
13. 00					
14.00	after December 31 of the cost reporting period (if calendar year				14.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding Swing-bed	days)	0 1, 845	
16. 00	Nursery days (title V or XIX only)			161	1
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0. 00	17. 00
10.00	reporting period	-ft D 21 -f	46	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	arter becember 31 or	the cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period	9			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			42, 705, 431	21. 00
21.00	Swing-bed cost applicable to SNF type services through December		ing period (line	42, 705, 451	1
22.00	5 x line 17)	or or the oper report	ing pointed (initial		22.00
23. 00		1 of the cost reportin	g period (line 6	0	23. 00
0.4.00	x line 18)	04 6 11			04.00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng perioa (iine	0	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
	x line 20)	, ,	` `		
26. 00	Total swing-bed cost (see instructions)			0	1
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		42, 705, 431	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation had ob	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed th	ai ges <i>j</i>	0	1
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	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			U. 00	33. 00

2. 00 3. 00		05, 132	1.00
3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	65, 132	2. 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.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	64, 585	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
0.00	reporting period (if calendar year, enter 0 on this line)	o l	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00		U	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 269	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)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 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)	0	12. 00
12.00	through December 31 of the cost reporting period	Ŭ,	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
14.00		0	14 00
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
	Total nursery days (title V or XIX only)		15. 00
16. 00	Nursery days (title V or XIX only)	161	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0 00	19. 00
	reporting period		
20.00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	report in g peri od	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	42, 705, 431	21 00
		42, 703, 431	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	U	22. 00
00.00	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6		
		0	23. 00
	x line 18)		
24. 00	X line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	
24. 00	l		
24. 00 25. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line		
	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	24. 00
25. 00 26. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions)	0	24. 00 25. 00 26. 00
25. 00 26. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0	24. 00 25. 00 26. 00
25. 00 26. 00 27. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0 0 0 42, 705, 431	24. 00 25. 00 26. 00 27. 00
25. 00 26. 00 27. 00 28. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0 0 0 42, 705, 431	24. 00 25. 00 26. 00 27. 00 28. 00
25. 00 26. 00 27. 00 28. 00 29. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0 0 0 42, 705, 431	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0 0 0 42,705,431 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0 0 0 42,705,431 0 0 0 0.000000	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0 0 0 42,705,431 0 0 0 0.000000	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0 0 42,705,431 0 0 0.00000 0.00000 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 30 ÷ line 4)	0 0 42,705,431 0 0 0.00000 0.00000 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0 0 42,705,431 0 0 0 0.000000 0.000000 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31)	0 0 42,705,431 0 0 0.000000 0.00 0.00 0.00 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 3 x line 31) Private room cost differential adjustment (line 3 x line 35)	0 0 42,705,431 0 0 0.000000 0.000 0.00 0.00 0.00 0.0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average per diem private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 0 42,705,431 0 0 0.000000 0.00 0.00 0.00 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	0 0 42,705,431 0 0 0.000000 0.000 0.00 0.00 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 30 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	0 0 42,705,431 0 0 0.000000 0.000 0.00 0.00 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 30 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	0 0 42,705,431 0 0 0.000000 0.00 0.00 0.00 0.00 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 35. 00 36. 00 37. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 3 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	0 0 42,705,431 0 0 0.000000 0.00 0.00 0.00 0.00 0.42,705,431	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 30 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	0 0 42,705,431 0 0 0.000000 0.00 0.00 0.00 0.00 0.00	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 35. 00 36. 00 37. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 3 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	0 0 42,705,431 0 0 0.000000 0.00 0.00 0.00 0.00 0.42,705,431	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average per diem private room cost differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 3 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38)	0 0 42,705,431 0 0 0.000000 0.00 0.00 0.00 0.00 0.42,705,431	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00

COMPUT	ATION OF INPATIENT OPERATING COST		Provider	CCN: 150017 I	Peri od:	u of Form CMS-2 Worksheet D-1	
	ATTOM OF THE ATTEM OF ENVIRON GOOD		l rovi dei		From 07/01/2015 To 06/30/2016		pared:
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	518, 835	1, 845	281. 2°	1 161	45, 275	42. 00
12 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT		1 0	0.00	0 0	0	12.00
43. 00 43. 01	PEDIATRIC INTENSIVE CARE UNIT	2, 135, 558				257, 142	
43. 02	NEONATAL INTENSIVE CARE UNIT	5, 118, 306				523, 742	
43. 03	CARDIO INTENSIVE CARE UNIT	24, 856, 619			578	683, 011	43. 03
44.00	CORONARY CARE UNIT	8, 542, 917	7, 205	1, 185. 6	9 139	164, 811	•
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description		'	1			
						1. 00	
48.00	Program inpatient ancillary service cost (Total Program inpatient costs (sum of line			ne)		3, 064, 103 5, 570, 142	1
49.00	PASS THROUGH COST ADJUSTMENTS	5 41 (111 Ough 46) (see mstructro	113)		5, 570, 142	49.00
50. 00	Pass through costs applicable to Program i	npatient routine	services (from	Wkst. D, sum	of Parts I and	336, 703	50.00
51. 00	Pass through costs applicable to Program in and IV)	npatient ancillar	ry services (fr	om Wkst. D, su	um of Parts II	264, 042	51.00
52.00	Total Program excludable cost (sum of line:	,				600, 745	•
53. 00	Total Program inpatient operating cost excluded and exclude the cost of the co		elated, non-phy	sician anesth	etist, and	4, 969, 397	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	e 52)					
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	•
56.00	Target amount (line 54 x line 55) Difference between adjusted inpatient opera	ating cost and to	argot amount (ino 54 minus I	ino 52)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	atting Cost and ta	inger amount (i	THE SO IIITIUS I	THE 53)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996, u	pdated and cor	mpounded by the	0.00	
	market basket						
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of lines				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see	han expected cost				O	01.00
62. 00	Relief payment (see instructions)	e Histructions)				0	62. 00
63. 00	, , , , , , , , , , , , , , , , , , , ,	yment (see instru	uctions)			0	ı
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine coinstructions)(title XVIII only)	osts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine co	osts after Decemb	oer 31 of the c	ost reporting	period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient rou CAH (see instructions)	tine costs (line	64 plus line 6	5)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient rout	ine costs through	n December 31 o	f the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient rout	ine costs after [December 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER		`			0	69. 00
70. 00	Skilled nursing facility/other nursing faci						70. 00
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		n (lina 1/ v li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine se						74.00
75. 00	Capital -related cost allocated to inpatien				art II, column		75. 00
7/ 00	26, line 45)	1: 2)					7,
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ Program capital-related costs (line 9 x li	,					76. 00 77. 00
78.00	Inpatient routine service cost (line 74 mi)	•					78.00
79. 00	Aggregate charges to beneficiaries for exce	ess costs (from p		*			79. 00
80.00	Total Program routine service costs for co	•	cost limitation	(line 78 minu	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem linpatient routine service cost limitation		1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs	* .	· * .				83. 00
84.00	Program inpatient ancillary services (see	instructions)	ŕ				84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (SPART IV - COMPUTATION OF OBSERVATION BED PART IV - COMPUTATION BED PART IV		ıı ouyıı 85)				86. 00
87. 00	Total observation bed days (see instruction					547	87. 00
	[6 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	r diem (line 27 :	line 2)			655. 68	88. 00
	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (•				358, 657	•

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2015 To 06/30/2016		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 834, 662	42, 705, 431	0. 13662	6 358, 657	49, 002	90.00
91.00 Nursing School cost	0	42, 705, 431	0.00000	0 358, 657	0	91.00
92.00 Allied health cost	389, 553	42, 705, 431	0.00912	2 358, 657	3, 272	92.00
93 00 All other Medical Education		42 705 431	0 00000	358 657	0	93 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
			From 07/01/2015 To 06/30/2016	Date/Time Pre	nared:
			10 00/30/2010	11/30/2016 5:	23 pm
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LNDATI ENT. DOUTLING CERVI OF COCT CENTERS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS			24 007 510		20.00
			34, 987, 510 0		30.00
31.00 03100 INTENSIVE CARE UNIT 31.01 02080 PEDIATRIC INTENSIVE CARE UNIT			0		31. 00 31. 01
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT 31. 02 02060 NEONATAL INTENSIVE CARE UNIT			0		31.01
31. 03 03101 CARDIO INTENSIVE CARE UNIT			24, 510, 169		31. 02
32. 00 03200 CORONARY CARE UNIT			10, 929, 633		32.00
40. 00 04000 SUBPROVI DER - 1 PF			10, 727, 033		40.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 09602	80, 708, 642	7, 749, 967	50.00
51. 00 05100 RECOVERY ROOM		0.00000		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 27279		10, 773	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 01192		113, 104	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11501		1, 774, 942	
54. 01 05401 PET SCAN		0. 10954			1
56. 00 05600 RADI 0I SOTOPE		0. 07522	2, 560, 333	192, 598	56.00
57. 00 05700 CT SCAN		0. 02699	12, 848, 926	346, 857	57.00
58. 00 05800 MRI		0.00000	0 0	0	58.00
60. 00 06000 LABORATORY		0. 10653		4, 590, 000	60.00
65. 00 06500 RESPIRATORY THERAPY		0. 10088	39 24, 744, 768	2, 496, 475	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 29022	5, 600, 805	1, 625, 505	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. 07419	12, 562, 200	932, 015	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 26153	413, 729	108, 203	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 20334			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 12978		6, 989, 069	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 11510			73. 00
74. 00 07400 RENAL DI ALYSI S		0. 38708			1
76. 00 03140 CARDI O CATH LAB		0. 06826			
76. 01 03050 ENDOSCOPY		0. 14678			
76. 02 03950 CARDI AC REHAB		0. 18852	1, 024, 688	193, 179	76. 02
90. 00 09000 CLINIC		1. 72224	0 470 471	200 522	00 00
GO ON THE PROPERTY OF THE PROP		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	9 179.174	308, 582	90.00

