PART II - CERTIFICATION

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN HOSPITAL OF INDIANA (15-0017) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)

Officer or Administrator of Provider(s)

SR VICE PRESIDENT-REVENUE MANAGEMENT

Title

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	1, 490, 252	76, 301	0	19, 731	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	1, 490, 252	76, 301	0	19, 731	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.

		In-State	In-State	Out-of	Out-of	Medicaid	Other	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the	2, 941	997	73	208	14, 761	176	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.							
25.00	If this provider is an IRF, enter the in-state	0	0	o	0	0		25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							

car tir i			L OF INDIANA			n Lie	u of For		
OSPI TA	L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC		eriod: rom 07/01/ o 06/30/		Date/Ti	me Prep	oared
					Urban/Rur	al S	11/30/2 Date of		38 pm
/ OO F	The your standard assurable alocal floation (not up	.aa) ata	tuo ot the bee	ainning of the	1. 00		2.0		26. (
7. 00 E	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural. ige) sta	tus at the end	d of the cost		1			27.
e	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi f this is a sole community hospital (SCH), enter the	cation i	in column 2.			C			35. (
	effect in the cost reporting period.		<u> </u>		Begi nni	na.	Endi	na	
					1. 00		2. 0		
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		ubscript line	36 for number					36.
7. 00 I i	f this is a Medicare dependent hospital (MDH), enters in effect in the cost reporting period.	the nur	•			C)		37.
a	s this hospital a former MDH that is eligible for thaccordance with FY 2016 OPPS final rule? Enter "Y" fornstructions)				N				37.
8. 00 9	fline 37 is 1, enter the beginning and ending dates preater than 1, subscript this line for the number of enter subsequent dates.								38.
ļc	sitter subsequent dates.				Y/N		Υ/		
9.00 [Ooes this facility qualify for the inpatient hospital	pavmen	t adjustment 1	for low volume	1. 00 N		2. C		39.
h f w	nospitals in accordance with 42 CFR §412.101(b)(2)(i) For yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column	or (ii))? Enter in co quirements in	olumn 1 "Y" accordance					
). 00 I	nstructions) s this hospital subject to the HAC program reduction N" for no in column 1, for discharges prior to Octob	er 1. Ei	nter "Y" for y		Y		Y		40
lr	no in column 2, for discharges on or after October 1.	(see ii	nstructions)			V 1.00	XVIII 0 2.00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	ıt for di	i sproporti opat	te share in acc	ordance	N	Y	N	45
s. 00 I	with 42 CFR Section §412.320? (see instructions) s this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption fo	or extraordina	ary circumstanc	es	N	N	N	46
F I 00 .'	ot. III. s this a new hospital under 42 CFR §412.300(b) PPS o s the facility electing full federal capital payment	api tal ?	Enter "Y for	r yes or "N" fo	or no.	N N	N N	N N	47 48
T	Teaching Hospitals s this a hospital involved in training residents in					Y			56
. 00 I	or "N" for no. f line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for	yes or	"N" for no ir	n column 1. If	column 1	N			57
f	s "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y N", complete Wkst. D, Parts III & IV and D-2, Pt. II	", compl	lete Worksheet						
3. 00 I	f line 56 is yes, did this facility elect cost reimb lefined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemen	t for physicia	ans' services a	ıs	N			58
	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I. NAHE 413.85	Workshee	N N	Pass-Th	may ab	59
				Y/N	Li ne		Qualifi Criterio	cation	
				1. 00	2. 00)	3.0	00	
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (Y					60
. 01 i	fline 60 is yes, complete columns 2 and 3 for each nstructions)	program.	. (see			23. 00	1		60
	fline 60 is yes, complete columns 2 and 3 for each nstructions)			Direct CHE		23. 01			60
		Y/N	I ME	Direct GME	IME		Di rect		
. 00 [oid your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	0.00	5.0	0. 00	61
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)								61
. 01 E	Enter the average number of unweighted primary care								
1. 01 E									

61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	Y/N 1.00	IME 2.00	Direct GME 3.00 Program Code	I ME 4.00 Unwei ghted I ME FTE Count	11/30/2018 3: Direct GME 5.00	
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary	1.00	2.00	3.00 Program Code	4.00	5.00	61. 0
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary		gram Name	Program Code	e Unweighted IME	E Unwei ghted	61. 0
and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary	Pro					61. 0
surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary	Pro					61. 0
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary	Pro					
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary	Prog					61. 0
	Pro					
Table		1.00			Count	
61.10 Of the FTEs in line 61.05, specify each new program			2. 00	3.00	4. 00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0. 00	61. 2
					1. 00	
ACA Provisions Affecting the Health Resources and Serv					0.00	
62.00 Enter the number of FTE residents that your hospital tyour hospital received HRSA PCRE funding (see instruct 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progr	tions) Teachir am. (se	ng Health Cen ee instructio	ter (THC) into			62. 0
Teaching Hospitals that Claim Residents in Nonprovider 63.00 Has your facility trained residents in nonprovider set			ost reporting	neriod? Enter	N	63.0
"Y" for yes or "N" for no in column 1. If yes, complet			67. (see inst	ructions)		
			Unwei ghted FTEs Nonprovi der	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	·		
Section 5504 of the ACA Base Year FTE Residents in Nor	anrovi d	or Sottings	1. 00	2.00	3.00	
period that begins on or after July 1, 2009 and before	e June :	30, 2010.				
64.00 Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted non-resident FTEs attributable to rotations occurring in a settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see i	primary all nong non-pri column	y care provider imary care 3 the ratio	0. (0. 00	0. 000000	64.0
Program Name		gram Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	

1.00

Unweighted FTEs Nonprovider Site

3. 00

2.00

Unweighted FTEs in Hospital

4.00

Ratio (col. 3/ (col. 3 + col. 4))

5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0017 Peri od: Worksheet S-2 From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/30/2018 3:38 pm Program Code Unwei ghted Unwei ghted 3/ Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0	Peri od: From 07/01/20 To 06/30/20		repare
		1.00	
Long Term Care Hospital PPS Oo Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost representation. "Y" for yes and "N" for no. TEFRA Providers	porting period? Ente	N N	80. 81.
On Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.). N	85. 86.
00 Is this hospital an extended neoplastic disease care hospital classified under so 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ecti on	N	87.
	V 1. 00	XI X 2. 00	
Title V and XIX Services			
00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" yes or "N" for no in the applicable column.	" for N	Y	90.
00 Is this hospital reimbursed for title V and/or XIX through the cost report either full or in part? Enter "Y" for yes or "N" for no in the applicable column.	rin N	Y	91
00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see	N	92
instructions) Enter "Y" for yes or "N" for no in the applicable column. OD Does this facility operate an ICF/IID facility for purposes of title V and XIX? I	Enter N	N	93
"Y" for yes or "N" for no in the applicable column.			
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	94
00 If line 94 is "Y", enter the reduction percentage in the applicable column. 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	e 0.00 N	0. 00 N	95
00 If line 96 is "Y", enter the reduction percentage in the applicable column. 00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents processed stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no column 1 for title V, and in column 2 for title XIX.	0. 00 Y	97 98	
O1 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column	n Wkst. N 2 for	Y	98
title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column for title VIX.		Y	98
for title V, and in column 2 for title XIX. 3 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in coffor title V, and in column 2 for title XIX.		N	98
Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V in column 2 for title XIX.	V, and	N	98
05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowal Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, column 2 for title XIX.		Y	98
O6 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and i column 2 for title XIX.	D, N i n	Y	98
Rural Providers 5.00 Does this hospital qualify as a CAH?	N		105
.00 This facility qualifies as a CAH, has it elected the all-inclusive method of productions for outpatient services? (see instructions)	payment		106
training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is	s) If		107
reimbursed. If yes complete Wkst. D-2, Pt. II. 8.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule?	See 42 N		108
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Dani' matam	
	ational Speech . 00 3.00	Respiratory 4.00	У
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109
	· · · · · · · · · · · · · · · · · · ·	1.00	
0.00Did this hospital participate in the Rural Community Hospital Demonstration proje	oct (8/10/	1.00 N	110

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 15-0017	Peri od:	1	Worksheet S	S-2552- -2
		From 07/01/2 To 06/30/2	2017 F 2018 E	Part I Date/Time P 11/30/2018	repare
		1. 00		2. 00	
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating i Enter all that apply: "A" for Ambulance services; "B" for additional bed for tele-health services.	period? Enter enter the n column 2.	N		2.00	111.
			1. 00	2.00 3.0	10
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no is yes, enter the method used (A, B, or E only) in column 2. If column 2 a either "93" percent for short term hospital or "98" percent for long to psychiatric, rehabilitation and long term hospitals providers) based on Pub. 15-1, chapter 22, §2208.1.	is "E", enter erm care (incl the definitior	in column udes	N	0	
16.00 s this facility classified as a referral center? Enter "Y" for yes or " 17.00 s this facility legally-required to carry malpractice insurance? Enter no.		"N" for	N N		116. 117.
18.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy	is	1		118.
erariii iliaac. Enter 2 11 the porrey 13 decarrence.	Premi ums	Losses		Insurance	
	1. 00	2.00		3.00	
18.01 List amounts of malpractice premiums and paid losses:	214, 5	37 423	, 630		0 118.
		1. 00		2. 00	
Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pr §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see ins	cost centers ovision in ACA Y" for yes or the Outpatient			N	118. 119. 120.
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devic	es charged to	Υ			121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §190 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ent the Worksheet A line number where these taxes are included.					122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N	" for no If	Υ			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the cert		11/05/20	08		126.
in column 1 and termination date, if applicable, in column 2. 7.00 f this is a Medicare certified heart transplant center, enter the certified heart transplant center, enter the certified heart transplant in column 2.	fication date	02/16/19	90		127.
in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certiin column 1 and termination date, if applicable, in column 2.	fication date				128.
9.00 If this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.	ication date i	n			129.
0.00 If this is a Medicare certified pancreas transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.					130
1.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2. 2.00 If this is a Medicare certified islet transplant center, enter the certi					131
2.00 this is a Medicare certified islet transplant center, enter the certific of the column 1 and termination date, if applicable, in column 2. 3.00 f this is a Medicare certified other transplant center, enter the certified other transplant center.					133
in column 1 and termination date, if applicable, in column 2. 4.00 If this is an organ procurement organization (0P0), enter the 0P0 number					134.
and termination date, if applicable, in column 2. All Providers					
40.00 Are there any related organization or home office costs as defined in CM chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and hom		Y		449008	140.

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act		
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		N	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the		0168. 00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	a hardshi p		168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions)	0.0	0169. 00	
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	(171. 00

County

1.00

State Zip Code

3.00

2.00

CBSA

4.00

FTE/Campus

5.00

0.00 166.00

Name

0

Enter "Y" for yes or "N" for no.