179, 174 12, 413, 937

1, 560, 366

426, 313, 449

426, 313, 449

1. 722249

0. 099293

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0.000000

308, 582

33, 340

0

49, 521, 395 200. 00

1, 232, 617

90.00

91.00

92.00

95.00

96. 00

201. 00

202. 00

09000 CLINIC

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

90.00

91.00

92.00

95.00

200.00

201.00

Health Financial Systems LUTHERAN HOSPITAL 0	F INDIANA		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Pre 11/30/2016 5:	pared:
	Ti t	le XIX	Hospi tal	PPS	20 piii
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 932, 725		30.00
31. 00 03100 NTENSI VE CARE UNI T			0		31.00
31. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T			493, 176		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT			1, 377, 760		31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT			2, 092, 690		31. 03
32. 00 03200 CORONARY CARE UNIT			537, 843		32. 00
40. 00 04000 SUBPROVI DER - PF			0		40.00
43. 00 04300 NURSERY			142, 610		43.00
ANCILLARY SERVICE COST CENTERS		•			
50. 00 05000 OPERATING ROOM		0. 09602	3, 823, 025	367, 102	50.00
51. 00 05100 RECOVERY ROOM		0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 27279	394, 872	107, 719	52.00
53. 00 05300 ANESTHESI OLOGY		0. 01192	456, 340	5, 441	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11501	0 864, 998	99, 483	54.00
54. 01 05401 PET SCAN		0. 10954		0	54. 01
56. 00 05600 RADI OI SOTOPE		0. 07522		9, 445	56. 00
57. 00 05700 CT SCAN		0. 02699		25, 694	57. 00
58. 00 05800 MRI		0.00000		0	58. 00
60. 00 06000 LABORATORY		0. 10653		311, 023	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 10088		296, 516	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 29022		76, 964	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 07419		37, 255	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 26153		15, 466	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 20334		367, 971	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 12978		283, 494	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 11510		812, 668	73. 00
74. 00 07400 RENAL DI ALYSI S		0. 38708		93, 055	74.00
76. 00 03140 CARDI O CATH LAB		0.06826		53, 824	76. 00
76. 01 03050 ENDOSCOPY		0. 14678		27, 867	76. 01
76. 02 03950 CARDI AC REHAB		0. 18852	24, 162	4, 555	76. 02

1. 722249

0. 099293

0.021367

0.000000

67, 408

524

629

0

3, 064, 103 200. 00

304

678, 879

26, 307, 555

26, 307, 555

29, 443

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

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)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

09000 CLI NI C

09100 EMERGENCY

		UTUEDAN 1100DI T					6.5	
		LUTHERAN HOSPIT			CCN: 150017	Period:	u of Form CMS-2	
	ATION OF ORGAN ACQUISITION COSTS AND CHARGES	FOR HOSPITALS	'	rovi der	CCN: 150017	Period: From 07/01/2015	Worksheet D-4	
WHICH	ARE CERTIFIED TRANSPLANT CENTERS			Component	CCN:	To 06/30/2016	Date/Time Pre	pared:
							11/30/2016 5:	
				Ki	dney	Hospi tal	PPS	
	Cost Center Description	Worksheet D-1			Per Diem Cost	s Organ	Cost (col. 2 x	
		Line Numbers	Routi	ne Organ	(from Wkst.	Acqui si ti on	col. 3)	
				arges	D-1, Part II			
		0		. 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		3, 768			1, 311	1. 00
2.00	INTENSIVE CARE UNIT	43. 00		0	0.0			2. 00
2. 01	PEDIATRIC INTENSIVE CARE UNIT	43. 01	1	14, 128			7, 295	2. 01
2. 02	NEONATAL INTENSIVE CARE UNIT	43. 02	1	0	1, 179. 6			2. 02
2. 03	CARDIO INTENSIVE CARE UNIT	43. 03	1	15, 552				2. 03
3. 00	CORONARY CARE UNIT	44. 00	1	0				3. 00
4.00	BURN INTENSIVE CARE UNIT	45. 00	1	0	0.0		0	4. 00
5.00	SURGICAL INTENSIVE CARE UNIT	46. 00	1	0	0.0		0	5. 00
6.00	OTHER SPECIAL CARE (SPECIFY)	47. 00	9	0	0.0			6. 00
7. 00	TOTAL (sum of lines 1-6)			33, 448		61	73, 598	7. 00
	Cost Center Description			sheet C	Ratio of	0rgan	0rgan	
			Line	Numbers	Cost/Charges		Acquisition	
					(from Wkst. 0	,	Ancillary	
				0	1.00	Charges 2.00	Costs 3.00	
	Computation of Ancillary Service Cost Applica	able to Organ A	l Voqui si		1.00	2.00	3.00	
8.00	OPERATING ROOM	ible to organiz	T	50.00	0. 09602	855, 690	82, 167	8.00
9. 00	RECOVERY ROOM		1	51. 00			1	9. 00
10. 00	DELIVERY ROOM & LABOR ROOM		ŀ	52. 00				10.00
11. 00	ANESTHESI OLOGY		ŀ	53. 00			· ·	•
12. 00	RADI OLOGY-DI AGNOSTI C		ŀ	54. 00	0. 11501		932	12.00
12. 00	PET SCAN		ŀ	54. 01	0. 10954		l e	12. 01
13. 00	RADI OLOGY-THERAPEUTI C		ŀ	55. 00			Ö	13. 00
14. 00	RADI OI SOTOPE			56. 00			0	14. 00
15. 00	CT SCAN			57. 00			421	15. 00
16. 00	MRI		1	58. 00			1	16. 00
17. 00	CARDI AC CATHETERI ZATI ON			59. 00				17. 00
18. 00	LABORATORY			60.00	0. 10653		13, 865	•
19. 00	PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00			0	19. 00
20. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS			62. 00	0.00000		0	20.00
21. 00	BLOOD STORING, PROCESSING & TRANS.			63. 00			0	21. 00
22. 00	INTRAVENOUS THERAPY			64.00			0	22. 00
23.00	RESPI RATORY THERAPY			65.00			8, 919	23. 00
24.00	PHYSI CAL THERAPY			66.00	0. 29022	27 0	0	24. 00
25.00	OCCUPATIONAL THERAPY			67.00	0. 00000	00	0	25. 00
26.00	SPEECH PATHOLOGY			68.00	0. 00000	0 0	0	26. 00
27. 00	ELECTROCARDI OLOGY			69.00	0. 07419	113, 284	8, 405	27. 00
28. 00	ELECTROENCEPHALOGRAPHY			70.00	0. 26153	0 0	0	28. 00
29.00	MEDICAL SUPPLIES CHARGED TO PATIENT			71.00	0. 20334	29, 150	5, 927	29. 00
30.00	IMPL. DEV. CHARGED TO PATIENTS			72.00	0. 12978	1, 939	252	30.00
31.00	DRUGS CHARGED TO PATIENTS			73.00	0. 11510	248, 523	28, 605	31. 00
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. 06826	0	0	34.00
34. 01	ENDOSCOPY			76. 01			0	34. 01
34. 02	CARDI AC REHAB			76. 02			0	34. 02
35. 00	RURAL HEALTH CLINIC			88. 00			0	35. 00
36.00	FEDERALLY QUALIFIED HEALTH CENTER			89. 00			0	36. 00
	CLINIC			90.00			34, 524	•
38. 00	EMERGENCY			91.00			0	38. 00
39. 00	OBSERVATION BEDS (NON-DISTINCT PART			92. 00	0. 02136	31, 539	674	l
	OTHER OUTPATIENT SERVICE COST CENTER					4 500 555	105.0:-	40.00
41.00	TOTAL (sum of lines 8-40)		I		l	1, 589, 209	185, 249	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.

Heal th	Financial Systems LUTHERAN HOSPI	TAL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
	ATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS	Provi der		Peri od:	Worksheet D-4	
WHI CH	ARE CERTIFIED TRANSPLANT CENTERS	Componen		From 07/01/2015 To 06/30/2016		pared.
		'			11/30/2016 5:	23 pm
			i dney	Hospi tal	PPS	
	Cost Center Description	Worksheet D-2, Part I Line			Organ Acqui si ti on	
		Numbers	Per Day (from Wkst. D-2,	Acquisition	Costs (col. 1	
		Number 5	Part I, col.		x col. 2)	
			4)		,	
		0	1.00	2. 00	3.00	
	PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER TH. Computation of the Cost of Inpatient Services of Interns a					1
42. 00	ADULTS & PEDIATRICS	2.00			0	42. 00
43. 00	INTENSIVE CARE UNIT	3.00				
43. 01	PEDIATRIC INTENSIVE CARE UNIT	3.0	•		0	43. 01
43. 02	NEONATAL INTENSIVE CARE UNIT	3. 02	1			
43. 03	CARDIO INTENSIVE CARE UNIT	3. 03	1			
44. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	4. 00 5. 00	1		_	
45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT	6. 00			0	46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)	7. 00				
48. 00	TOTAL (sum of lines 42 through 47)			61		48. 00
	Cost Center Description	Worksheet D-2,	Organ Charges		0rgan	
		Part I Line	(see	To Charges	Acqui si ti on	
		Numbers	instructions)		Costs (col. 1	
				D-2, Part I, col. 4	x col. 2)	
		0	1.00	2.00	3.00	
	Computation of the Cost of Outpatient Services of Interns	and Residents N				
49. 00	RURAL HEALTH CLINIC	21.00	1	0.000000		
50.00	FEDERALLY QUALIFIED HEALTH CENTER	22. 00		0.000000		
51. 00 52. 00	CLINIC EMERGENCY	23. 00 24. 00	1	0.000000 0.000000		51. 00 52. 00
53. 00	OBSERVATION BEDS (NON-DISTINCT PART	25. 00				53.00
54. 00	OTHER OUTPATIENT SERVICE COST CENTER	26. 00	1	0.000000		54.00
55. 00	TOTAL (sum of lines 49 through 52)		51, 58		0	55. 00
		Co	ost	Cha	rges	
	Cost Center Description	Part A	Part B	Part A	Part B	
	·	Part A 1.00	Part B 2.00			
56, 00	PART III - SUMMARY OF COSTS AND CHARGES	1.00	2.00	Part A 3.00	Part B 4.00	56. 00
56. 00 57. 00	·		2.00	Part A	Part B 4.00	56. 00 57. 00
57. 00 58. 00	PART III - SUMMARY OF COSTS AND CHARGES Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient)	1. 00 258, 84	2.00	Part A 3. 00 1, 622, 657	Part B 4.00	57. 00 58. 00
57. 00 58. 00 59. 00	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)	1. 00	2.00	Part A 3.00	Part B 4.00	57. 00 58. 00 59. 00
57. 00 58. 00	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 hospital (see	1. 00 258, 84	2.00	Part A 3. 00 1, 622, 657	Part B 4.00	57. 00 58. 00
57. 00 58. 00 59. 00 60. 00	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 hospital (see intructions)	1. 00 258, 847 ((1, 603, 95	2.00	Part A 3. 00 1, 622, 657 0 0 1, 596, 686	Part B 4.00	57. 00 58. 00 59. 00 60. 00
57. 00 58. 00 59. 00	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 hospital (see	1. 00 258, 84	2.00	Part A 3.00 1, 622, 657 0 1, 596, 686 0 3, 219, 343	Part B 4.00	57. 00 58. 00 59. 00
57. 00 58. 00 59. 00 60. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60)	1. 00 258, 847 ((1, 603, 95	2.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00
57. 00 58. 00 59. 00 60. 00 61. 00 62. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs	1. 00 258, 847 ((1, 603, 95	2.00	Part A 3.00 1,622,657 0 0 1,596,686 0 3,219,343	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)	1. 00 258, 841 (1, 603, 95' (1, 862, 798	2. 00 3 5 4. 0. 72413	Part A 3.00 1,622,657 0 0 1,596,686 0 3,219,343	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions)	1. 00 258, 847 ((1, 603, 95 (1, 862, 798 1, 348, 923	2.00 7 8 9 9 0.72413	Part A 3.00 1,622,657 0 0 1,596,686 0 3,219,343	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 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 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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold	1, 00 258, 847 ((1, 603, 95 (1, 862, 798 1, 348, 923 108, 007	2.00 7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	Part A 3.00 1,622,657 0 0 1,596,686 0 3,219,343 8 2 2,331,249	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions)	1. 00 258, 847 ((1, 603, 95 (1, 862, 798 1, 348, 923	2.00 7 8 9 9 0.72413	Part A 3.00 1,622,657 0 0 1,596,686 0 3,219,343	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 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 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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B	1, 00 258, 847 ((1, 603, 95 (1, 862, 798 1, 348, 923 108, 007	2. 00 3. 5 4. 0. 72413	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2 8 2,331,249 0 2,331,249 0 2,331,249	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
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 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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B	1, 348, 925 1, 240, 916	2. 00 5. 4. 0. 72413	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2 3 2,331,249 0 2,331,249 0 2,331,249 d Cadaveric	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
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 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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description	1, 348, 925 1, 240, 916	2. 00 3. 5 4. 0. 72413	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2 8 2,331,249 0 2,331,249 0 2,331,249	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
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 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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description	1, 348, 925 1, 240, 916	2.00 5. 4. 0.72413. Li vi ng Rel ate. 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249	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 66. 00 67. 00 68. 00 69. 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	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS Organs Excised in Provider (1)	1, 348, 923 1, 240, 916	2.00 5 4 0.72413 6 Li vi ng Rel ate	Part A 3.00 1,622,657 0 1,596,686 3,219,343 3 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 d 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
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 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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description	1, 348, 923 1, 240, 916	2.00 5.00 6.00 7.00 5.00 6.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249	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
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 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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS Organs Excised in Provider (1) Organs Purchased from Other Transplant Hospitals (2)	1, 348, 923 1, 240, 916	2.00 5.00 6.00 7.00 6.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 d 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 70. 00 71. 00 72. 00 73. 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 70. 00 71. 00 72. 00 73. 00 74. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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 Mon-Transplant Hospitals Organs Purchased from OPOs Total (sum of lines 70 thru 73)	1, 348, 923 1, 240, 916	2.00 5.4 0.72413 6.5 Li vi ng Rel ate 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 0 2,331,249 1 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	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
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 74. 00 75. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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) Organs Transplanted	1, 348, 923 1, 240, 916	2.00 5.4 0.72413 6.5 Li vi ng Rel ate 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 0 1,331,249 0 0 1,331,249 0 0 1,331,249 0 0 1,331,249 0 0 1,331,249 0 1,331,249 0 0 1,331,249 0 0 1,331,249 0 0 1,331,249 0 0 1,331,249 0 0 1,331,249 0 0 1,331,249 0 0 0 1,331,249 0 0 0 0 0 0 1,331,349	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 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 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 76. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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) Organs Transplanted Organs Sold to Other Hospitals	1, 348, 923 1, 240, 916	2.00 5. 4. 0.72413. Li vi ng Rel ate. 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 1 3 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 73. 00 74. 00 75. 00 76. 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 74. 00 75. 00 76. 00 77. 00 77. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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) Organs Transplanted Organs Sold to Other Hospitals Organs Sold to OPOs	1, 348, 923 1, 240, 916	2.00 5.00 6.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 d Cadaveric 2.00 5 0 0 13 13 0 0 0 2,55 13	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 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 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 76. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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) Organs Transplanted Organs Sold to Other Hospitals Organs Sold to Transplant Hospitals	1, 348, 923 1, 240, 916	2.00 5. 4. 0.72413 6. Li vi ng Rel ater 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 1 3 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 76. 00 77. 00 77. 00 78. 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 78. 00 77. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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) Organs Transplanted Organs Sold to Other Hospitals Organs Sold to OPOs	1, 348, 923 1, 240, 916	2.00 5.4 0.72413 6.5 Li vi ng Rel ater 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 1 3,300 0 1,31 133 0 0 0 2,500 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 Revenue 3.00 108,007 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
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 80. 00 81. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Redicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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) Organs Transplanted Organs Sold to Other Hospitals Organs Sold to Transplant Hospitals Organs Sold to Military or VA Hospitals Organs Sold Outside the U.S. Organs Sond Outside the U.S. Organs Sond Outside the U.S.	1, 348, 923 1, 240, 916	2.00 5.4 0.72413 Li vi ng Rel ate 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 3,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 Revenue 3.00 108,007 0 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 67. 00 68. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 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 78. 00 79. 00 80. 00 81. 00 82. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Retic of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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) Organs Transplanted Organs Sold to Other Hospitals Organs Sold to Transplant 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 Sent Outside the U.S. Organs Sent Outside the U.S. (no revenue received) Organs Used for Research	1, 348, 923 1, 240, 916	2.00 5.4 0.72413 6.5 Li vi ng Rel ate 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 1,331,349 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 2,331,249 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 Revenue 3.00 108,007 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 82. 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 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 83. 00	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 hospital (see intructions) Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) Medicare Usable Organs (see instructions) Redicare Usable Organs (see instructions) Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) Medicare Cost/Charges (see instructions) Revenue for Organs Sold Subtotal (line 65 minus line 66) Organs Furnished Part B Net Organ 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) Organs Transplanted Organs Sold to Other Hospitals Organs Sold to Transplant Hospitals Organs Sold to Military or VA Hospitals Organs Sold Outside the U.S. Organs Sond Outside the U.S. Organs Sond Outside the U.S.	1, 348, 923 1, 240, 916	2.00 5.4 0.72413 6.5 Li vi ng Rel ate 1.00	Part A 3.00 1,622,657 0 1,596,686 0 3,219,343 8 2,331,249 0 2,331,249 0 2,331,249 1 0 2,331,249 1 0 0 2,331,249 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Part B 4.00 0 0 Revenue 3.00 108,007 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 73. 00 74. 00 75. 00 76. 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.

							6.5	
		LUTHERAN HOSPIT	AL OF		CCN: 150017	Period:	eu of Form CMS-2	2552-10
	ATION OF ORGAN ACQUISITION COSTS AND CHARGES	FOR HOSPITALS		Provi der	CCN: 150017	Period: From 07/01/2015	Worksheet D-4	
WHICH	ARE CERTIFIED TRANSPLANT CENTERS			Component	CCN:	To 06/30/2016	Date/Time Pre	pared:
				•			11/30/2016 5:	
					eart	Hospi tal	PPS	
	Cost Center Description	Worksheet D-1			Per Diem Cost	. 3	Cost (col. 2 x	
		Line Numbers		ne Organ	(from Wkst.	Acqui si ti on	col. 3)	
				narges	D-1, Part II		4.00	
	PART I - COMPUTATION OF ORGAN ACQUISITION COS	O CLNDATIENT		1. 00	2.00	3. 00	4. 00	
	Computation of Inpatient Routine Service Cos					CES)		
1.00	ADULTS & PEDIATRICS	38. 00		yarı Acqui	655.6	.8 0	0	1. 00
2.00	INTENSIVE CARE UNIT	43. 00	1	0				2.00
2.00	PEDIATRIC INTENSIVE CARE UNIT	43. 00		0			1	2. 00
2. 02	NEONATAL INTENSIVE CARE UNIT	43. 02	1	0			1	2. 01
2. 03	CARDIO INTENSIVE CARE UNIT	43. 03	1	0	1, 181. 6		1	2. 03
3.00	CORONARY CARE UNIT	44. 00	1	131, 257	1, 185. 6		5, 928	3. 00
4. 00	BURN INTENSIVE CARE UNIT	45. 00	1	0.7207	0. (0,720	4. 00
5.00	SURGICAL INTENSIVE CARE UNIT	46. 00	1	0	0. (0	5. 00
6.00	OTHER SPECIAL CARE (SPECIFY)	47. 00		0	0.0	00	0	6. 00
7.00	TOTAL (sum of lines 1-6)			131, 257		5	5, 928	7. 00
	Cost Center Description		Worl	ksheet C	Ratio of	0rgan	0rgan	
			Li ne	Numbers	Cost/Charges	Acquisition	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 s		0.00/0/	044 700	00.700	0.00
8.00	OPERATING ROOM			50.00				8. 00
9.00	RECOVERY ROOM			51.00	•		1	9.00
10. 00 11. 00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY		ŀ	52. 00 53. 00	l .		0 1, 669	10. 00 11. 00
12. 00	RADI OLOGY – RADI OLOGY			54. 00	0.01192			12.00
12. 00	PET SCAN			54. 00	0. 10954			12. 00
13. 00	RADI OLOGY-THERAPEUTI C			55. 00			0	13. 00
14. 00	RADI OI SOTOPE			56.00	l .		1	14. 00
15. 00	CT SCAN			57. 00				15. 00
16. 00	MRI			58. 00				16. 00
17. 00	CARDI AC CATHETERI ZATI ON			59. 00	l .		0	17. 00
18.00	LABORATORY			60.00	0. 10653		165, 363	18. 00
19.00	PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00	0. 00000	00	0	19. 00
20.00	WHOLE BLOOD & PACKED RED BLOOD CELLS			62.00	0.00000	00	0	20. 00
21. 00	BLOOD STORING, PROCESSING & TRANS.			63.00	0.00000	00	0	21. 00
22. 00	INTRAVENOUS THERAPY			64. 00	1		0	22. 00
23. 00	RESPI RATORY THERAPY			65. 00			8, 919	23. 00
24. 00	PHYSI CAL THERAPY		ļ	66. 00	l .		0	24. 00
25. 00	OCCUPATIONAL THERAPY			67.00	•		0	25. 00
26. 00	SPEECH PATHOLOGY			68.00			0	26. 00
27. 00	ELECTROCARDI OLOGY			69.00	0. 07419		26, 158	
	ELECTROENCEPHALOGRAPHY			70.00	•	-	0	28. 00
	MEDI CAL SUPPLIES CHARGED TO PATIENT			71.00	•			
30.00	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS			72. 00 73. 00	1			
32. 00	RENAL DIALYSIS			74.00			174,000	32.00
33. 00	ASC (NON-DISTINCT PART)			75. 00	1		0	33. 00
34. 00	CARDIO CATH LAB			76. 00	1		0	34. 00
34. 01	ENDOSCOPY			76. 00	1		1	34. 01
34. 02	CARDI AC REHAB			76. 01	1		0	34. 02
35. 00	RURAL HEALTH CLINIC			88.00	l .		Ö	35. 00
36. 00	FEDERALLY QUALIFIED HEALTH CENTER			89. 00			0	36. 00
	CLINIC			90.00	1		218, 724	37. 00
38. 00	EMERGENCY			91.00	l .			38. 00
39. 00	OBSERVATION BEDS (NON-DISTINCT PART			92.00			0	39. 00
40. 00								40. 00
41. 00	TOTAL (sum of lines 8-40)					6, 624, 391	892, 733	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.