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)

166.00 If line 165 is yes, for each

	Financial Systems LUTHERAN HOSPIT				u of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Pro 11/30/2018 3:	epared:
		<u> </u>		Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Openiant on and Openian	l for all NO re	sponses. Ente	er all dates in t	he	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e heainnina of	the cost	N		1.00
00	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)			
			Y/N	Date	V/I	
	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.	mn 3, "V" for	N			2. 00
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3. 00
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
4 00	Financial Data and Reports		T			4
4.00	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 avacclumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	N 			4. 00
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	e provider is	s N		6. 00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.					7. 00
8. 00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.					8. 00
9. 00	Are costs claimed for Interns and Residents in an approved graduate medical education Y					9. 00
10. 00	program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current N					10.00
11. 00	cost reporting period? If yes, see instructions. 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	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s soo instruct	Long		Υ	12. 00
12. 00 13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst		Y t B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Y	09/04/2018	Y	09/04/2018	16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 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 HOSPIT. L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0017	Peri od:	u of Form CMS- Worksheet S-2		
HOSFI IA	E AND HOSFITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Frovider C	UN. 15-0017	From 07/01/2017 To 06/30/2018	Part II Date/Time Pro 11/30/2018 3:	epared:	
		Descr	ipti on	Y/N	Y/N	J 50	
)	1. 00	3. 00		
	f 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		
	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
C	OMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)		1.00		
C	apital Related Cost		ĺ				
	Have assets been relifed for Medicare purposes? If yes, see					22. 00	
	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost		23. 00	
24. 00	Were new leases and/or amendments to existing leases entere f yes, see instructions	ed into during	this cost re	eporting period?		24. 00	
25. 00 I	Have there been new capitalized leases entered into during	the cost repor	ting period?	Plf yes, see		25. 00	
	instructions.) Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see						
	were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ie cost reporti	ng perioa? I	ı yes, see		26.00	
	has the provider's capitalization policy changed during the copy.	cost reportir	g period? If	yes, submit		27. 00	
	nterest Expense						
28. 00	Vere new Loans, mortgage agreements or Letters of credit en	ntered into dur	ing the cost	reporting		28. 00	
	period? If yes, see instructions. 						
-	treated as a funded depreciation account? If yes, see instructions						
31. 00 I	nstructions. Has debt been recalled before scheduled maturity without is nstructions.	suance of new	debt? If yes	s, see		31.00	
F	urchased Services	nd ood Europi oba	d through or	entroctual		32.00	
	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		a tili ougii ce	JIIII actual		32.00	
33. 00	fline 32 is yes, were the requirements of Sec. 2135.2 app		g to competi	tive bidding? If		33. 0	
	no, see instructions.					-	
	rovider-Based Physicians Are services furnished at the provider facility under an ar	rangement with	provi der-ba	sed physicians?		34.00	
	f yes, see instructions.	· ·	•	. ,			
	fline 34 is yes, were there new agreements or amended exichysicians during the cost reporting period? If yes, see in		its with the	provi der-based		35. 00	
				Y/N	Date		
L	ome Office Costs			1.00	2. 00		
	Were home office costs claimed on the cost report?			Y		36.00	
	fline 36 is yes, has a home office cost statement been pr	epared by the	home office?			37. 00	
	f yes, see instructions. f line 36 is yes , was the fiscal year end of the home off	ice different	from that of	- Y	12/31/2016	38. 00	
	the provider? If yes, enter in column 2 the fiscal year end fline 36 is yes, did the provider render services to othe			s, Y		39. 00	
1	see instructions. fline 36 is yes, did the provider render services to the	home office?	If ves see	N		40.00	
I	nstructions.					1.5.50	
		1.	00	2.	00		
C	ost Report Preparer Contact Information			2.			
	neld by the cost report preparer in columns 1, 2, and 3,	KUZI WA		TSI GA		41.00	
42. 00 I		CHS				42. 00	
	preparer. Enter the telephone number and email address of the cost	615-465-3416		KUZI WA_TSI GA@CI	IS NET	43.00	
	report preparer in columns 1 and 2, respectively.	013-403-3410		NOZI WA_I SI GA@CI	IJ. IVL I	43.00	

Health Financial Systems LUTHERAN HOS	PITAL OF INDIANA	In Lie	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/30/2018 3:38 pm
	3. 00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	MANAGER		41. 00
held by the cost report preparer in columns 1, 2, and 3,			
respecti vel y.			
42.00 Enter the employer/company name of the cost report			42. 00
preparer.			
43.00 Enter the telephone number and email address of the cost			43.00
report preparer in columns 1 and 2, respectively.			

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0017

				T	06/30/2018	Date/Time Prep 11/30/2018 3:3	
						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	254	92, 710	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4. 00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		05.4	00 740	0.00	0	6. 00
7. 00	Total Adults and Peds. (exclude observation		254	92, 710	0. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00	0	0	0.00	o	8. 00
8. 00 8. 01			10	_			8. 00 8. 01
	PEDIATRIC INTENSIVE CARE UNIT	31. 01					8. 01
8. 02 8. 03	NEONATAL INTENSIVE CARE UNIT	31. 02 31. 03	24 84				8. 02 8. 03
9. 00	CARDIO INTENSIVE CARE UNIT	31.03	24				9. 00
10. 00	BURN INTENSIVE CARE UNIT	32.00	24	0, 700	0.00	١	10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)	43.00	396	144, 540	0.00		14. 00
15. 00	CAH visits		070	111,010	0.00	Ö	15. 00
16. 00	SUBPROVI DER - I PF	40. 00	0	0		o l	16. 00
17. 00	SUBPROVI DER – I RF	10.00	, , , , , , , , , , , , , , , , , , ,	Ĭ		Ĭ	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	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		396				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
00.00	outpatient days (see instructions)						00.00
33. 00	LTCH non-covered days						33. 00
33. UI	LTCH site neutral days and discharges			I			33. 01

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0017

				Т	o 06/30/2018	Date/Time Pre 11/30/2018 3:	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	oo piii
	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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	20, 658	1, 427	61, 712			1. 00
2. 00 3. 00	for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	20, 326	16, 745 0				2. 00 3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	20, 658	0 1, 427	0 61, 712			6. 00 7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0	0			8. 00
8. 01	PEDIATRIC INTENSIVE CARE UNIT	2	87	535			8. 01
8. 02	NEONATAL INTENSIVE CARE UNIT	7 050	128	4, 271			8. 02
8. 03 9. 00	CARDIO INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 858 2, 635	430 138	21, 115 6, 230			8. 03 9. 00
10.00	BURN INTENSIVE CARE UNIT	2,033	130	0, 230			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		25	1, 644			13. 00
14. 00	Total (see instructions)	31, 153	2, 235	95, 507	23. 58	2, 128. 92	ı
15. 00	CAH visits	01,100	2, 200	70, 007	20.00	2, 120. 72	15.00
16. 00	SUBPROVIDER - I PF	o	0	0	0.00	0.00	
17. 00	SUBPROVI DER - I RF			·			17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0. 00	l
27. 00	Total (sum of lines 14-26)		_		23. 58	2, 128. 92	1
28. 00	Observation Bed Days	_	0	562			28. 00
29. 00	Ambul ance Tri ps	O		4 000			29. 00
30.00	Employee discount days (see instruction)			1, 820			30.00
31.00	Employee discount days - IRF		47/	0			31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	176	360 0			32. 00 32. 01
32. UI	outpatient days (see instructions)			0			32.01
33. 00	LTCH non-covered days	0					33. 00
	LTCH site neutral days and discharges	Ö					33. 01

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0017

				To	06/30/2018	Date/Time Prep 11/30/2018 3:3	
		Full Time		Di scha	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	40.00	11.00	Pati ents	
1 00	Harrital Adulta & Dada (calumna E. (7 and	11. 00	12.00	13.00	14.00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	5, 667	3, 375	20, 097	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			3, 369	o		2. 00
3.00	HMO IPF Subprovider				ol		3. 00
4.00	HMO IRF Subprovider				o		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
8. 01	PEDIATRIC INTENSIVE CARE UNIT						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
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			•			11. 00 12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	5, 667	3, 375	20, 097	14. 00
15. 00	CAH visits	0.00	O	0,007	0, 070	20,077	15. 00
16. 00	SUBPROVIDER - IPF	0. 00	0	o	ol	0	16. 00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC			•			24. 10 25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					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
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| Period: | Worksheet S-3 | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0017

					To	06/30/2018		
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	,		11/30/2018 3:3 Average Hourly Wage (col. 4 ÷	38 pili
			nopol tou	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200. 00	130, 028, 818	0	130, 028, 818	4, 411, 507. 00	29. 47	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
	В		0	_				
4. 00	Physician-Part A - Administrative		Ü	0	0	0. 00		4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	_	0. 00 0. 00		4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for		0	0	0	0.00		6. 00
0.00	hospital-based RHC and FQHC		U		0	0.00	0.00	0.00
7. 00	services Interns & residents (in an	21. 00	2, 620	О	2, 620	122. 00	21. 48	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0.00	0.00	7. 01
7.01	residents (in an approved		O			0.00	0.00	7.01
8. 00	programs) Home office and/or related		0	О	0	0.00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	0	0	0	0.00	0. 00	9. 00
10. 00	Excluded area salaries (see	55	2, 992, 212	568, 491	3, 560, 703			
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		13, 402, 063	0	13, 402, 063	212, 153. 00	63. 17	11. 00
12. 00	Contract Labor: Top Level management and other		283, 166	0	283, 166	4, 406. 00	64. 27	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		579, 258	О	579, 258	6, 485. 00	89. 32	13. 00
14. 00	A - Administrative Home office and/or related		0	0	0	0.00	0.00	14. 00
	organization salaries and		_	_			3.33	
14. 01	wage-related costs Home office salaries		13, 608, 297	0	13, 608, 297	450, 474. 00	30. 21	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
	- Administrative		O					
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 00
17 00	WAGE-RELATED COSTS Wage-related costs (core) (see		29, 112, 383	0	29, 112, 383			17. 00
17.00	instructions)		24, 112, 303		24, 112, 303			17.00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		760, 996	0	760, 996			19. 00 20. 00
	A		U		0			
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23. 00 24. 00
25. 00	Interns & residents (in an		421	Ö	421			25. 00
25. 50	approved program) Home office wage-related		2, 642, 310	О	2, 642, 310			25. 50
25. 51	(core) Related organization		n	0	0			25. 51
	wage-related (core)		^					
25. 52	Home office: Physician Part A - Administrative -		O	0	0			25. 52
25. 53	wage-related (core) Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	600, 706 13, 307, 902			•		26. 00 27. 00
			., ,	., .,		. , , , , , , , , ,	,	

| Peri od: | Worksheet S-3 | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: | Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0017

					''	0 00/30/2010	11/30/2018 3:	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	1, 940, 114	0	1, 940, 114			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32. 00	Housekeepi ng	9. 00	1, 531, 401	0	1, 531, 401	109, 750. 00	13. 95	
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	0	0	0	1, 681. 65	0. 00	34.00
35.00	Dietary under contract (see		2, 363, 115	121, 123	2, 484, 238	249, 712. 12	9. 95	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	0	0	3, 345. 35		36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00	Nursing Administration	13. 00	7, 538, 709	-3, 840, 010	3, 698, 699	125, 373. 00	29. 50	38. 00
39. 00	Central Services and Supply	14. 00	1, 932, 301	380, 120	2, 312, 421	132, 382. 00	17. 47	39. 00
40.00	Pharmacy	15. 00	6, 871, 970	0	6, 871, 970	163, 865. 00	41. 94	40.00
41.00	Medical Records & Medical	16. 00	1, 367, 973	940, 122	2, 308, 095	89, 852. 00	25. 69	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	2, 521, 107	2, 521, 107	72, 034. 00	35. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 15-0017 Peri od: From 07/01/2017 To 06/30/2018 11/30/2018 3:38 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. (from Salaries in col . 5) 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 132, 389, 313 121, 123 132, 510, 436 4, 661, 097. 12 28. 43 1.00 instructions) 2.00 Excluded area salaries (see 2, 992, 212 568, 491 3, 560, 703 131, 135. 00 27. 15 2.00 instructions) 3.00 Subtotal salaries (line 1 129, 397, 101 -447, 368 128, 949, 733 4, 529, 962. 12 28.47 3.00

27, 872, 784

31, 754, 693

188, 577, 210

37, 575, 314

C

-447, 368

121, 123

673, 518. 00

5, 203, 480. 12

1, 548, 042. 12

0.00

41. 38

24.63

36. 24

24. 27

4.00

5.00

6.00

7.00

27, 872, 784

31, 754, 693

189, 024, 578

37, 454, 191

minus line 2)

(see inst.)

instructions)

costs (see inst.)

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

4.00

5.00

6.00

7.00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0017	Period: Worksheet S-3 From 07/01/2017 Part IV

	To 06/30/2018	Date/Time Prep 11/30/2018 3:3	pared: 38 pm
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		l
	RETI REMENT COST		l
1.00	401K Employer Contributions	2, 539, 630	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)		l
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		l
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	16, 763, 192	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	108, 169	
11. 00	Life Insurance (If employee is owner or beneficiary)	120, 890	
12.00	Accident Insurance (If employee is owner or beneficiary)	6, 521	12. 00
	Disability Insurance (If employee is owner or beneficiary)	46, 876	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	889, 752	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)		l
	TAXES		
	FICA-Employers Portion Only	7, 549, 574	
	Medicare Taxes - Employers Portion Only	1, 765, 626	
	Unemployment Insurance	0	19. 00
20. 00	State or Federal Unemployment Taxes	391, 200	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	-153, 861	23. 00
	Total Wage Related cost (Sum of Lines 1 -23)	30, 027, 569	
	Part B - Other than Core Related Cost		l
25. 00	OTHER EMPLOYEE BENEFITS	0	25. 00

Heal th	Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu of Form CMS-2552-10		
HOSPI 1	TAL CONTRACT LABOR AND BENEFIT COST		Period: From 07/01/2017 To 06/30/2018		
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ident	ti fi cati on:			
1.00	Total facility's contract labor and benefi	t cost	13, 402, 063	30, 027, 750	1.00
2.00	Hospi tal		13, 402, 063	30, 027, 750	2.00
3.00	Subprovi der - IPF		0	0	3.00
4.00	Subprovi der - IRF				4.00
5.00	Subprovider - (Other)		0	ol	5.00
6.00	Swing Beds - SNF		0	ol	6.00
7.00	Swing Beds - NF		0	ol	7.00
0 00	LI LE LONE				

8.00

9.00 10.00 11.00

12.00

13.00 14. 00 15.00 16.00 0 17. 00 0 18. 00

Hospi tal -Based SNF

12.00 Separately Certified ASC

12.00 | Separately Certified ASC 13.00 | Hospital - Based Hospice 14.00 | Hospital - Based Health Clinic RHC 15.00 | Hospital - Based Health Clinic FQHC 16.00 | Hospital - Based - CMHC 17.00 | Renal Dialysis 18.00 | Other

9. 00 Hospi tal -Based NF 10. 00 Hospi tal -Based NF 11. 00 Hospi tal -Based HHA

8.00

	Financial Systems LUTHERAN HOSPITAL OF IND	I ANA	In Lie	eu of Form CMS-2	2552-10						
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 15-0017	Peri od:	Worksheet S-10	0						
			From 07/01/2017 To 06/30/2018	Date/Time Pre	nared:						
			10 00/30/2018	11/30/2018 3:							
				1. 00							
	Uncompensated and indigent care cost computation										
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 colum	n 8)	0. 144351	1. 00						
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			61, 955, 286	2. 00						
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Y	3. 00						
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental pa	ayments from Medic	ai d?	Y	4. 00						
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Me	edi cai d		0	5. 00						
6.00	Medi cai d charges 424, 687,										
7. 00	Medicaid cost (line 1 times line 6) 61,304,000										
8. 00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 0 8.0 < zero then enter zero)										
	Children's Health Insurance Program (CHIP) (see instructions for each line)										
9.00	Net revenue from stand-alone CHIP	,		0	9. 00						
10.00	Stand-al one CHIP charges										
11. 00	Stand-alone CHIP cost (line 1 times line 10)				11. 00						
12. 00	Difference between net revenue and costs for stand-alone CHIP (line enter zero)	11 minus line 9;	if < zero then	0	12. 00						
	Other state or local government indigent care program (see instructi	ons for each line)	L							
13.00	Net revenue from state or local indigent care program (Not included			272, 611	13. 00						
14.00	Charges for patients covered under state or local indigent care prog	gram (Not included	in lines 6 or	3, 354, 058	14. 00						
	10)										
15.00	State or local indigent care program cost (line 1 times line 14)	Z1.1	45 ' ''	484, 162							
16. 00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 211, 551 16 13; if < zero then enter zero)										
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see										
47.00	instructions for each line)										
17. 00 18. 00		,		0 Private grants, donations, or endowment income restricted to funding charity care							
19. 00											
	8, 12 and 16)		s (sum of lines	0 211, 551	17. 00 18. 00 19. 00						
		gent care program Uni nsured	Insured	211, 551 Total (col. 1	18. 00						
		gent care program Uni nsured patients	I nsured pati ents	211, 551 Total (col. 1 + col. 2)	18. 00						
	8, 12 and 16)	gent care program Uni nsured	Insured	211, 551 Total (col. 1	18. 00						
20. 00		gent care program Uni nsured pati ents 1.00	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00	18. 00 19. 00						
	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions)	Uni nsured	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998	18. 00 19. 00 20. 00						
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (Uni nsured	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998	18. 00 19. 00 20. 00						
21. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions)	Uni nsured pati ents 1.00 38,782,9 (see 5,598,3	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365	18. 00 19. 00 20. 00 21. 00						
	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a	Uni nsured pati ents 1.00 38,782,9 (see 5,598,3	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365	18. 00 19. 00 20. 00 21. 00						
21. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions)	Uni nsured pati ents 1.00 38,782,9 (see 5,598,3	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924	18. 00 19. 00 20. 00 21. 00 22. 00						
21. 00 22. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care	Uni nsured	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441	18. 00 19. 00 20. 00 21. 00 22. 00						
21. 00 22. 00 23. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)	Uni nsured	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00						
21. 00 22. 00 23. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day	Uni nsured	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441	18. 00 19. 00 20. 00 21. 00 22. 00						
21. 00 22. 00 23. 00 24. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prografiline 24 is yes, enter the charges for patient days beyond the incompanion of the charges for patient days beyond the incompani	Uni nsured	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3. 00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441 1. 00 N	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00						
21. 00 22. 00 23. 00 24. 00 25. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the incostay limit	Uni nsured	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441 1.00 N 0	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00						
21. 00 22. 00 23. 00 24. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prografiline 24 is yes, enter the charges for patient days beyond the incompanion of the charges for patient days beyond the incompani	Uni nsured pati ents 1.00 7 38, 782, 9 (see 5, 598, 3 1, 984, 9 3, 613, 4 7 beyond a Length ram? di gent care progrations)	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3. 00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441 1. 00 N	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00						
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the incostay limit Total bad debt expense for the entire hospital complex (see instructions)	Uni nsured pati ents 1.00 7 38, 782, 9 (see 5, 598, 3 1, 984, 9 3, 613, 4 7 beyond a length ram? di gent care progrations) e instructions)	Insured patients 2.00	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441 1.00 N 0 17, 980, 535	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00						
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prografiline 24 is yes, enter the charges for patient days beyond the incomposition of the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions)	Uni nsured pati ents 1.00 / 38,782,9 (see 5,598,3 1,984,9 3,613,4 // s beyond a length am? di gent care progrations) e i instructions) estructions)	Insured patients 2.00 98 065 041 0 of stay limit m's length of	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441 1.00 N 0 17, 980, 535 784, 694 1, 207, 222 16, 773, 313	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00						
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 01 28. 00 29. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prografiline 24 is yes, enter the charges for patient days beyond the incomposed in the composed of the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	Uni nsured pati ents 1.00 / 38,782,9 (see 5,598,3 1,984,9 3,613,4 // s beyond a length am? di gent care progrations) e i instructions) estructions)	Insured patients 2.00 98 065 041 0 of stay limit m's length of	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441 1.00 N 0 17, 980, 535 784, 694 1, 207, 222 16, 773, 313 2, 843, 773	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00 29. 00						
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prografiline 24 is yes, enter the charges for patient days beyond the incomposition of the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions)	Uni nsured pati ents 1.00 (see 5,598,3 3,613,4 (sbeyond a length am? digent care progrations) e instructions (see instructions)	Insured patients 2.00 98 065 041 0 of stay limit m's length of	211, 551 Total (col. 1 + col. 2) 3.00 38, 782, 998 5, 598, 365 1, 984, 924 3, 613, 441 1.00 N 0 17, 980, 535 784, 694 1, 207, 222 16, 773, 313	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00 29. 00 30. 00						