Health Financial Systems	LUTHERAN HOSPITA				u of Form CMS-2	
COMPUTATION OF ORGAN ACQUISITION WHICH ARE CERTIFIED TRANSPLANT C	COSTS AND CHARGES FOR HOSPITALS ENTERS			Period: From 07/01/2015 To 06/30/2016	Worksheet D-4	
		Component			11/30/2016 5:	23 pm_
Cost Contar Descript	i on	Morksheet D-2,	eart Average Cost	Hospi tal Organ	PPS Organ	
Cost Center Descript	ı on	Part I Line	Per Day (from		Acquisition	
		Numbers	Wkst. D-2,		Costs (col. 1	
			Part I, col.		x col. 2)	
	-	0	4) 1. 00	2. 00	3. 00	
PART II - COMPUTATION OF (DRGAN ACQUISITION COSTS (OTHER THAN					
	f Inpatient Services of Interns and					
42. 00 ADULTS & PEDIATRICS		2.00			0	
43.00 INTENSIVE CARE UNIT 43.01 PEDIATRIC INTENSIVE CARE	IINI T	3. 00 3. 01	0. 00 0. 00			43. 00 43. 01
43. 02 NEONATAL INTENSIVE CARE U		3. 02			1	43. 02
43.03 CARDIO INTENSIVE CARE UNI	Т	3. 03			0	43. 03
44. 00 CORONARY CARE UNIT		4.00			0	44.00
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE U	NI T	5. 00 6. 00			0	45. 00 46. 00
47. 00 OTHER SPECIAL CARE (SPECI		7. 00			Ö	47. 00
48.00 TOTAL (sum of lines 42 th				5	0	48. 00
Cost Center Descript	i on V	Worksheet D-2,			0rgan	
		Part I Line Numbers	(see instructions)	To Charges from Wkst.	Acquisition Costs (col. 1	
		Number 3	Thistructions)	D-2, Part I,	x col. 2)	
				col. 4	ŕ	
C	S Outration Compiler of Internal	0	1.00	2.00	3. 00	
49. 00 RURAL HEALTH CLINIC	f Outpatient Services of Interns ar	na kesi dents N 21.00		0. 000000		49.00
50. 00 FEDERALLY QUALIFIED HEALT	H CENTER	22. 00		0. 000000	ő	50.00
51. 00 CLINIC		23. 00			i e	51.00
52. 00 EMERGENCY	TINCT DADT	24.00			0	52.00
53.00 OBSERVATION BEDS (NON-DIS 54.00 OTHER OUTPATIENT SERVICE		25. 00 26. 00		0. 000000 0. 000000	0 0	53. 00 54. 00
55.00 TOTAL (sum of lines 49 th		20.00	129, 79		Ö	55. 00
		Co	st	Chai	rges	
0 1 0 1 0 1 1			D 1 D		D 1 D	
Cost Center Descript	i on	Part A	Part B	Part A	Part B	
Cost Center Descript PART III - SUMMARY OF COST			Part B 2.00		Part B 4.00	
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from	TS AND CHARGES m Part I	Part A 1.00		Part A	4.00	56. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 57.00 Interns and Residents (in	TS AND CHARGES m Part I patient)	Part A 1.00 898, 661 0		Part A 3.00	4.00	57. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 57.00 Interns and Residents (in 58.00 Interns and Residents (ou	TS AND CHARGES m Part I patient) tpatient)	Part A 1.00 898,661 0		Part A 3. 00 6, 755, 648 0	4.00	57. 00 58. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 57.00 Interns and Residents (in 58.00 Interns and Residents (ou 59.00 Direct Organ Acquisition	TS AND CHARGES m Part I patient) tpatient)	Part A 1.00 898, 661 0		Part A 3.00	4.00	57. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 57.00 Interns and Residents (in 18.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions)	TS AND CHARGES m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see	Part A 1.00 898, 661 0 0 567, 987	2.00	Part A 3.00 6,755,648 0 0 580,377	4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 57.00 Interns and Residents (in 58.00 Interns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' servicintructions) 61.00 Total (sum of lines 56 th	TS AND CHARGES m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see ru 60)	Part A 1.00 898,661 0	2.00	Part A 3. 00 6, 755, 648 0 580, 377 0 7, 336, 025	4.00	57. 00 58. 00 59. 00 60. 00 61. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 57.00 Interns and Residents (in 58.00 Interns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th 62.00 Total Usable Organs (see	TS AND CHARGES m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see ru 60) instructions)	Part A 1.00 898, 661 0 0 567, 987	2.00	Part A 3. 00 6, 755, 648 0 580, 377 0 7, 336, 025	4.00	57. 00 58. 00 59. 00 60. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 178.00 Interns and Residents (in 178.00 Direct Organ Acquisition 179.00 Cost of physicians' service 170.00 Total (sum of lines 56 th 170.00 Total Usable Organs (see 170.00 Medicare Usable Organs (see 170.00 Ratio of Medicare Usable	TS AND CHARGES m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see ru 60) instructions)	Part A 1.00 898, 661 0 0 567, 987	2.00	Part A 3. 00 6, 755, 648 0 0 580, 377 0 7, 336, 025	4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from Interns and Residents (in Interns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' servicintructions) 61.00 Total (sum of lines 56 th Total Usable Organs (see 63.00 Medicare Usable Organs (see 64.00 Ratio of Medicare Usable of (line 63 ÷ line 62)	rs AND CHARGES m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648	2. 00 1 0. 81818:	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025	4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 157.00 Interns and Residents (in 158.00 Direct Organ Acquisition 60.00 Cost of physicians' servicintructions) 61.00 Total (sum of lines 56 th 62.00 Total Usable Organs (see 63.00 Medicare Usable Organs (see (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see 65.00 Medicare Cost/Charges (see	rs AND CHARGES m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648	2. 00 1 0. 81818:	Part A 3. 00 6, 755, 648 0 0 580, 377 0 7, 336, 025	4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from Interns and Residents (in Interns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' servicintructions) 61.00 Total (sum of lines 56 th Total Usable Organs (see 63.00 Medicare Usable Organs (see 64.00 Ratio of Medicare Usable of (line 63 ÷ line 62)	rs and charges m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions)	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648	2. 00 1 0. 81818:	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025	4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COST Routine and Ancillary from 157.00 Interns and Residents (in 158.00 Interns and Residents (ou 159.00 Interns and Residents it in 159.00 Interns and Residents (ou 159.00 Int	rs and charges m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66)	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1 0. 81818;	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 6,002,204 0 6,002,204 0 0 0	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 COST 56.00 Routine and Ancillary from 157.00 Interns and Residents (in 158.00 Direct Organ Acquisition 60.00 Cost of physicians' service 159.00 Interns and Residents (ou 159.00 Direct Organ Acquisition 150.00 Cost of physicians' service 150.00 Total (sum of lines 56 th 150.00 Medicare Usable Organs (see 150.00 Medicare Usable Organs (see 150.00 Medicare Cost/Charges (see	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions)	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671	2. 00 1 0. 81818:	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 1 9 2 6,002,204 0 6,002,204 0 6,002,204	4. 00 0 0	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 COST Routine and Ancillary from 157.00 Interns and Residents (in 158.00 Interns and Residents (ou 159.00 Interns and Residents it in 159.00 Interns and Residents (ou 159.00 Int	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions)	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1 0. 81818:	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 1 9 2 6,002,204 0 6,002,204 0 6,002,204 d Cadaveri c	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
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 157.00 Interns and Residents (in 158.00 Direct Organ Acquisition 60.00 Cost of physicians' service 159.00 Interns and Residents (ou 159.00 Direct Organ Acquisition 150.00 Cost of physicians' service 150.00 Total (sum of lines 56 th 150.00 Medicare Usable Organs (see 150.00 Medicare Usable Organs (see 150.00 Medicare Cost/Charges (see	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions)	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1 0. 81818:	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 1 9 2 6,002,204 0 6,002,204 0 6,002,204	4. 00 0 0	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 COST 56.00 Routine and Ancillary from 1nterns and Residents (in 1s.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th 62.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see (line 63 ÷ line 62) Medicare Usable Organs (some of Medicare Ost/Charges (some of Organs Sold of Organs Furnished Part Boundary of Organs Acquisition Cost Center Descript Organs Excised in Provide	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) cion	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2.00 1.00 0.818183	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 6,002,204 0 6,002,204 0 6,002,204 dd Cadaveri c 2.00	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 COST 56.00 Routine and Ancillary from 1sterns and Residents (in 1sterns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' serviciantructions) 61.00 Total (sum of lines 56 th 62.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see Medicare Usable Organs (see Ratio of Medicare Usable (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see Revenue for Organs Sold 67.00 Subtotal (line 65 minus I 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost Cost Center Descript PART IV - STATISTICS 70.00 Organs Excised in Provide 71.00 Organs Purchased from Other	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) r (1) er Transplant Hospitals (2)	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1: 0. 81818: Li vi ng Rel ater 1. 00	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 6,002,204 0 6,002,204 0 6,002,204 d Cadaveric 2.00	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 COST 56.00 Routine and Ancillary from 1nterns and Residents (in 1st. 00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th 62.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see (line 63 ÷ line 62) Medicare Usable Organs (some of Medicare Ost/Charges (some of Organs Furnished Part Boundary Organs Furnished Part Boundary Organs Furnished Part Boundary Organs Furnished Part Boundary Organs Excised in Provide	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) ition r (1) er Transplant Hospitals (2) -Transplant Hospitals	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1: 0. 81818: Li vi ng Rel ater 1. 00	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 6,002,204 0 6,002,204 0 6,002,204 dd Cadaveri c 2.00	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 COST 56.00 Routine and Ancillary froo Interns and Residents (in Interns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th Total Usable Organs (see 63.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see 64.00 Ratio of Medicare Usable of (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus I 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cos Cost Center Descript PART IV - STATISTICS 70.00 Organs Excised in Provide Organs Purchased from Oth 72.00 Organs Purchased from Non 73.00 Organs Purchased from OPO 74.00 Total (sum of lines 70 th	rs AND CHARGES m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) ition r (1) er Transplant Hospitals (2) -Transplant Hospitals	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1: 0. 81818: Li vi ng Rel ater 1. 00	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 6,002,204 0 6,002,204 0 6,002,204 d Cadaveric 2.00	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 70. 00 71. 00 72. 00 73. 00 74. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 1nterns and Residents (in 18.00 Direct Organ Acquisition 60.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th Total Usable Organs (see 63.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see 64.00 Ratio of Medicare Usable of (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus I 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cos Cost Center Descript PART IV - STATISTICS 70.00 Organs Purchased from Oth 72.00 Organs Purchased from Oth 73.00 Organs Purchased from OPO 74.00 Total (sum of lines 70 th 75.00 Organs Transplanted	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) iion r (1) er Transplant Hospitals (2) -Transplant Hospitals s ru 73)	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1: 0. 81818: Li vi ng Rel ater 1. 00	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 6,002,204 0 6,002,204 0 6,002,204 d Cadaveric 2.00	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 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 1 Interns and Residents (in 1 Interns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th 62.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see (line 63 ÷ line 62) Medicare Cost/Charges (see 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus I 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cos Cost Center Descript PART IV - STATISTICS 70.00 Organs Purchased from Oth 72.00 Organs Purchased from OPO 73.00 Organs Transplanted 76.00 Organs Transplanted 76.00 Organs Sold to Other Hosp	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) iion r (1) er Transplant Hospitals (2) -Transplant Hospitals s ru 73)	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2.00 1 0.818183 Li vi ng Rel ater 1.00	Part A 3.00 6,755,648 0 580,377 0 7,336,025 19 2 6,002,204 0 6,002,204 0 6,002,204 d Cadaveric 2.00 6 0 0 0 5 6 0 0 0 0 0 0 0 0 0 0 0 0	4.00 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
PART III - SUMMARY OF COST 56.00 Routine and Ancillary from 158.00 Interns and Residents (ou 159.00 Direct Organ Acquisition 159.00 Cost of physicians' service 159.00 Total (sum of lines 56 th 159.00 Total Usable Organs (see 159.00 Medicare Usable Organs (see 159.00 Medicare Usable Organs (see 159.00 Medicare Cost/Charges (see 159.00 Medicare Usable Organs Sold 159.00 Medicar	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) ition r (1) er Transplant Hospitals (2) -Transplant Hospitals s ru 73) itals	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2.00 1 0.818183 Li vi ng Rel ater 1.00	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 6,002,204 0 6,002,204 0 6,002,204 d Cadaveric 2.00	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
PART III - SUMMARY OF COST 56.00 Routine and Ancillary froo Interns and Residents (in 18.00 Direct Organ Acquisition 60.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th Total Usable Organs (see 63.00 Medicare Usable Organs (see 64.00 Ratio of Medicare Usable of (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus I 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cos Cost Center Descript PART IV - STATISTICS 70.00 Organs Purchased from Oth 72.00 Organs Purchased from Oth 72.00 Organs Purchased from OPO 74.00 Total (sum of lines 70 th 75.00 Organs Sold to Other Hosp 77.00 Organs Sold to Other Hosp 77.00 Organs Sold to Transplant 79.00 Organs Sold to Transplant 79.00 Organs Sold to Military o	rs AND CHARGES m Part I patient) tpatient) (see instructions) ces in a teaching hospital (see ru 60) instructions) organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) ition r (1) er Transplant Hospitals (2) -Transplant Hospitals s ru 73) itals Hospitals r VA Hospitals	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2.00 1 0.818183 Li vi ng Rel ater 1.00	Part A 3.00 6,755,648 0 580,377 0 7,336,025 19 2 6,002,204 0 6,002,204 0 6,002,204 d Cadaveric 2.00 6 0 0 0 5 6 0 0 0 0 0 0 0 0 0 0 0 0	0 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
PART III - SUMMARY OF COST 56.00 Routine and Ancillary froo Interns and Residents (in 18.00 Interns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th Total Usable Organs (see 63.00 Medicare Usable Organs (see 64.00 Ratio of Medicare Usable of (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus I 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cos Cost Center Descript PART IV - STATISTICS 70.00 Organs Purchased from Oth 72.00 Organs Purchased from Oth 72.00 Organs Purchased from OPO 74.00 Total (sum of lines 70 th 75.00 Organs Sold to Other Hosp 77.00 Organs Sold to Other Hosp 77.00 Organs Sold to Transplant 79.00 Organs Sold to Transplant 79.00 Organs Sold to Military o 80.00 Organs Sold Outside the U	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) ition r (1) er Transplant Hospitals (2) -Transplant Hospitals s ru 73) itals Hospitals r VA Hospitals .S.	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2.00 1 0.818183 Li vi ng Rel ater 1.00	Part A 3.00 6,755,648 0 580,377 0 7,336,025 19 2 6,002,204 0 6,002,204 0 6,002,204 d Cadaveric 2.00 6 0 0 0 5 6 0 0 0 0 0 0 0 0 0 0 0 0	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 COST 56.00 Routine and Ancillary from 57.00 Interns and Residents (in 58.00 Interns and Residents (ou 59.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th Total Usable Organs (see 63.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see 63.00 Ratio of Medicare Usable of (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus I 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cos Cost Center Descript PART IV - STATISTICS 70.00 Organs Purchased from Non 73.00 Organs Purchased from OPO 74.00 Total (sum of lines 70 th 75.00 Organs Sold to Other Hosp 77.00 Organs Sold to Other Hosp 77.00 Organs Sold to Transplant 79.00 Organs Sold to Military o 80.00 Organs Sold Outside the U 81.00 Organs Sent Outside the U	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) ition r (1) er Transplant Hospitals (2) -Transplant Hospitals s ru 73) itals Hospitals r VA Hospitals .S.	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2.00 1.00 Li vi ng Rel ater 1.00	Part A 3.00 6,755,648 0 580,377 0 7,336,025 6,002,204 0 6,002,204 0 6,002,204 0 6,002,204 0 6,002,204 0 6,002,204 0 6,002,204 0 6,002,50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 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 70. 00 71. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00
PART III - SUMMARY OF COST 56.00 Routine and Ancillary froo 57.00 Interns and Residents (in 58.00 Direct Organ Acquisition 60.00 Direct Organ Acquisition 60.00 Cost of physicians' service intructions) 61.00 Total (sum of lines 56 th 100 Total Usable Organs (see 63.00 Medicare Usable Organs (see 63.00 Medicare Usable Organs (see 64.00 Ratio of Medicare Usable of 64.00 Ratio of Medicare Usable of 65.00 Medicare Cost/Charges (see 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus I 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cos Cost Center Descript PART IV - STATISTICS 70.00 Organs Purchased from Oth 72.00 Organs Purchased from Oth 72.00 Organs Purchased from OPO 74.00 Total (sum of lines 70 th 75.00 Organs Transplanted 76.00 Organs Sold to Other Hosp 77.00 Organs Sold to Transplant 79.00 Organs Sold to Transplant 79.00 Organs Sold to Military o 80.00 Organs Sold to Military o 80.00 Organs Sold Outside the U	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) ition r (1) er Transplant Hospitals (2) -Transplant Hospitals s ru 73) itals Hospitals r VA Hospitals .S.	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1 0. 81818:	Part A 3.00 6,755,648 0 580,377 0 7,336,025 19 2 6,002,204 0 6,002,204 0 6,002,204 d Cadaveric 2.00 6 0 0 0 5 6 0 0 0 0 0 0 0 0 0 0 0 0	0 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 COST 56. 00 Routine and Ancillary from 57. 00 Interns and Residents (in 58. 00 Interns and Residents (ou 59. 00 Direct Organ Acquisition 60. 00 Cost of physicians' service intructions) 61. 00 Total (sum of lines 56 th 62. 00 Medicare Usable Organs (see 63. 00 Medicare Usable Organs (see 63. 00 Medicare Usable Organs (see 64. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus I 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost Cost Center Descript PART IV - STATISTICS 70. 00 Organs Purchased from Oth 72. 00 Organs Purchased from OPO 74. 00 Total (sum of lines 70 th 75. 00 Organs Transplanted 76. 00 Organs Sold to Other Hosp 77. 00 Organs Sold to Other Hosp 77. 00 Organs Sold to Military of 80. 00 Organs Sold to Military of 81. 00 Organs Sold Outside the U 82. 00 Organs Used for Research 83. 00 Unusable/Discarded Organs	rs AND CHARGES m Part I patient) (see instructions) ces in a teaching hospital (see ru 60) instructions) ee instructions) Organs to Total Usable Organs e instructions) ine 66) t and Charges (see instructions) ition r (1) er Transplant Hospitals (2) -Transplant Hospitals s ru 73) itals Hospitals r VA Hospitals .S.	Part A 1.00 898, 661 0 0 567, 987 0 1, 466, 648 1, 199, 985 20, 671 1, 179, 314 0	2. 00 1. 0. 81818: Li vi ng Rel ater 1. 00	Part A 3.00 6,755,648 0 0 580,377 0 7,336,025 6,002,204 6,002,204 0 6,002,204 dd Cadaveric 2.00 6,000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 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 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 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.