Heal th	Financial Systems	LUTHERAN HOSPITAL	OF INDIANA		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	CN: 15-0017 F	Peri od:	Worksheet A	
					From 07/01/2017 To 06/30/2018	Date/Time Pre 11/30/2018 3:	pared:
	Cost Center Description	Sal ari es	Other		Reclassi fi cati	Recl assi fi ed	36 piii
				+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
	OFNEDAL CEDIUSE COCT OFNEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		7, 605, 134	7, 605, 134	5, 176, 387	12, 781, 521	1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT		12, 975, 337	12, 975, 337		19, 475, 433	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	600, 706	1, 091, 903	1, 692, 609		21, 742, 593	4. 00
5. 01	00540 ADMITTING	5, 586, 686	6, 285, 950	11, 872, 636		11, 578, 351	5. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	7, 721, 216	85, 249, 579	92, 970, 795	-26, 726, 498	66, 244, 297	5. 02
7.00	00700 OPERATION OF PLANT	1, 940, 114	11, 646, 169	13, 586, 283	-7, 516	13, 578, 767	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 755, 373	1, 755, 373		1, 755, 373	8. 00
9.00	00900 HOUSEKEEPI NG	1, 531, 401	1, 329, 305	2, 860, 706		2, 856, 206	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	7, 012, 052	7, 012, 052 (2, 343, 856	
13.00	01300 NURSING ADMINISTRATION	7, 538, 709	2, 246, 742	9, 785, 451		4, 662, 681 4, 301, 943	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	1, 932, 301	54, 371, 318	56, 303, 619		8, 751, 028	1
15. 00	01500 PHARMACY	6, 871, 970	32, 840, 229	39, 712, 199		7, 790, 872	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 367, 973	3, 418, 999	4, 786, 972	1, 374, 662	6, 161, 634	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	(-,,,	3, 330, 814	1
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	2, 620	3, 285, 053	3, 287, 673		2, 536	1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	100 000	204.044	205.046	3, 285, 137	3, 285, 137	
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PHARMACY RESIDENCY PROGRAM	190, 883 179, 106	204, 966 26, 413	395, 849 205, 519		394, 717 205, 519	1
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	177, 100	20, 413	203, 31	<u>/ </u>	203, 317	23.01
30. 00	03000 ADULTS & PEDI ATRI CS	20, 998, 192	13, 188, 608	34, 186, 800	-2, 192, 308	31, 994, 492	30.00
31.00	03100 INTENSIVE CARE UNIT	17, 012, 705	8, 189, 576	25, 202, 281		0	31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 661, 925	715, 741	3, 377, 666	-2, 394, 748	982, 918	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	0	0	(3, 377, 666	3, 377, 666	1
31. 03	03101 CARDIO INTENSIVE CARE UNIT	0	0	(18, 378, 369	18, 378, 369	
32. 00 40. 00	03200 CORONARY CARE UNIT 04000 SUBPROVIDER - IPF	0	0	(5, 839, 556	5, 839, 556 0	32. 00 40. 00
43. 00	04300 NURSERY	0	75, 614	75, 614	296, 034	371, 648	1
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	73,014	75, 01-	270,034	371,040	1 43.00
50.00	05000 OPERATI NG ROOM	11, 621, 915	15, 256, 933	26, 878, 848	-5, 386, 668	21, 492, 180	50.00
51.00	05100 RECOVERY ROOM	2, 201, 321	588, 059	2, 789, 380		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	6, 879	6, 879		1, 876, 929	
53.00	05300 ANESTHESI OLOGY	88, 877	4, 300, 022	4, 388, 899		4, 388, 899	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 PET SCAN	5, 479, 942 900, 681	3, 325, 588 143, 728	8, 805, 530 1, 044, 409		9, 023, 426 28, 894	
56. 00	05600 RADI OI SOTOPE	536, 558	1, 749, 962	2, 286, 520		316, 904	
57. 00	05700 CT SCAN	1, 135, 731	512, 455	1, 648, 186		1, 636, 641	1
58.00	05800 MRI	472, 466	112, 330	584, 796	-582, 906	1, 890	58. 00
60.00	06000 LABORATORY	5, 021, 925	11, 697, 639	16, 719, 564		16, 337, 749	
65.00	06500 RESPI RATORY THERAPY	4, 819, 086	1, 142, 187	5, 961, 273		5, 879, 837	
66.00	06600 PHYSI CAL THERAPY	2, 436, 631	560, 376			5, 164, 099	
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	1, 456, 915 893, 580	122, 890 106, 134	1, 579, 805 999, 714		43, 580 70, 064	
69. 00	06900 ELECTROCARDI OLOGY	5, 236, 199	4, 078, 464	9, 314, 663		3, 062, 704	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0,200,177	0	7, 01 1, 000	2, 060, 744	2, 060, 744	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	О	(7, 388, 102	7, 388, 102	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(41, 016, 246	41, 016, 246	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(31, 261, 687	31, 261, 687	73.00
74.00	07400 RENAL DI ALYSI S	147	3, 027, 520	3, 027, 667		3, 027, 667	1
76. 00 76. 01	03140 CARDI O CATH LAB 03050 ENDOSCOPY	538, 644	138, 534	677, 178	4, 101, 835 4, 993, 244	4, 101, 835 5, 670, 422	
76. 02	03950 CARDI AC REHAB	75, 272	5, 454	80, 726		647, 886	76. 02
70.02	OUTPATIENT SERVICE COST CENTERS	70/2/2	57 15 1	00,720	,	3177 333	70.02
90.00	09000 CLI NI C	2, 516, 501	949, 256	3, 465, 757		4, 500, 360	90.00
91. 00	09100 EMERGENCY	5, 837, 697	6, 794, 472	12, 632, 169	-160, 653	12, 471, 516	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	2, 570, 135	9, 671, 039	12, 241, 174	-115, 498	12, 125, 676	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2,570,135	1, 457, 392	1, 457, 392		1, 433, 344	
70.00	SPECIAL PURPOSE COST CENTERS	9	1, 107, 072	1, 107, 072	21,010	1, 100, 011	70.00
105.00	10500 KIDNEY ACQUISITION	0	0	(1, 493, 041	1, 493, 041	105. 00
	10600 HEART ACQUISITION	0	0	(592, 925	
118.00		129, 976, 730	319, 261, 374	449, 238, 104	65, 070	449, 303, 174	118.00
100.00	NONREI MBURSABLE COST CENTERS	7		,		^	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	3, 228	429, 403	432, 631	0 -65, 070	0 367, 561	190.00
	07950 CLOSED PSYCH UNIT	3, 220	427, 403 N	432, US) -00,070		194. 00
	07951 MARKETI NG	l ő	ől	(ol ől		194. 01
	07952 SENI OR CI RCLE	48, 860	23, 390	72, 250	ol ol		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	o	(이		194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	130, 028, 818	319, 714, 167	449, 742, 985	5 0	449, 742, 985	200. 00

alth Financial Systems	LUTHERAN HOSPITA	AL OF INDIANA		In Lie	u of Form CMS-2552-
CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provi der CCI	N: 15-0017	Peri od:	Worksheet A
				From 07/01/2017 To 06/30/2018	Date/Time Prepared
Cost Conton Docomintion	Adiustments	Not Evnences			11/30/2018 3: 38 pm
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
	6. 00	7. 00			
GENERAL SERVICE COST CENTERS	0.44/.000	44 007 704			
00 00100 CAP REL COSTS-BLDG & FLXT 00 00200 CAP REL COSTS-MVBLE EQUIP	2, 146, 200 1, 010, 521	14, 927, 721 20, 485, 954			1. (
00 00400 EMPLOYEE BENEFITS DEPARTMENT	-65, 593	20, 465, 954			4.0
00540 ADMITTING	-536, 667	11, 041, 684			5. (
12 00560 OTHER ADMINISTRATIVE AND GENERAL	-5, 142, 279	61, 102, 018			5. (
0 00700 OPERATION OF PLANT	-300, 118	13, 278, 649			7.0
0 00800 LAUNDRY & LINEN SERVICE	64, 216	1, 819, 589			8. (
0 00900 HOUSEKEEPI NG	0	2, 856, 206			9. (
00 01000 DI ETARY	o	2, 343, 856			10.0
00 01100 CAFETERI A	-54, 525	4, 608, 156			11. (
00 01300 NURSI NG ADMINISTRATION	0	4, 301, 943			13. (
00 01400 CENTRAL SERVICES & SUPPLY	0	8, 751, 028			14. (
00 01500 PHARMACY	0	7, 790, 872			15. (
00 01600 MEDI CAL RECORDS & LI BRARY	0	6, 161, 634			16. (
00 01700 SOCIAL SERVICE	0	3, 330, 814			17. (
00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	2, 536			21. (
00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV 00 02300 PARAMED ED PRGM-(SPECIFY)	0	3, 285, 137			22. (
01 02300 PARAMED ED PROM-(SPECIFY) 01 02301 PHARMACY RESIDENCY PROGRAM	0	394, 717 205, 519			23. (
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	205, 514			23. (
00 03000 ADULTS & PEDIATRICS	-1, 965, 438	30, 029, 054			30.0
00 03100 INTENSIVE CARE UNIT	0	0			31. (
01 02080 PEDIATRIC INTENSIVE CARE UNIT	-82, 025	900, 893			31. (
02 02060 NEONATAL INTENSIVE CARE UNIT	O	3, 377, 666			31. 0
03 03101 CARDIO INTENSIVE CARE UNIT	o	18, 378, 369			31. (
00 03200 CORONARY CARE UNIT	0	5, 839, 556			32. 0
00 04000 SUBPROVI DER - I PF	0	0			40.0
00 04300 NURSERY	-11, 705	359, 943			43. 0
ANCILLARY SERVICE COST CENTERS	1 405 704	00 004 470			
00 05000 OPERATING ROOM	-1, 105, 701	20, 386, 479			50. (
00 05100 RECOVERY ROOM	0	1 070 050			51. (
00 05200 DELIVERY ROOM & LABOR ROOM 00 05300 ANESTHESI OLOGY	-6, 879	1, 870, 050			52. (
00 05300 ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C	-4, 141, 580 -3, 996	247, 319 9, 019, 430			53. (54. (
00 05400 RADI 0E001 - DI AGNOSTI C 01 05401 PET SCAN	-3, 990	28, 894			54.0
00 05600 RADI OI SOTOPE		316, 904			56.0
00 05700 CT SCAN	o o	1, 636, 641			57.0
00 05800 MRI	Ö	1, 890			58.0
00 06000 LABORATORY	-2,000	16, 335, 749			60. (
00 06500 RESPIRATORY THERAPY	o	5, 879, 837			65. (
00 06600 PHYSI CAL THERAPY	o	5, 164, 099			66. (
00 06700 OCCUPATIONAL THERAPY	o	43, 580			67. 0
00 06800 SPEECH PATHOLOGY	o	70, 064			68. 0
00 06900 ELECTROCARDI OLOGY	0	3, 062, 704			69. (
00 07000 ELECTROENCEPHALOGRAPHY	0	2, 060, 744			70.0
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 388, 102			71. (
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	41, 016, 246			72.0
00 07300 DRUGS CHARGED TO PATIENTS	0	31, 261, 687			73. (
00 07400 RENAL DIALYSIS 00 03140 CARDIO CATH LAB	0	3, 027, 667			74.0
1	0	4, 101, 835 5, 670, 422			76.0
01 03050 ENDOSCOPY 02 03950 CARDI AC REHAB		647, 886			76. (76. (
OUTPATIENT SERVICE COST CENTERS	<u> </u>	047,000			70.0
00 09000 CLINIC	-180, 941	4, 319, 419			90.0
00 09100 EMERGENCY	-4, 358, 978	8, 112, 538			91. (
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,000,770	0, 1.12, 000			92. (
OTHER REIMBURSABLE COST CENTERS					
00 09500 AMBULANCE SERVICES	-6, 459, 341	5, 666, 335			95. (
00 09600 DURABLE MEDICAL EQUIP-RENTED	-1, 433, 344	0			96.0
SPECIAL PURPOSE COST CENTERS					
00 10500 KI DNEY ACQUI SI TI ON	0	1, 493, 041			105. (
. 00 10600 HEART ACQUI SI TI ON	0	592, 925			106. (
.00 SUBTOTALS (SUM OF LINES 1 through 117)	-22, 630, 173	426, 673, 001			118. (
NONREI MBURSABLE COST CENTERS					
. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190. (
00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	367, 561			192. (
. 00 07950 CLOSED PSYCH UNIT	0	0			194. (
. 01 07951 MARKETI NG	0	70.050			194. (
. 02 07952 SENI OR CI RCLE	0	72, 250			194. (
. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	ı Ol	0			194. (
TOTAL (SUM OF LINES 118 through 199)	-22, 630, 173	427, 112, 812			200. (

| Period: | Worksheet A-6 | From 07/01/2017 | To 06/30/2018 | Date/Time Prepared: | 11/30/2018 3: 38 pm Provider CCN: 15-0017

					11/30/2018 3	3:38 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
4 00	A - EMPLOYEE BENEFITS	4 00		00 055 004		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	20, 055, 001		1.00
2.00	OPERATION OF PLANT	7. 00	0	216		2. 00
3.00	NURSI NG ADMI NI STRATI ON	1300	0_	<u>30, 587</u>		3. 00
	TOTALS		0	20, 085, 804		
4 00	C - RENTAL AND LEASE	2 20	ما	(100 0/0		1 00
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6, 400, 962		1.00
2. 00	OTHER ADMINISTRATIVE AND	5. 02	0	74, 540		2. 00
2 00	GENERAL	0.00	o	0		3. 00
3. 00 4. 00		0.00	- 1			1
			0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
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	-1			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	0	0		25. 00
26. 00	TOTAL C — — — — —			0		26. 00
	TOTALS		U	6, 475, 502		
1. 00	D - OTHER CAPITAL COSTS CAP REL COSTS-BLDG & FIXT	1.00	O	222, 145		1.00
2.00	CAP REL COSTS-BLDG & FIXT		-	4, 954, 242		1
	I I	1. 00 2. 00	0			2.00
3. 00	CAP REL COSTS-MVBLE EQUIP			99, 134		3. 00
	TOTALS		U	5, 275, 521		
1 00	F - CNO RECLASS	12.00	2/2 /45			1 00
1. 00	NURSI NG ADMI NI STRATI ON	1300	262, 645	0		1. 00
	TOTALS		262, 645	U		
4 00	G - MEDICAL SUPPLIES	74 00		7 000 400		4 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	7, 388, 102		1. 00
2 00	PATI ENT	72.00		41 017 247		2.00
2. 00	I MPL. DEV. CHARGED TO PATIENTS	72. 00	0	41, 016, 246		2. 00
3. 00	OPERATING ROOM	50.00	o	1, 250, 075		3. 00
4.00	OLEKATING KOOM	0.00	0	1, 250, 075		4. 00
5. 00		0.00	0	0		5. 00
5.00	TOTALS — — — —			49, 654, 423		3.00
	H - DRUGS / IVS		U U	47, 034, 423		+
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	31, 261, 687		1.00
1.00	TOTALS			31, 261, 687		1.00
	I - LABOR AND DELIVERY		U U	31, 201, 007		\dashv
1.00	NURSERY	43.00	303, 274	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 531, 624	338, 426		2. 00
2.00	TOTALS		1, 834, 898	338, 426		2.00
	L - A&G COSTS		1, 034, 070	330, 420		
1.00	OTHER ADMINISTRATIVE AND	5. 02	262, 289	47, 224		1.00
1.00	GENERAL	3. 02	202, 209	71,224		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	380, 120	1, 774, 305		2. 00
2.00	TOTALS		642, 409	1, 821, 529		2.00
	M - RADIOLOGY COSTS		042, 407	1, 021, 027		-
1.00	RADI OLOGY - DI AGNOSTI C	54.00	1, 373, 147	215, 792		1.00
2.00	PET SCAN	54. 00	30, 279	215, 792		2. 00
3.00	I SOM	0.00	30, 217	0		3. 00
5.00	TOTALS — — — — —	<u> </u>	1, 403, 426	215, 792		3.00
	N - DIETARY		1, 400, 420	213, 172		\dashv
1.00	CAFETERI A	11. 00	0	4, 662, 681		1.00
1.00	TOTALS			4, 662, 681		1.00
	1.020	ı	બ	1, 002, 001		I

Health Financial Systems RECLASSIFICATIONS LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Provider CCN: 15-0017

Peri od: Worksheet A-6 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

						11/30/2018 3:38 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00	 	
	O - MISC DEPARTMENT					
1.00	OTHER ADMINISTRATIVE AND	5. 02	641, 426	51, 335		1. 00
	GENERAL					
2.00	MEDICAL RECORDS & LIBRARY	16. 00	940, 122	480, 305		2. 00
3.00	SOCI AL SERVI CE	17. 00	2, 521, 107	809, 707		3. 00
4.00	OPERATING ROOM	50.00	2, 201, 321	588, 059		4. 00
5.00	PHYSI CAL THERAPY	66.00	2, 349, 051	116, 823		5. 00
6.00	ELECTROENCEPHALOGRAPHY	70.00	1, 255, 327	805, 417		6. 00
7.00	CARDIO CATH LAB	76.00	1, 670, 473	2, 431, 362		7. 00
8.00	ENDOSCOPY	76. 01	3, 285, 779	2, 384, 138		8. 00
9.00	CARDI AC REHAB	76. 02	505, 719	61, 441		9. 00
	TOTALS	— — T	15, 370, 325	7, 728, 587		
	P - ORGAN ACQUISITION			·		
1.00	CLINIC	90.00	397, 987	636, 616		1. 00
2.00	KIDNEY ACQUISITION	105.00	425, 490	1, 067, 551		2. 00
3.00	HEART ACQUISITION	106.00	143, 001	449, 924		3. 00
	TOTALS		966, 478	2, 154, 091		
	Q - ICU COSTS					
1.00	PEDIATRIC INTENSIVE CARE	31.01	796, 505	187, 851		1. 00
	UNI T			·		
2.00	NEONATAL INTENSIVE CARE UNIT	31. 02	2, 661, 925	715, 741		2. 00
3.00	CARDIO INTENSIVE CARE UNIT	31. 03	11, 709, 738	6, 668, 631		3. 00
4.00	CORONARY CARE UNIT	32.00	4, 506, 462	1, 333, 094		4. 00
	TOTALS		19, 674, 630	8, 905, 317		
	R - INTERNS AND RESIDENTS					
1.00	I&R SERVICES-OTHER PRGM	22. 00	0	3, 285, 137		1. 00
	COSTS APPRV					
	TOTALS	$$ \dagger		3, 285, 137		
500.00	Grand Total: Increases		40, 154, 811	141, 864, 497		500. 00
	'	'				· ·

Peri od: From 07/01/2017 To 06/30/2018 Date/Time Prepared: 11/30/2018 3:38 pm

		Docrosco			L.	11/30/2018 3:	. 38 pm
	Cost Center	Decreases Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10, 00		
	A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND	5. 02	0	20, 085, 764	0		1. 00
	GENERAL	20.00					
2.00	ADULTS & PEDIATRICS	30.00	0	40	0		2.00
3.00	TOTALS — — — — —			0 20, 085, 804	9		3. 00
	C - RENTAL AND LEASE		<u> </u>	20, 065, 604			-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 017	10		1.00
2. 00	ADMITTING	5. 01	o	9, 729	0		2. 00
3.00	OPERATION OF PLANT	7. 00	O	7, 732	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	0	4, 500	0		4. 00
5.00	DI ETARY	10.00	0	5, 515	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	0	332, 738	0		6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 516, 107	0		7. 00
8.00	PHARMACY	15.00	0	659, 640	0		8. 00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	45, 765	0		9. 00
10. 00 11. 00	PARAMED ED PRGM-(SPECIFY) ADULTS & PEDIATRICS	23. 00 30. 00	0	1, 132 26, 020	0		10. 00 11. 00
12.00	PEDIATRIC INTENSIVE CARE	31. 01	0	1, 438	0		12. 00
12.00	UNIT	31.01		1, 430			12.00
13.00	OPERATING ROOM	50.00	О	635, 637	0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	О	1, 242, 595	0		14. 00
15.00	PET SCAN	54. 01	0	39, 761	0		15. 00
16. 00	RADI OI SOTOPE	56. 00	0	617, 793	0		16. 00
17. 00	CT SCAN	57. 00	0	11, 545	0		17. 00
18. 00	LABORATORY	60.00	0	381, 815	0		18. 00
19. 00	RESPIRATORY THERAPY	65. 00	0	81, 436	0		19. 00
20.00	PHYSI CAL THERAPY	66.00	0	298, 782	0		20.00
21. 00 22. 00	ELECTROCARDI OLOGY ENDOSCOPY	69. 00 76. 01	0	178, 748 6, 788	0		21. 00 22. 00
23. 00	EMERGENCY	91.00	o	160, 653	0		23. 00
24. 00	AMBULANCE SERVICES	95. 00	Ö	115, 498	o o		24. 00
25. 00	DURABLE MEDICAL EQUIP-RENTED	96.00	O	24, 048	0		25. 00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	<u>65, 0</u> 70	0		26. 00
	TOTALS		0	6, 475, 502			
	D - OTHER CAPITAL COSTS		_1				4
1. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	5, 275, 521	12		1. 00
2.00	GENERAL	0.00	0	o	13		2. 00
3.00		0.00	Ö	0	12		3. 00
	TOTALS			5, 275, 521			1
	F - CNO RECLASS						
1.00	OTHER ADMINISTRATIVE AND	5. 02	262, 645	0	0		1. 00
	GENERAL	+					
	TOTALS G - MEDICAL SUPPLIES		262, 645	0			-
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	48, 190, 909	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	164	0		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	ő	98, 169			3. 00
4.00	RADI OI SOTOPE	56.00	O	1, 351, 823			4. 00
5.00	ELECTROCARDI OLOGY	69. 00	0	13, 358	0		5. 00
	TOTALS		0	49, 654, 423			
	H - DRUGS / IVS						4
1. 00	PHARMACY	15.00		<u>31, 261, 6</u> 87	0		1. 00
	TOTALS		0	31, 261, 687			-
1.00	I - LABOR AND DELIVERY ADULTS & PEDIATRICS	30.00	1, 834, 898	331, 186	0		1.00
2.00	NURSERY	43. 00	1, 034, 070	7, 240			2.00
2.00	TOTALS		1, 834, 898	338, 426			2.00
	L - A&G COSTS		.,				i
1.00	ADMITTING	5. 01	262, 289	22, 267	0		1. 00
2.00	OTHER ADMINISTRATIVE AND	5. 02	380, 120	1, 799, 262	0		2. 00
	GENERAL						
	TOTALS		642, 409	1, 821, 529			-
1 00	M - RADI OLOGY COSTS RADI OLOGY-DI AGNOSTI C	E4 00	20. 270				1 00
1. 00 2. 00	PET SCAN	54. 00 54. 01	30, 279 900, 681	0 105, 352	- 1		1. 00 2. 00
3.00	MRI	58. 00	472, 466	110, 440			3. 00
5.00	TOTALS — — — — —		1, 403, 426	215, 792	— — — - 4		3.00
	N - DIETARY		., .50, 120	= , , , , , , ,			1
1.00	DI ETARY	10.00	0	4, 662, 681	0		1.00
	TOTALS			4, 662, 681			

Health Financial Systems RECLASSIFICATIONS LUTHERAN HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Provider CCN: 15-0017

Peri od: Worksheet A-6 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

						11/30/2018 3	:38 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
	O - MISC DEPARTMENT						
1.00	OPERATING ROOM	50.00	3, 285, 779	2, 384, 138	0		1. 00
2.00	ENDOSCOPY	76. 01	538, 644	131, 241	0		2. 00
3.00	NURSING ADMINISTRATION	13.00	4, 102, 655	1, 341, 347	0		3. 00
4.00	RECOVERY ROOM	51.00	2, 201, 321	588, 059	0		4. 00
5.00	OCCUPATI ONAL THERAPY	67.00	1, 455, 471	80, 754	0		5. 00
6.00	SPEECH PATHOLOGY	68.00	893, 580	36, 070	0		6. 00
7.00	ELECTROCARDI OLOGY	69.00	2, 892, 875	3, 166, 978	0		7. 00
8.00		0.00	0	0	0		8. 00
9.00		0.00	O	0	o		9. 00
	TOTALS		15, 370, 325	7, 728, 587			
	P - ORGAN ACQUISITION						
1.00	OPERATING ROOM	50.00	966, 478	2, 154, 091	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
	TOTALS		966, 478	2, 154, 091			
	Q - ICU COSTS						
1.00	PEDIATRIC INTENSIVE CARE	31. 01	2, 661, 925	715, 741	0		1. 00
	UNI T						
2.00	INTENSIVE CARE UNIT	31.00	17, 012, 705	8, 189, 576	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
	TOTALS		19, 674, 630	8, 905, 317			
	R - INTERNS AND RESIDENTS						
1.00	I&R SERVICES-SALARY &	21.00	0	3, 285, 137	0		1. 00
	FRI_NGES_ APPRV						
	TOTALS		0	3, 285, 137			
500.00	Grand Total: Decreases		40, 154, 811	141, 864, 497			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0017