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150	From 07/01/2015	Worksheet E Part A Date/Time Prepared: 11/30/2016 5:23 pm
	T' 11 \ \\ \\ \\ 11 \ \\ \\ \\ \\ \\ \\ \\	11 ' 1	DDC

		Title XVIII	Hospi tal	11/30/2016 5: PPS	23 pm
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	0 15, 130, 133	1. 00 1. 01		
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring	on or after October 1	l (see	43, 172, 421	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for (discharges occurring p	orior to October	0	1. 03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCl for a October 1 (see instructions)	discharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			3, 646, 903 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions Managed Care Simulated Payments	;)		0 33, 777, 114	2. 02
4. 00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	ng period (see instruc	ctions)	381. 51	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most reor before 12/31/1996. (see instructions)	ecent cost reporting p	period ending on	10. 13	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)		·	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA Section 5503 reduction amount to the IME cap as specified under the IME cap as speci			0. 00 0. 00	7. 00 7. 01
8.00	If the cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) 1998), and 67 FR 50069 (August 1, 2002).		, ,	0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots the cost report straddles July 1, 2011, see instructions.	under section 5503 of	the ACA. If	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under section 5506 of ACA. (see instructions)	from a closed teaching	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (instructions)	(8, 8,01 and 8,02) (s	see	10. 13	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current FTE count for residents in dental and podiatric programs.	year from your record	ds	6. 07 0. 00	
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			6. 07 8. 36	
14. 00	Total allowable FTE count for the penultimate year if that year elotherwise enter zero.	ended on or after Sept	tember 30, 1997,	8. 14	
15. 00	Sum of lines 12 through 14 divided by 3.			7. 52	15. 00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital closure	2		0.00	16. 00 17. 00
18. 00	Adjusted rolling average FTE count	•		7. 52	
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 019711	
20.00	Prior year resident to bed ratio (see instructions)			0. 021907	20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 019711	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			624, 712 361, 922	22. 00 22. 01
22.01	Indirect Medical Education Adjustment for the Add-on for Section	422 of the MMA	l	301, 722	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$.		ec. 412.105	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			-4. 06	
25. 00	If the amount on line 24 is greater than -O-, then enter the lower instructions)	er of line 23 or line	24 (see	0.00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000 0	27. 00 28. 00
28. 00	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 00
29. 00	Total IME payment (sum of lines 22 and 28)			624, 712	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			361, 922	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruct	tions)	4. 15	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)			18. 71	
32.00	Sum of lines 30 and 31			22. 86	
33.00	Allowable disproportionate share percentage (see instructions)			8.07	33.00
34.00	Disproportionate share adjustment (see instructions)		I	1, 176, 255	34.00

	Financial Systems LUTHERAN HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150017	Period:	eu of Form CMS-2 Worksheet E	∠၁၁∠- I
CALCOL	ATTOW OF REFINENCE SETTLEMENT	TTOVIGET CON. 130017	From 07/01/2015	Part A	
			To 06/30/2016	Date/Time Prep 11/30/2016 5::	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)			6, 406, 145, 534	
35. 01	Factor 3 (see instructions)	or zono on this line)	0. 000516382	0. 000518884	
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter (see instructions)	er zero on this line)	3, 949, 106	3, 324, 047	35. 0
35. 03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	995, 392	2, 488, 495	35. 0
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		3, 483, 887		36.0
40. 00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges on Worksheet S-3, Part I excluding of		0 0		40.0
	652, 682, 683, 684 and 685 (see instructions)	Ü			
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83, 684 an 685. (see	0		41.0
41. 01	<pre>instructions) Total ESRD Medicare covered and paid discharges excluding MS-D</pre>	DRGs 652, 682, 683, 684	0		41.0
	an 685. (see instructions)				
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qualif Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682		0.00		42.0
43.00	instructions)	2, 683, 684 an 685. (See	0		43. 0
44. 00	Ratio of average length of stay to one week (line 43 divided by	by line 41 divided by 7	0. 000000		44.0
45. 00	days) Average weekly cost for dialysis treatments (see instructions)	1	0.00		45. 0
46. 00	Total additional payment (line 45 times line 44 times line 41.		0.00		46. 0
47. 00	Subtotal (see instructions)	•	67, 234, 311		47. 0
48. 00	Hospital specific payments (to be completed by SCH and MDH, sn	mall rural hospitals	0		48. 0
	only. (see instructions)			Amount	
				1. 00	
49. 00 50. 00	Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I and			67, 596, 233 5, 673, 814	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			3, 073, 014	1
52. 00	Direct graduate medical education payment (from Wkst. E-4, lir			282, 797	
53.00	Nursing and Allied Health Managed Care payment			0	
54. 00 55. 00	Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		56, 711 2, 420, 230	
56. 00	Cost of physicians' services in a teaching hospital (see intru	•		0	56.0
57. 00	Routine service other pass through costs (from Wkst. D, Pt. II		hrough 35).	196, 266	1
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58)	IV, col. 11 line 200)		58, 368 76, 284, 419	
50.00	Primary payer payments			36, 767	1
51. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		76, 247, 652	
52.00	Deductibles billed to program beneficiaries			5, 065, 508	
3. 00 4. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			335, 461 657, 134	1
5. 00	, ,			427, 137	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		219, 432	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	!: +- MC DDC- (-	!+	71, 273, 820	1
8. 00 9. 00	Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
70.00	MSP PASS THROUGH RECONCILIATION	(23.1 233 TH31 WOLFOIL	-/	339	1
70. 50	RURAL DEMONSTRATI ON PROJECT			0	
	SCH or MDH volume decrease adjustment	ructions)		0	1
70. 88	1	i ucti uis)		0	1
70. 88 70. 89				O	1
70. 88 70. 89 70. 90	HSP bonus payment HRR adjustment amount (see instructions)				
70. 88 70. 89 70. 90 70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	ı
70. 88 70. 89 70. 90 70. 91 70. 92 70. 93				0 -229, 599 -45, 398	70. 9

Heal th	Financial Systems LUTHERAN HOSPITAL O	F INDIANA		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016	Worksheet E Part A	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96		column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
	the corresponding federal year for the period ending on or afte	r 10/1)				
70. 98	Low Volume Payment-3				0	1 . 0 0
70. 99	HAC adjustment amount (see instructions)				537, 954	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			70, 461, 208	
71. 01	Sequestration adjustment (see instructions)				1, 409, 224	
	Interim payments				69, 317, 290	
73. 00	1	>			0	
74. 00					-265, 306	
75. 00	Protested amounts (nonallowable cost report items) in accordance	e with			5, 290, 158	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	`				
90.00	-	uctions)			0	
91.00					0	
92.00	Operating outlier reconciliation adjustment amount (see instruc				0	, ,
93.00	Capital outlier reconciliation adjustment amount (see instructi				0	
	The rate used to calculate the time value of money (see instruc	TI ons)			0.00	
95.00		>			0	
96. 00	Time value of money for capital related expenses (see instructi	ons)		Prior to 10/1	0 /45+ 10 /1	96. 00
				1.00	2. 00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)			0	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			0	0	100.00
101 00	HVBP adjustment factor (see instructions)			0.000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions)			0.000000000		102.00
102.00	HRR Adjustment for HSP Bonus Payment (see Histructions)			<u> </u>	<u> </u>	1102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103 00
	HRR adjustment amount for HSP bonus payment (see instructions)			0.0000		104.00
10 1. 00	Think day as the first amount for his solids payment (see Thisti detroits)			1	0	1101.00

Health Financial Systems	LUTHERAN HOSPITAL OF I	NDI ANA		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovider CCN:	150017	From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/30/2016 5:23 pm
		Title XVI	11	Hospi tal	PPS

			10 00/30/2010	11/30/2016 5:	
-		Title XVIII	Hospi tal	PPS	20 0111
		THE ATTE	1105pr tur	113	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			22, 183	1. 00
2.00	Medical and other services (see mistractions) Medical and other services reimbursed under OPPS (see instructions)	one)		24, 461, 768	
3.00	PPS payments	0113)		25, 518, 971	3. 00
4.00	1 ' 3				
5.00	Outlier payment (see instructions)	i ana)		143, 953	•
	Enter the hospital specific payment to cost ratio (see instructi	i ons)		0.000	
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	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		17, 530	
10.00	Organ acquisitions			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			22, 183	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12. 00	Ancillary service charges			193, 935	
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			193, 935	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pay	yment for services on a	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services o	n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			193, 935	18. 00
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	ne 11) (see	171, 752	19. 00
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		22, 183	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			25, 680, 454	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	
26.00	Deductibles and Coinsurance relating to amount on line 24 (for			4, 733, 175	26. 00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plo	us the sum of lines 22	and 23] (see	20, 969, 462	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		88, 070	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			21, 057, 532	30. 00
31.00	Primary payer payments			5, 630	31.00
32.00	Subtotal (line 30 minus line 31)			21, 051, 902	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			804, 451	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			522, 893	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		595, 240	36. 00
37.00	Subtotal (see instructions)			21, 574, 795	37. 00
38.00	MSP-LCC reconciliation amount from PS&R			722	38. 00
39.00	OTHER ADJUSTMENTS			9, 421	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	o	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	o	39. 99
40. 00	Subtotal (see instructions)			21, 583, 494	
40. 01	Sequestration adjustment (see instructions)			431, 670	
41. 00	Interim payments			21, 017, 112	1
42. 00	Tentative settlement (for contractors use only)			0	
43. 00	Balance due provider/program (see instructions)			134, 712	
44. 00	Protested amounts (nonallowable cost report items) in accordance	o with CMS Dub 15.2	chantor 1	134, 712	1
44.00	§115. 2	e with cms rub. 19-2, t	Juapter 1,		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)			0	
					91.00
92.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)				94.00
74. UU	Total (Sum Of Titles 71 and 73)		ļ	, 0	74.00

Health Financial Systems LUTHE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 07/01/2015 | Part I | To 06/30/2016 | Date/Time Prepared: Provider CCN: 150017