					To 06/30/2018	Date/Time Pre 11/30/2018 3:	pared:
				Acqui si ti ons		1173072010 3.	JO PIII
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	9, 502, 329	0	(0	9, 045, 201	1. 00
2.00	Land Improvements	11, 138, 143	1, 179, 475	(1, 179, 475		2. 00
3.00	Buildings and Fixtures	154, 088, 107	136, 441	(136, 441		3. 00
4.00	Building Improvements	34, 582, 042	3, 562, 778		3, 562, 778		1
5.00	Fixed Equipment	51, 202, 907	2, 879, 104		2, 879, 104		5. 00
6.00	Movable Equipment	140, 348, 120	21, 946, 822		21, 946, 822		
7.00	HIT designated Assets	2, 999, 700	7, 007		7, 007		
8.00	Subtotal (sum of lines 1-7)	403, 861, 348	29, 711, 627		29, 711, 627	226, 584, 676	
9.00	Reconciling Items	0	0		0	0	9. 00
10. 00	Total (line 8 minus line 9)	403, 861, 348	29, 711, 627	(29, 711, 627	226, 584, 676	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				
1.00	Land	457, 128	0				1.00
2.00	Land Improvements	3, 236, 362	0				2. 00
3.00	Buildings and Fixtures	31, 191, 267	0				3. 00
4.00	Building Improvements	37, 898, 206	0				4. 00
5.00	Fixed Equipment	11, 608, 908	0				5. 00
6.00	Movable Equipment	119, 592, 801	0				6. 00
7.00	HIT designated Assets	3, 003, 627	0				7. 00
8.00	Subtotal (sum of lines 1-7)	206, 988, 299	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	206, 988, 299	0				10. 00

Health Financial Systems L		LUTHERAN HOSPIT.	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Date/Time Pre	pared:
			SU	JMMARY OF CAP	ITAL	11/30/2018 3:	38 pm
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FLXT	7, 605, 134	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	12, 975, 337	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	20, 580, 471	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	7, 605, 134				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12, 975, 337				2. 00
2 00	Total (cum of lines 1 2)	ا ما	20 500 471	I			2 00

0 0 0

7, 605, 134 12, 975, 337 20, 580, 471

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 07/01/2017 To 06/30/2018	Worksheet A-7 Part III Date/Time Pre 11/30/2018 3:	pared:
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	эв р
	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 C						
1.00	CAP REL COSTS-BLDG & FLXT	87, 395, 499				0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	119, 592, 801		1 , 0 , 2 , 00			2. 00
3.00	Total (sum of lines 1-2)	206, 988, 300		206, 988, 30			3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART III DECONOLILATION OF CARLTAL COCTO C	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS	1		0 5, 647, 068	0	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	0	0		0 12, 639, 474		2.00
3.00	Total (sum of lines 1-2)				0 18, 286, 542		3. 00
3.00	Total (Suil of Titles 1-2)	0	SI SI	I JMMARY OF CAPI		0, 400, 702	3.00
			30	NIMPART OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART LILL DECONOLILATION OF CARLEY COMME	11.00	12. 00	13. 00	14. 00	15. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C		000 445	1.054.04		44 007 704	4 00
1.00	CAP REL COSTS BLDG & FLXT	4, 104, 266				, , _ , , ,	1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	1, 346, 384			0	20, 100, 701	2.00
3.00	Total (sum of lines 1-2)	5, 450, 650	321, 279	4, 954, 24	2 0	35, 413, 675	3. 00

| Period: | Worksheet A-8 | From 07/01/2017 | To 06/30/2018 | Date/Time Prepared: Provider CCN: 15-0017

				To	06/30/2018	Date/Time Prep 11/30/2018 3:3	
	,			Expense Classification on			зо рііі
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2) Trade, quantity, and time		-				
4. 00	discounts (chapter 8)		U		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by suppliers (chapter 8)	В	-927, 655	CAP REL COSTS-BLDG & FIXT	1. 00	9	6. 00
7. 00	Telephone services (pay stations excluded) (chapter	А	-65, 431	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce		0	SEIVERVIE	0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-23, 721, 931		0.00	Ö	10. 00
11. 00	adjustment Sale of scrap, waste, etc.	В	-761	RADI OLOGY-DI AGNOSTI C	54.00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	9, 101, 063			0	12. 00
13. 00	Laundry and linen service	_	0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-54, 525 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
	pati ents		0				
18. 00	Sale of medical records and abstracts		Ü		0.00	0	
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00	Vending machines	В	-26, 924	OTHER ADMINISTRATIVE AND	5. 02	О	20. 00
21. 00	Income from imposition of interest, finance or penalty		0	GENERAL	0.00	0	21. 00
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 therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25 00	limitation (chapter 14)		0	*** C+ C+ D- -+ ***	114 00		25 00
25. 00	Utilization review - physicians' compensation (chapter 21)		U	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	Depreciation - CAP REL	А	-1, 094, 205	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL	A	-346, 955	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
J∠. UU	Depreciation and Interest		U		0.00		J∠. UU

					06/30/2018	11/30/2018 3:	
				Expense Classification on	Worksheet A	117 007 2010 01	<u> Б</u>
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	·	1.00	2. 00	3.00	4. 00	5. 00	
33. 00	SPECIAL EVENTS	Α	-31, 597	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
33. 01	OTHER MISC REVENUES	В	-1, 328, 961	OTHER ADMINISTRATIVE AND	5. 02	0	33. 01
				GENERAL			
33. 02	PATIENT PHONES WAGE COST	A	-147, 212	OTHER ADMINISTRATIVE AND	5. 02	0	33. 02
				GENERAL			
33. 03	PATIENT PHONEES BENEFITS COST	A	-33, 996	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 03
33. 04	EVENT PLANNING	A	-2, 108	OTHER ADMINISTRATIVE AND	5. 02	0	33. 04
				GENERAL			
33. 05	SPECIAL EVENTS	A		AMBULANCE SERVICES	95. 00	0	33. 05
33.06	PATIENT TV - CABLE EXPENSE	A	-74, 627	OPERATION OF PLANT	7. 00	0	33. 06
33. 07	MARKETING EXPENSE	l A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 07
			,	GENERAL			
33. 08	LEGAL FEES	A	-434, 448	OTHER ADMINISTRATIVE AND	5. 02	0	33. 08
				GENERAL			
33. 09	PHYSICIAN RECRUITING	l A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 09
				GENERAL			
33. 10	ASSOCIATION DUES - LOBBYING	A	-27, 745	OTHER ADMINISTRATIVE AND	5. 02	0	33. 10
			,	GENERAL			
33. 11	CHARITABLE CONTRIBUTIONS	A	-261, 412	OTHER ADMINISTRATIVE AND	5. 02	0	33. 11
				GENERAL			
33. 12	PENALTI ES	A	-581	OTHER ADMINISTRATIVE AND	5. 02	0	33. 12
				GENERAL			
33. 14	GRANT INCOME	В	-47, 500	OTHER ADMINISTRATIVE AND	5. 02	0	33. 14
				GENERAL			
33. 15	MARKETING DEPT EXPENSE	A	-2, 049, 309	OTHER ADMINISTRATIVE AND	5. 02	0	33. 15
				GENERAL			
33. 16	CORPORATE SPONSOR RESEARCH	A	-140, 319	OTHER ADMINISTRATIVE AND	5. 02	0	33. 16
				GENERAL			
33. 17	LOBBYING EXPENSES	A	-52, 063	OTHER ADMINISTRATIVE AND	5. 02	0	33. 17
				GENERAL			
33. 18	DURABLE GOODS EXPENSE	A	-897	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33. 18
33. 19	VALET - SECURITY	A	-225, 491	OPERATION OF PLANT	7. 00	0	33. 19
50.00	TOTAL (sum of lines 1 thru 49)		-22, 630, 173				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) Do	scription all chapter referen	sees in this sel	ump portoin to	CMC Dub 1E 1			

⁽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.

Worksheet A-8-1

OFFICE	COSTS			rom 07/01/2017		
				Γο 06/30/2018	Date/Time Pre 11/30/2018 3:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	JO PIII
	ETTIC NO.	Sost some		Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			DIRECT CAPITAL INTEREST	3, 891, 144	0	1. 00
2.00	1		PASI CAPITAL - BLDG	63, 794	0	2.00
3.00	1		PASI CAPITAL - EQUIP	11, 092	0	3.00
3. 01		OTHER ADMINISTRATIVE AND GEN		1, 166	1, 200	3. 01
3. 02	l control of the cont	OTHER ADMINISTRATIVE AND GEN		0	2, 268, 200	
3. 03	l control of the cont	OTHER ADMINISTRATIVE AND GEN		6, 888, 832	2, 745, 060	
4.00			PASI OPERATING	1, 004, 332	0	4. 00
4. 01	1		POOLED CAPITAL - BLDG	213, 122	0	4. 01
4. 02			POOLED CAPITAL - EQUIP	1, 346, 384	0	4. 02
4.03		OTHER ADMINISTRATIVE AND GEN		13, 638, 144	0	4. 03
4.04		OTHER ADMINISTRATIVE AND GEN		1, 706, 557	3, 528, 188	
4.06	1	l l	HLS - CAPITAL	118, 126	330, 825	4. 06
4.07			HLS - OPERATING	1, 176, 750	899, 835	4. 07
4.08		OTHER ADMINISTRATIVE AND GEN		0	5, 750, 347	4. 08
4.09		OTHER ADMINISTRATIVE AND GEN		0	5, 990	4. 09
4. 10	1	OTHER ADMINISTRATIVE AND GEN		0	102, 091	4. 10
4. 16	1	OTHER ADMINISTRATIVE AND GEN		0	33, 665	4. 16
4. 19	1	_	PASI COLLECTION FEES	0	1, 245, 609	4. 19
4. 20		OTHER ADMINISTRATIVE AND GEN	l .	0	1, 826, 980	4. 20
4. 22	1	k	PASI LIEN UNIT COLLECTION FE	0	295, 390	4. 22
4. 23	l control of the cont	OTHER ADMINISTRATIVE AND GEN	INTEREST EXPENSE	0	1, 925, 000	
5.00	TOTALS (sum of lines 1-4).			30, 059, 443	20, 958, 380	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	0.00 COMMUNITY HEALT 100.0	6.00
7.00	В	0.00 PASI 100.0	7.00
8. 00	E	0.00 HOSPI TAL LAUNDR 100.0	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:		<u> </u>

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

011102	00010				To 06/30/2018	Date/Time Pre	epared: 38 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED O	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO						
1.00	3, 891, 144						1. 00
2.00	63, 794	9					2. 00
3.00	11, 092	9					3. 00
3. 01	-34	0					3. 01
3.02	-2, 268, 200	0					3. 02
3.03	4, 143, 772	0					3. 03
4.00	1, 004, 332	0					4. 00
4. 01	213, 122	11					4. 01
4.02	1, 346, 384	11					4. 02
4.03	13, 638, 144	0					4. 03
4.04	-1, 821, 631	0					4. 04
4.06	-212, 699	0					4. 06
4.07	276, 915	0					4. 07
4.08	-5, 750, 347	0					4. 08
4.09	-5, 990	0					4. 09
4. 10	-102, 091	0					4. 10
4. 16	-33, 665	0					4. 16
4. 19	-1, 245, 609	0					4. 19
4. 20	-1, 826, 980	0					4. 20
4. 22	-295, 390	0					4. 22
4. 23	-1, 925, 000	0					4. 23
5.00	9, 101, 063						5. 00
* The	amaunta an Lin	aa 1 4 (and aub		afarrad in datail to Warl	chast A saluma	/ lines es	

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

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

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

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

6.00	HOSP COMPANY	6. 00
7.00	COLLECTI ONS	7. 00
	LAUNDRY	8. 00
9.00		9. 00
10.00		10.00
10. 00 100. 00		100. 00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0017

| Period: | Worksheet A-8-2 | From 07/01/2017 | To 06/30/2018 | Date/Time Prepared: | 11/30/2018 3: 38 pm

							11/30/2018 3:	38 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
		1 40.1.1.1.0.	Tromarior a cr orr	oopor.orre	- component		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1 00		OTHER ADMINISTRATIVE AND				211, 500		1. 00
1. 00			3, 977, 477	3, 969, 810	7, 667	211, 500	57	1.00
		GENERAL			_	_	_	
2.00		ADULTS & PEDIATRICS	1, 965, 438			0		2. 00
3.00	31. 01	PEDIATRIC INTENSIVE CARE	82, 025	82, 025	0	0	0	3. 00
		UNI T						
4.00	43.00	NURSERY	11, 705	11, 705	0	0	0	4.00
5.00	50.00	OPERATING ROOM	1, 105, 701	1, 105, 701	0	0	0	5. 00
6.00		DELIVERY ROOM & LABOR ROOM	6, 879			0	0	6. 00
7. 00		ANESTHESI OLOGY	4, 141, 580			0	o o	7. 00
8. 00		RADI OLOGY-DI AGNOSTI C				0	0	8. 00
			3, 235	3, 235		0		
9. 00		LABORATORY	1, 000	1, 000		0	0	9. 00
10. 00		LABORATORY	1, 000	1, 000		0	0	10. 00
11. 00	90.00	CLINIC	180, 941	180, 941	0	0	0	11. 00
12.00	91.00	EMERGENCY	4, 358, 978	4, 358, 978	0	0	0	12.00
13.00	95. 00	AMBULANCE SERVICES	6, 459, 321	6, 459, 321	0	0	0	13.00
14.00		DURABLE MEDICAL EQUIP-RENTED	1, 432, 447			0	0	14.00
200.00			23, 727, 727			_	57	200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WKSt. A LITTE #	I denti fi er		Unadjusted RCE			of Malpractice	
		rdentiffei	LIIIII L					
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00		OTHER ADMINISTRATIVE AND	5, 796	290	0	0	0	1. 00
		GENERAL						
2.00		ADULTS & PEDIATRICS	0	0	0	0	0	2. 00
3.00	31. 01	PEDIATRIC INTENSIVE CARE	0	0	0	0	0	3.00
		UNI T						
4.00	43.00	NURSERY	0	0	0	0	0	4. 00
5.00	50.00	OPERATING ROOM	l o	0	0	0	0	5. 00
6. 00		DELIVERY ROOM & LABOR ROOM	ĺ	0	n	0	o o	6. 00
7. 00		ANESTHESI OLOGY	١	0	0	0	0	7. 00
			0	0	0	0		
8.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	8. 00
9.00		LABORATORY	0	0	0	0	0	9. 00
10. 00		LABORATORY	0	0	0	0	0	10. 00
11. 00	90.00	CLI NI C	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
13.00	95. 00	AMBULANCE SERVICES	0	0	0	0	0	13.00
14.00	96, 00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	14.00
200.00			5, 796	290	0	0	o	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	J	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		ruenti i ei	Share of col.	LIIIII	bi sai i Owalice			
	1 00	3 00	14	1/ 00	17.00	10.00		
1 00	1.00	2. 00 OTHER ADMI NI STRATI VE AND	15. 00 0	16. 00 5. 796	17.00	18.00		1 00
1.00			0	5, 796	1, 871	3, 971, 681		1. 00
2 22		GENERAL	_	_	_	1 0/5 /00		2 22
2.00		ADULTS & PEDIATRICS	0					2. 00
3.00	31. 01	PEDIATRIC INTENSIVE CARE	0	0	0	82, 025		3. 00
		UNI T						
4.00	43.00	NURSERY	0	0	0	11, 705		4.00
5.00	50.00	OPERATING ROOM	0	0	0	1, 105, 701		5. 00
6.00		DELIVERY ROOM & LABOR ROOM	0			6, 879		6. 00
7. 00		ANESTHESI OLOGY	0		0	4, 141, 580		7. 00
8. 00		RADI OLOGY-DI AGNOSTI C	Ö		_	3, 235	1	8. 00
			0	0				
9.00		LABORATORY	1	_	_	1,000		9.00
10.00		LABORATORY	0	0	0	1, 000		10.00
11. 00		CLI NI C	0	0	0	180, 941		11. 00
12. 00		EMERGENCY	0	0	0	4, 358, 978		12. 00
13.00	95. 00	AMBULANCE SERVICES	0	0	0	6, 459, 321		13.00
14.00	96. 00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	1, 432, 447		14.00
200.00			0	5, 796	1, 871	23, 721, 931		200.00
			•	•	•			

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0017 P		ri od: Worksheet B om 07/01/2017 Part I 06/30/2018 Date/Time Prepare 11/30/2018 3:38 p		pared:
			CAPITAL RELATED COSTS			11/30/2018 3.	30 pili
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	
		col. 7) 0	1. 00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	14, 927, 721	14, 927, 721				1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	20, 485, 954 21, 677, 000	391, 035	20, 485, 954 25, 771			2. 00 4. 00
5. 01	00540 ADMI TTI NG	11, 041, 684	325, 201			12, 313, 066	5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	61, 102, 018	632, 132			0	5. 02
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	13, 278, 649 1, 819, 589	3, 231, 508 18, 750			0	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	2, 856, 206	62, 952			0	9. 00
10.00	01000 DI ETARY	2, 343, 856	605, 845			0	10.00
11.00	01100 CAFETERI A	4, 608, 156	142.257			0	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	4, 301, 943 8, 751, 028	143, 256 261, 622			0	13. 00 14. 00
15. 00	01500 PHARMACY	7, 790, 872	149, 770			0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 161, 634	159, 959			0	
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRV	3, 330, 814	107, 760			0	17. 00 21. 00
21.00	02200 I &R SERVI CES-SALARY & FRINGES APPRV	2, 536 3, 285, 137	0			0	21.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	394, 717	60, 384			0	1
23. 01	02301 PHARMACY RESIDENCY PROGRAM	205, 519	0	(30, 574	0	23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	30, 029, 054	2, 081, 830	823, 662	3, 271, 269	556, 151	30.00
31. 00	03100 NTENSI VE CARE UNIT	0	2,001,030	023, 002		0	
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	900, 893	137, 702			10, 723	
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	3, 377, 666	231, 096			65, 696	
31. 03 32. 00	03101 CARDIO INTENSIVE CARE UNIT	18, 378, 369 5, 839, 556	825, 750 321, 547			333, 326 117, 650	
40. 00	04000 SUBPROVI DER - I PF	0	0	0.,		0	
43. 00	04300 NURSERY	359, 943	11, 400	1, 082	51, 770	7, 132	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	20, 386, 479	2, 207, 755	2, 163, 180	1, 633, 795	2, 104, 206	50.00
51. 00	05100 RECOVERY ROOM	0	2,207,700			0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 870, 050		C		36, 018	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	247, 319 9, 019, 430	1, 670 330, 880			271, 532 575, 698	
54. 00	05401 PET SCAN	28, 894	36, 017			25, 286	•
56. 00	05600 RADI OI SOTOPE	316, 904	83, 895	46, 008	91, 592	161, 727	
57. 00	05700 CT SCAN	1, 636, 641	41, 488			524, 907	
58. 00 60. 00	05800 MRI	1, 890 16, 335, 749	352, 929	353, 933		144 962, 496	
	06500 RESPIRATORY THERAPY	5, 879, 837	119, 954			379, 926	
66. 00	06600 PHYSI CAL THERAPY	5, 164, 099	253, 897	21, 218		126, 589	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	43, 580 70, 064	0	392, 523		14 11, 721	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 062, 704	300, 500			373, 155	
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 060, 744	31, 403	•		47, 444	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 388, 102	0	(0	867, 937	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	41, 016, 246 31, 261, 687	0		-	1, 131, 808 2, 152, 933	
74. 00	07400 RENAL DI ALYSI S	3, 027, 667	165, 785		-	55, 382	
76. 00	03140 CARDIO CATH LAB	4, 101, 835	135, 133			447, 794	
76. 01 76. 02	03050 ENDOSCOPY 03950 CARDI AC REHAB	5, 670, 422	145, 239 0			269, 208	
70.02	OUTPATIENT SERVICE COST CENTERS	647, 886	0	16, 127	99, 177	18, 001	76. 02
90.00	09000 CLI NI C	4, 319, 419	426, 614	46, 024		15, 989	90. 00
91.00	09100 EMERGENCY	8, 112, 538	421, 206	250, 512	996, 512	598, 577	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	5, 666, 335	9, 646	783, 033	438, 730	39, 562	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		o	0	96. 00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	1, 493, 041	54, 016		72, 632	7 404	105. 00
	10500 REDNET ACQUISITION	592, 925	54, 016			16, 840	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	426, 673, 001	14, 877, 526			12, 313, 066	•
100 0	NONREI MBURSABLE COST CENTERS	_T	F0 455	-			100 35
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 367, 561	50, 195 0	165, 450			190. 00 192. 00
194.00	07950 CLOSED PSYCH UNIT	0	0	103, 430		0	194. 00
	07951 MARKETI NG	0	0	l c	o	0	194. 01

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B		
				From 07/01/2017 To 06/30/2018	Part Date/Time Pre	pared:	
					11/30/2018 3:		
		CAPITAL REI	CAPITAL RELATED COSTS				
		DI DO 4 51 VT					
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG		
	for Cost			BENEFI TS			
	Allocation			DEPARTMENT			
	(from Wkst A						
	col. 7)	1, 00	2.00	4. 00	5. 01		
194. 02 07952 SENI OR CI RCLE	72, 250		2.00	0 8, 341		194. 02	
	12, 230	0		0, 341		194. 02	
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	U		U U	U		
200.00 Cross Foot Adjustments		_			_	200. 00	
201.00 Negative Cost Centers		0		0 0		201. 00	
202.00 TOTAL (sum lines 118 through 201)	427, 112, 812	14, 927, 721	20, 485, 95	4 22, 093, 806	12, 313, 066	202. 00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0017

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2017 Part I
To 06/30/2018 Date/Time Prepared:
11/30/2018 3:38 pm