InterIm payments' payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or enter a zero						10 00/30/2010	11/30/2016 5:	
1.00				Ti tl	e XVIII	Hospi tal		•
1.00				Inpatier	nt Part A	Par	T B	
1.00			mm /	/dd /\\\\\	Amount	mm/dd/\\\\\\	Amount	
Total Interim payments paid to provider 69,317,290 21,017,112 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 2.00 1.00 2.								
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	1 00	Total interim payments paid to provider		1.00				1. 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					07,017,27	n	21,017,112	
Services rendered in the cost reporting period. If none, write "NONE" or neter a zero.	2.00							2.00
write "NONE" or enter a zero 3. 00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 ADJUSTMENTS TO PROVIDER 3. 02 0 0 0 3. 03 3. 03 0 0 0 0 3. 03 3. 03 0 0 0 0 3. 03 3. 04 0 0 0 0 3. 03 3. 05 0 0 0 3. 03 3. 05 0 0 0 3. 03 3. 05 0 0 0 3. 03 3. 06 0 0 0 3. 03 3. 07 0 0 0 3. 03 3. 08 0 0 0 0 3. 03 3. 09 0 0 0 3. 03 3. 09 0 0 0 3. 05 3. 00 0 0 3. 05 3. 00 0 0 0 0 3. 05 3. 00 0 0 0 0 3. 05 3. 00 0 0 0 0 3. 05 3. 00 0 0 0 3. 05 3. 00 0 0 0 0 3. 05 3. 00 0 0 0 0 3. 05 3. 00 0 0 0 0 3. 05 3. 00 0 0 0 0 0 3. 05 3. 00 0 0 0 0 0 0 3. 05 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0								
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider								
amount based on subsequent revision of the interim rate for the cast reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines appropriate) TO BE COMPLETED BY CONTRACTOR LIST separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Provider to Program 5.00 LIST separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ENTATIVE TO PROGRAM O	3.00							3.00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) NONE" o								
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider								
ADJUSTMENTS TO PROVIDER								
3.02 3.03 3.04 3.05 3.06 3.07		Program to Provider						
3.04 3.05 3.04 3.05 3.06 3.06 3.06 3.06 3.07 3.07 3.08 3.09 3.09 3.50 3.51 3.51 3.52 3.53 3.54 3.54 3.59 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50	3. 01	ADJUSTMENTS TO PROVIDER				0	0	3. 01
3.04	3.02					0	0	3. 02
ADJUSTMENTS TO PROGRAM	3.03					0	0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0	3.04					0	0	3. 04
ADJUSTMENTS TO PROGRAM	3.05					0	0	3. 05
3.51 3.52 3.53 0 0 0 3.55 3.53 0 0 0 0 3.53 3.53 0 0 0 3.53 3.54 0 0 0 3.55 3.54 0 0 0 3.55 3.59 0 0 0 3.50 3.99 3.50 3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E -3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 5.01 5.01 5.02 0 0 0 5.02 5.03 Provider to Program TENTATIVE TO PROGRAM 0 0 5.55 5.51 5.51 5.52 0 0 0 5.55 5.52 5.50 5.98 0 0 0 5.55 5.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 0 0 0 5.55 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 5.99 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETILEMENT TO PROGRAM 0 0 134,712 6.01 6.01 SETILEMENT TO PROGRAM 0 0 134,712 6.01 6.02 SETILEMENT TO PROGRAM 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 0		Provider to Program	•					
3.52	3.50	ADJUSTMENTS TO PROGRAM				0	0	3. 50
3.53 3.54 3.54 3.55 3.59 3.50	3.51					0	0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Contractor Number (Mo/Day/ryr) Contractor (Mo/Day/r	3.52					0	0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98) Contractor Number	3.53		İ			0	0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99)	3.54					0	0	3. 54
A.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR								
appropriate TO BE COMPLETED BY CONTRACTOR	4.00				69, 317, 29	0	21, 017, 112	4. 00
TO BE COMPLÉTED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER O								
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider								
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					T		1	
Write "NONE" or enter a zero. (1) Program to Provider	5.00							5.00
Program to Provider								
TENTATI VE TO PROVI DER								
5. 02 0	г 01		1		T			
Solid		TENTATIVE TO PROVIDER			1			
Provider to Program					1			
S. 50 TENTATI VE TO PROGRAM 0 0 5. 50	5.03	Dravidar to Dragram				U	0	5.03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 0 5.52 6.00 6.00 6.00 7.00 Total Medicare program liability (see instructions) 0 0 1.00 7.00 Total Medicare program liability (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5 50		Т					5 50
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) O 1.00 2.00		IENTATIVE TO FROGRAM			1			
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00						~	_	
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00		Subtotal (sum of lines 5 01 5 40 minus sum of lines						
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	J. 77					o e		J. 77
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 00							6.00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 00							0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 265, 306 69, 051, 984 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6, 01					ol	134. 712	6. 01
7.00 Total Medicare program liability (see instructions) 69,051,984 21,151,824 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00					265 30	6		6. 02
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00								
Number (Mo/Day/Yr) 0 1.00 2.00		, , , , , , , , , , , , , , , , , , ,			2.700.770			
0 1.00 2.00								
8.00 Name of Contractor 8.00				(0	1. 00		
	8.00	Name of Contractor						8. 00

Heal th	Financial Systems LUTHERAN HOSPITAL C	DF INDIANA	In Lie	u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150017 Period: From 07/01/2015 To 06/30/2016 11					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S	S-3, Pt. I col. 15 line	14	19, 801	1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		32, 722	2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			19, 588	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-7	12		98, 335	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			2, 536, 362, 933	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	ne 20		10, 843, 725	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of celline 168	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00	
9.00	Sequestration adjustment amount (see instructions)			0	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		0	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00	
31.00	Other Adjustment (specify)			ol	31. 00	
22 00	20 Belones due provider (line 0 (or line 10) rinus line 30 and line 31) (occ instructions)					

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

0 30.00 0 31.00 0 32.00

Health Financial Systems	LUTHERAN HOSPITAL OF	I NDI ANA	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Pre 11/30/2016 5:	pared:
		Title XIX	Hospi tal	PPS	

			10 06/30/2016	11/30/2016 5:	
		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			1, 748, 376	
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	l	
5. 00	Inpatient primary payer payments		0	1, 710, 070	5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0		
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>	1, 740, 370	7.00
	Reasonable Charges				1
8. 00	Routi ne servi ce charges		0		8.00
9. 00	Ancillary service charges		26, 307, 555	12, 795, 702	9. 00
10.00	Organ acquisition charges, net of revenue		20, 307, 555	12, 793, 702	10.00
11. 00	Incentive from target amount computation				11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		26, 307, 555	12, 795, 702	
12.00	CUSTOMARY CHARGES		20, 307, 333	12, 193, 102	12.00
13. 00	Amount actually collected from patients liable for payment for	sorvi cos on a chargo	0	0	13. 00
13.00	basis	ser vices on a charge		l	13.00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42			l	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	OTR 3413. 13(c)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		26, 307, 555	l	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	26, 307, 555		
17.00	line 4) (see instructions)	TT TTHE TO EXCECUS	20, 307, 333	11,047,320	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)	r chocodoc		l	
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0		
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co		ers.	.,	
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		21, 065	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		21, 065	l e	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		21, 065	1, 748, 376	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		,		
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		21, 065	1, 748, 376	31.00
32.00	Deducti bl es		0	0	32. 00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36, 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	21, 065	1, 748, 376	36. 00
37. 00	PPS PAYMENT METHODOLOGY ADJUSTMENT	,	-21, 065		
38. 00			0		
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	Ī	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41. 00	Interim payments		0	0	
42. 00	Balance due provider/program (line 40 minus line 41)		0	l e	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2.	0	l e	43. 00
-	chapter 1, §115.2			1	
					•

Heal th	Financial Systems LUTHERAN HOSPITAL O	F INDIANA		In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der		Period: From 07/01/2015 To 06/30/2016	Worksheet E-4 Date/Time Prep 11/30/2016 5:2	
		Ti tl	e XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic prending on or before December 31, 1996.	· ·	•		8. 95	1. 00
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 CFR Amount of reduction to Direct GME cap under section 422 of MMA	413.79(e)(1) (see instr	uctions)	0. 00 0. 00	2. 00 3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance w	vith 42 CFR	§413.79 (m).	(see	0. 00	3. 01
4.00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	steopathi c	programs due	to a Medicare	0.00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instrustraddling 7/1/2011)	uctions for	cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	(see inst	ructions for	cost reporting	0.00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus 4.02 plus applicable subscripts	or minus	line 4 plus I	ines 4.01 and	8. 95	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic prrecords (see instructions)	rograms for	the current	year from your	6. 07	6. 00
7. 00	Enter the lesser of line 5 or line 6		D-: C	0+1	6. 07	7. 00
			Primary Care 1.00	0ther 2.00	<u>Total</u> 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteopat	hi c	6.0		6. 07	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwis		6.0		6. 07	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 Total weighted FTE count	,	6. 0			10.00
12. 00	Total weighted resident FTE count for the prior cost reporting instructions)		8. 3			12. 00
13. 00	Total weighted resident FTE count for the penultimate cost repoyear (see instructions)		8. 1			13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided by	oy 3).	7.5			14. 00
15. 00 16. 00	Adjustment for residents in initial years of new programs Adjustment for residents displaced by program or hospital closu	ıro	0. 0 0. 0			15. 00 16. 00
17. 00	Adjusted rolling average FTE count	n e	7. 5			17. 00
18. 00	Per resident amount		98, 241. 2			18. 00
19. 00	Approved amount for resident costs		738, 77	·	738, 774	
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FTE	resident	cap slots rec	eived under 42		20. 00
	Sec. 413.79(c)(4)					
21. 00	Direct GME FTE unweighted resident count over cap (see instruct					21. 00 22. 00
22. 00 23. 00	Allowable additional direct GME FTE Resident Count (see instructional the locally adjustment national average per resident amount of the locally adjustment national average per resident amount of the local ly adjustment national average per resident amount of the local ly adjustment national average per resident amount of the local ly adjustment of the local ly adjustme		etructione)		0.00	23. 00
	1	iiit (See iii	Structions)		0.00	
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				738, 774	
20.00	Total direct one amount (Sam of Times 17 and 21)		Inpatient Par	t Managed care	700,771	20.00
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD				2. 00	
26. 00	Inpatient Days (see instructions)		32, 72	2 19, 588		26. 00
27.00	Total Inpatient Days (see instructions)		98, 68	9 98, 689		27.00
28. 00	Ratio of inpatient days to total inpatient days		0. 33156	7 0. 198482		28. 00
29. 00	Program direct GME amount		244, 95	3 146, 633		29. 00
30. 00	Reduction for direct GME payments for Medicare Advantage			20, 719	370, 867	30.00
31. 00	1.00 Net Program direct GME amount					

Heal th	Financial Systems LUTHERAN HOSPITAL OF	- I NDI ANA	In Lie	u of Form CMS-2	2552-10	
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 150017	Peri od:	Worksheet E-4		
MEDI CA	L EDUCATION COSTS		From 07/01/2015 To 06/30/2016	Date/Time Prep 11/30/2016 5:2		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE > EDUCATION COSTS)	`		CAL		
32.00		. I, sum of col. 20 and	d 23, lines 74	0	32. 00	
	and 94)					
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I,		74 and 94)	9, 639, 209	1	
34. 00	Ratio of direct medical education costs to total charges (line 3	32 ÷ line 33)		0. 000000		
35. 00	Medicare outpatient ESRD charges (see instructions)	0				
36. 00	Medicare outpatient ESRD direct medical education costs (line 34	0	36. 00			
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ON	NLY				
07.00	Part A Reasonable Cost					
37. 00	Reasonable cost (see instructions)			76, 274, 200 2, 420, 230		
38. 00	.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) .00 Cost of physicians' services in a teaching hospital (see instructions)				1	
				0	39. 00	
40. 00				36, 767		
41.00	00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 78,657,663 Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		T	24, 501, 481	42. 00	
43. 00	Primary payer payments (see instructions)			5, 630		
44. 00				24, 495, 851		
45. 00				103, 153, 514	•	
46. 00	· · · · · · · · · · · · · · · · · · ·			0. 762530		
	00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0. 237470	1	
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART			0. 237470	77.00	
48 00	Total program GME payment (line 31)			370, 867	48. 00	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		282, 797		
	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (s			88, 070	1	
55.00	oo frant b medicare ome payment (Time 47 x 40) (title xviii only) (see Histractions)					

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 | Period: | From 07/01/201

Peri od: Worksheet G From 07/01/2015 To 06/30/2016 Date/Time Prepared: 11/30/2016 5: 23 pm

			''	0 00/30/2010	11/30/2016 5:	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	CURRENT ACCETC	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	-1, 054, 435	Ιο	0	0	1. 00
2.00	Temporary investments	-1,054,455	1	0	0	2.00
3.00	Notes recei vabl e	٥		0	0	3. 00
4.00	Accounts receivable	97, 728, 061	0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-12, 701, 152	0	0	0	6. 00
7.00	Inventory	15, 379, 218		0	0	7. 00
8.00	Prepai d expenses	4, 280, 451		0	0	8. 00
9.00	Other current assets	2, 349, 212		0	0	9. 00
10.00	Due from other funds	0	1	0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	105, 981, 355	0	0	0	11. 00
12. 00	Land	13, 479, 606	0	0	0	12. 00
13. 00	Land improvements	3, 940, 567		0	0	13. 00
14. 00	Accumulated depreciation	-1, 447, 843		0	0	14. 00
15. 00	Bui I di ngs	235, 001, 573		0	0	15. 00
16.00	Accumulated depreciation	-40, 948, 485	0	0	0	16. 00
17. 00	Leasehold improvements	24, 962, 811	0	0	0	17. 00
18. 00	Accumulated depreciation	-7, 665, 606		0	0	18. 00
19. 00	Fixed equipment	10, 536, 332		0	0	19. 00
20.00	Accumulated depreciation	-3, 459, 474		0	0	20.00
21. 00	Automobiles and trucks	1, 461, 860		0	0	21. 00
22. 00	Accumulated depreciation	-999, 709		0	0	22. 00
23. 00 24. 00	Major movable equipment Accumulated depreciation	67, 616, 213 -48, 234, 042		0	0	23. 00 24. 00
25. 00	Mi nor equi pment depreci abl e	31, 067, 539		0	0	25. 00
26. 00	Accumulated depreciation	-23, 198, 819	•	0	0	26. 00
27. 00	HIT designated Assets	0	Ō	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	262, 112, 523	0	0	0	30. 00
	OTHER ASSETS					
31.00	Investments	0		0	0	
32. 00	Deposits on Leases	0		0	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	12 220 710	0	0	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	12, 320, 710 12, 320, 710		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	380, 414, 588		0	0	36.00
00.00	CURRENT LI ABILITIES	000, 111, 000		0		00.00
37. 00	Accounts payable	16, 595, 443	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	12, 049, 636	0	0	0	38. 00
39. 00	Payroll taxes payable	1, 382, 965	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	100, 000	0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41. 00
42. 00	Accel erated payments	0				42. 00
43.00	Due to other funds	-894, 743, 820		0	0	
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	6, 794, 138 -857, 821, 638	_	-	0	
43.00	LONG TERM LIABILITIES	-037, 021, 030	0	U	0	45.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	164, 723		0	0	
48. 00	Unsecured Loans	0	Ō	0	0	48. 00
49.00	Other long term liabilities	-618, 857	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-454, 134	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-858, 275, 772	0	0	0	51. 00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	1, 238, 690, 360				52. 00
53.00	Specific purpose fund		0	0		53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on				· ·	
59. 00	Total fund balances (sum of lines 52 thru 58)	1, 238, 690, 360	0	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	380, 414, 588	0	0	0	60. 00
	[59]	l	I			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150017

In Lieu of Form CMS-2552-10

					To 06/30/201	6 Date/Time Pre 11/30/2016 5:	
		Genera	I Fund	Speci al	Purpose Fund	Endowment Fund	25 piii
		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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0	l			0 0 0 0 0 0 0 0 0 0 0 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	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 sheet (line 11 minus line 18)	0 12 0 0 0 0	0 1, 238, 690, 372 1, 238, 690, 360		0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	Sheet (Trie Trimings Trie 10)	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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems LUSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150017

			10 06/30/2016	11/30/2016 5:3	
	Cost Center Description	I npati ent	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	101, 682, 99		101, 682, 990	1. 00
2.00	SUBPROVI DER - I PF		O	0	2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF)	0	5. 00
6. 00 7. 00	Swing bed - NF SKILLED NURSING FACILITY		O	U	6. 00
7. 00 8. 00	NURSING FACILITY				7. 00 8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	101, 682, 99	1	101, 682, 990	
10.00	Intensive Care Type Inpatient Hospital Services	101,002,77	<u> </u>	101,002,770	10.00
11. 00	INTENSIVE CARE UNIT		O	0	11. 00
11. 01	PEDIATRIC INTENSIVE CARE UNIT	4, 176, 08		4, 176, 088	
11. 02	NEONATAL INTENSIVE CARE UNIT	14, 255, 88		14, 255, 881	11. 02
11. 03	CARDIO INTENSIVE CARE UNIT	71, 991, 93		71, 991, 933	
12.00	CORONARY CARE UNIT	27, 943, 08		27, 943, 089	12. 00
13.00	BURN INTENSIVE CARE UNIT	, , , , , , , , , , , , , , , , , , , ,		,	13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	118, 366, 99	1	118, 366, 991	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	220, 049, 98		220, 049, 981	17.00
18. 00	Ancillary services	1, 263, 909, 32			18. 00
19. 00	Outpati ent servi ces	40, 544, 29			19. 00
20. 00	RURAL HEALTH CLINIC		0		20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES		7, 280, 243	7, 280, 243	
24. 00	CMHC				24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)	1 524 502 40	J 011 0E0 220	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst G-3, line 1)	. 1, 524, 503, 60	3 1, 011, 859, 330	2, 530, 302, 933	28. 00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		363, 702, 150		29. 00
30.00	ADD (SPECIFY)		000, 702, 100		30. 00
31. 00	(6. 26.1.1)	•	0		31. 00
32. 00			0		32. 00
33. 00			Ö		33. 00
34.00			O		34.00
35.00			o		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		O		37.00
38. 00			O		38. 00
39. 00			C		39. 00
40.00			O		40. 00
41. 00			O		41.00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	363, 702, 150		43. 00
	to Wkst. G-3, line 4)				

	Financial Systems LUTHERAN HOSPITAL			u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 150017	Peri od: From 07/01/2015	Worksheet G-3	
			To 06/30/2016	Date/Time Pre	pared:
				11/30/2016 5: 2	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	•		2, 536, 362, 933	1. 00
2.00	Less contractual allowances and discounts on patients' account	S		2, 029, 603, 866	2. 00
3.00	Net patient revenues (line 1 minus line 2)			506, 759, 067	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	3)		363, 702, 150	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			143, 056, 917	5. 00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8. 00					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	
12.00	Parking lot receipts				12.00
13.00	Revenue from laundry and linen service				13.00
	Revenue from meals sold to employees and guests				14.00
	Revenue from rental of living quarters				15. 00
	Revenue from sale of medical and surgical supplies to other th	an patrents			16. 00
	Revenue from sale of drugs to other than patients				17. 00
	Revenue from sale of medical records and abstracts				18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)				19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER REVENUE			4, 786, 582	
25. 00	Total other income (sum of lines 6-24)			4, 786, 582	
	Total (line 5 plus line 25)			147, 843, 499	
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)		ļ	147, 843, 499	29. 00

	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 150017	Peri od: From 07/01/2015 To 06/30/2016	Date/Time Pre	
		Title XVIII	Hospi tal	11/30/2016 5: 2 PPS	23 pm
		II the Aviii	Tiospi tai	FF3	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT			4 (24 210	1 00
1. 00 1. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			4, 634, 318 0	1
2.00	Capital DRG outlier payments			783, 218	
2.00	Model 4 BPCI Capital DRG outlier payments			703, 210	2. 00
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	269. 64	
4.00	Number of interns & residents (see instructions)	the stand have a feet a second		7. 52	
5.00	Indirect medical education percentage (see instructions)			0. 79	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	36, 611	6. 00
	1.01)(see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	, part A line	4. 15	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instru	ictions)		18. 71	8. 00
9.00	Sum of lines 7 and 8	ictions)		22. 86	
10.00	Allowable disproportionate share percentage (see instructions	:)		4. 74	
11. 00	Disproportionate share adjustment (see instructions)	3)		219, 667	
12. 00	Total prospective capital payments (see instructions)			5, 673, 814	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstanc	ces (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4. 00 5. 00	Applicable exception percentage (see instructions)			0. 00 0	
6.00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	petructions)		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary		line 6)	0.00	
8.00	Capital minimum payment level (line 5 plus line 7)	Circuiistances (iiile 2 x	. Title 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as appli	cable)		Ö	
10.00	Current year comparison of capital minimum payment level to c		less line 9)	0	
11. 00	Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)		,	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital pa	avments (line 10 nlus lin	e 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, enter			0	
14. 00	Carryover of accumulated capital minimum payment level over c		,	0	
	(if line 12 is negative, enter the amount on this line)		5 1		
15. 00	Current year allowable operating and capital payment (see ins	structions)		0	
16. 00	Current year allowable operating and capital payment (see ins	structions)		0	16. 00