			''	00/30/2010	11/30/2018 3:	
Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE		
	5A. 01	AND GENERAL 5. 02	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS	071. 01	0.02	7.00	0.00	7. 00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00540 ADMI TTI NG						5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	72, 526, 797	72, 526, 797				5. 02
7. 00 00700 0PERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	17, 367, 085 1, 838, 339	3, 552, 246 376, 012	20, 919, 331 37, 905	2, 252, 256		7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	3, 210, 164	656, 604			3, 994, 033	
10. 00 01000 DI ETARY	3, 029, 175	619, 584			235, 703	1
11. 00 01100 CAFETERI A	4, 608, 156	942, 548		0	0	11.00
13. 00 01300 NURSING ADMINISTRATION	5, 096, 782	1, 042, 491	289, 607	0	55, 733	1
14.00 01400 CENTRAL SERVICES & SUPPLY	9, 634, 429	1, 970, 616	528, 899	0	101, 784	
15. 00 01500 PHARMACY	9, 256, 465	1, 893, 308	302, 777	0	58, 268	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	6, 733, 386	1, 377, 240	323, 376	0	62, 232	16. 00
17. 00 01700 SOCI AL SERVI CE	3, 868, 935			0	41, 924	
21. 00 02100 1 &R SERVI CES-SALARY & FRINGES APPRV	2, 983	610		0	0	21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	3, 285, 137	671, 939		0	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	487, 972	99, 809		7, 093	23, 492	
23. 01 02301 PHARMACY RESIDENCY PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	236, 093	48, 290	0	U	0	23. 01
30. 00 03000 ADULTS & PEDIATRICS	36, 761, 966	7, 519, 256	4, 208, 652	863, 192	809, 934	30.00
31. 00 03100 NTENSI VE CARE UNI T	30, 701, 900 N	7,317,230	4, 200, 032	003, 172	007, 734	31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 214, 967	248, 508	_	152, 804	53, 573	
31. 02 02060 NEONATAL NTENSIVE CARE UNIT	4, 834, 936	988, 933		9, 207	89, 908	1
31.03 03101 CARDIO INTENSIVE CARE UNIT	21, 835, 171	4, 466, 144			321, 257	
32. 00 03200 CORONARY CARE UNIT	7, 082, 296	1, 448, 606			125, 098	
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	431, 327	88, 223	23, 047	0	4, 435	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	28, 495, 415	5, 828, 424	4, 463, 226	402, 962	858, 925	1
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	2, 167, 521	443, 343	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	535, 693	109, 570		107 041	650	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 PET SCAN	12, 652, 278	2, 587, 884	668, 912	106, 041	128, 729 14, 013	
56. 00 05600 RADI 01 SOTOPE	128, 853 700, 126	26, 355 143, 203		0	32, 639	1
57. 00 05700 CT SCAN	2, 486, 763	508, 640		39, 702	16, 141	
58. 00 05800 MRI	2, 400, 703	416		37, 702 N	0, 141	58.00
60. 00 06000 LABORATORY	18, 862, 365	3, 858, 089		624	137, 307	60.00
65. 00 06500 RESPIRATORY THERAPY	7, 380, 306	1, 509, 560			46, 668	1
66. 00 06600 PHYSI CAL THERAPY	6, 382, 733	1, 305, 518		0	98, 778	
67. 00 06700 OCCUPATI ONAL THERAPY	43, 840	8, 967	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	474, 308	97, 014	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 136, 371	846, 049	607, 495	0	116, 909	
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 698, 944	552, 039			12, 217	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 256, 039		0	0	_	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	42, 148, 054	8, 621, 051	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	33, 414, 620	6, 834, 593	0	7 221	0	73. 00
74. 00 07400 RENAL DI ALYSI S	3, 251, 421	665, 042		7, 001	64, 498	
76. 00 03140 CARDI 0 CATH LAB 76. 01 03050 ENDOSCOPY	5, 754, 673 7, 468, 787	1, 177, 055 1, 527, 658		19, 153 64, 673	52, 573 56, 505	76. 00 76. 01
76. 02 03950 CARDI AC REHAB	7, 408, 787	1, 327, 038	· ·	04, 073 N	0 30, 303	76. 01
OUTPATIENT SERVICE COST CENTERS	701, 171	137, 704		0	0	, 5. 52
90. 00 09000 CLINIC	5, 305, 558	1, 085, 194	862, 447	38, 375	165, 974	90.00
91. 00 09100 EMERGENCY	10, 379, 345	2, 122, 981	851, 515		163, 870	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		·			92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	6, 937, 306	1, 418, 950	19, 501	0	3, 753	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	1, 627, 183					105.00
106. 00 10600 HEART ACQUI SI TI ON	634, 176	129, 714		350		106.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	426, 448, 464	72, 390, 912	20, 817, 857	2, 252, 256	3, 974, 505	1118.00
NONREI MBURSABLE COST CENTERS	FO 10F	10.277	101 474	0	10 520	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	50, 195 533, 562	10, 267 109, 134	101, 474	0		190. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 194. 00 07950 CLOSED PSYCH UNIT	533, 562 0	107, 134	0	0		194. 00
194. 01 07951 MARKETI NG	0	0	n	0		194. 00
194. 02 07952 SENI OR CI RCLE	80, 591	16, 484	l 0	n		194. 01
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	00,071	n .5, 154	0	n		194. 03
200.00 Cross Foot Adjustments	Ō					200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA				In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Pre 11/30/2018 3:		
Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG		
	5A. 01	5. 02	7. 00	8. 00	9. 00		
202.00 TOTAL (sum lines 118 through 201)	427, 112, 812	72, 526, 797	20, 919, 331	2, 252, 256	3, 994, 033	202. 00	

| Peri od: | Worksheet B | From 07/01/2017 | Part | To 06/30/2018 | Date/Time Prepared: |

Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	06/30/2018 CENTRAL	Date/Time Pre 11/30/2018 3: PHARMACY	
South Selecting the Selecting the Selection Se	DIEMM		ADMI NI STRATI ON	SERVI CES & SUPPLY		
GENERAL SERVICE COST CENTERS	10.00	11. 00	13. 00	14. 00	15. 00	
1. 00						1. 00 2. 00 4. 00 5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY	5, 109, 245					5. 02 7. 00 8. 00 9. 00 10. 00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0 0 0	5, 550, 704 365, 767 178, 549 249, 266 98, 181	6, 850, 380 0 146, 667 0	12, 414, 277 234, 609 1, 747	12, 141, 360 0	11. 00 13. 00 14. 00 15. 00 16. 00
17. 00 01700 SOCIAL SERVICE 21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRV 22. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 23. 00 02300 PARAMED ED PRGM-(SPECIFY) 23. 01 02301 PHARMACY RESIDENCY PROGRAM	0 0 0 0	100, 776 63 0 8, 037 8, 353	0 0 0 0	0 0 0 322 0	0 0 0 0	17. 00 21. 00 22. 00 23. 00 23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	0.070.001	1 100 (01	1 000 700	07/ 054		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 31. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T	3, 372, 321 0 0	1, 102, 681 0 34, 014	1, 938, 790 0 437, 984	376, 851 0 64, 710	0 0 0	30. 00 31. 00 31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT 31. 03 03101 CARDIO INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	989, 757 310, 445	110, 236 535, 488		0 312, 882	0 0	31. 02 31. 03 32. 00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	265, 457 0 0	182, 978 0 13, 036	0	97, 616 0 9, 661	0	40. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	٥	(42.407	1 02/ 00/	1 257 452	0	EO 00
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	0	642, 497 0	1, 026, 906 0	1, 257, 453 0	0	50. 00 51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	65, 813	0	O	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 397	04 274	22, 854	0	53. 00 54. 00
54. 00 05400 RADI OLOGI - DI AGNOSTI C 54. 01 05401 PET SCAN	0	332, 797 41, 196	94, 376	142, 214 0	0	54. 00
56. 00 05600 RADI OI SOTOPE	o	21, 104	7, 254	o	0	56. 00
57. 00 05700 CT SCAN	О	56, 099		32, 299	0	57.00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0	241, 988	64, 746	1, 315, 176	0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	245, 216 198, 166) 	204, 615 10, 123	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	170, 100	0	0, 123	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	4, 819	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	166, 033	33, 981	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	63, 130	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	1, 242, 399 6, 421, 004	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0	Ö	0, 121, 001	12, 141, 360	73. 00
74. 00 07400 RENAL DI ALYSI S	0	32	0	9, 974	0	74.00
76. 00 03140 CARDI O CATH LAB	0	30, 312	l	239, 384	0	76. 00
76. 01 03050 ENDOSCOPY 76. 02 03950 CARDI AC REHAB	0	32, 274 36, 102		15, 648 0	0	76. 01 76. 02
OUTPATIENT SERVICE COST CENTERS	<u> </u>	337.132	<u> </u>	<u> </u>		, 0. 02
90. 00 09000 CLI NI C	0	131, 752	1	65, 334	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	302, 169	746, 815	206, 900	0	91. 00 92. 00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0 0	145, 516 0	97, 459 0	28, 507 0	0 0	95. 00 96. 00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION	ol	20, 946	0	٥	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	o	6, 486	1	o		106. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	4, 937, 980	5, 547, 287	1	12, 414, 212	12, 141, 360	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	171 0/5	0	0	O		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 CLOSED PSYCH UNIT	171, 265 0	253 0		0		192. 00 194. 00
194. 01 07951 MARKETI NG	ő	0		o		194. 01
194. 02 07952 SENI OR CI RCLE	0	3, 164	0	65		194. 02
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	Λ	0	0		200. 00 201. 00
-1 1 -0	<u> </u>			<u> </u>		

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 07/01/2017	Part I	
			-	Γo 06/30/2018		
					11/30/2018 3:	38 pm_
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OI	N SERVICES &		
				SUPPLY		
	10.00	11. 00	13.00	14.00	15. 00	
202.00 TOTAL (sum lines 118 through 201)	5, 109, 245	5, 550, 704	6, 850, 380	12, 414, 277	12, 141, 360	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2017 Part I
To 06/30/2018 Date/Time Prepared:
11/30/2018 3:38 pm

					06/30/2018	11/30/2018 3:	
				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	17.00	APPRV	APPRV	22.00	
	GENERAL SERVICE COST CENTERS	16. 00	17. 00	21. 00	22.00	23. 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 7. 00	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT						5. 02 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	8, 596, 162					16. 00
17. 00	01700 SOCIAL SERVICE	0	l				17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	3, 656			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		3, 957, 076	740 700	22. 00
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PHARMACY RESIDENCY PROGRAM	0	0			748, 798	23. 00 23. 01
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0				23.01
30. 00	03000 ADULTS & PEDI ATRI CS	388, 289	226, 766	2, 333	2, 523, 544	479, 404	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	7, 486	l ·		0	6, 807	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	45, 867	26, 787	85	92, 486	37, 656	31. 02
31. 03 32. 00	03101 CARDIO INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	232, 718 82, 140		0	U O	156, 163 53, 704	31. 03 32. 00
40. 00	04000 SUBPROVI DER - I PF	02, 140	0	0	0	0	40.00
43. 00	04300 NURSERY	4, 979	2, 908	0	Ō	15, 064	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 469, 097	857, 972	262	284, 064	0	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 25, 147	0 14, 686	0	0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	189, 576	110, 715	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	401, 936	1	Ō	Ō	0	54. 00
54. 01	05401 PET SCAN	17, 654	10, 310	0	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	112, 913	1		0	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MRI	366, 475 100		0	0	0	57. 00 58. 00
60.00	06000 LABORATORY	671, 987	392, 450	_	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	265, 253	1	l o	o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	88, 381	51, 616	0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	10	6	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	8, 183			0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	260, 526 33, 124			0	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	605, 969			0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	790, 196			Ō	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 502, 649	l ·		0	0	73. 00
74. 00	07400 RENAL DIALYSIS	38, 666	l		0	0	74.00
76. 00 76. 01	03140 CARDIO CATH LAB 03050 ENDOSCOPY	312, 637 187, 953] 0	O O	0	76. 00 76. 01
76. 01	1 1	12, 568	l	_	0	0	76. 01
70.02	OUTPATIENT SERVICE COST CENTERS	12,000	7,010		<u> </u>		70.02
90.00	09000 CLI NI C	11, 163		549	594, 552	0	90. 00
91. 00	09100 EMERGENCY	417, 909	244, 065	427	462, 430	0	91.00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	27, 621	16, 131	0	ol	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0			o	0	96.00
	SPECIAL PURPOSE COST CENTERS				-,		
	10500 KIDNEY ACQUISITION	5, 232	1		0		105. 00
	10600 HEART ACQUISITION	11, 758			0		106. 00
118. 00	,	8, 596, 162	5, 020, 832	3, 656	3, 957, 076	748, 798	118.00
190 0	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	n	0	nl	n	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1	0	ol		192. 00
194.00	07950 CLOSED PSYCH UNIT	0	0	0	O	0	194. 00
	07951 MARKETI NG	0	0	0	0		194. 01
	207952 SENI OR CI RCLE	0		0	0		194. 02
194.0	3 07953 OTHER NONREIMBURSABLE COST CENTERS	0	1 0	ı U	· η	0	194. 03

Health Financial S	Systems	LUTHERAN HOSPITAL	OF INDIANA	In Li	eu of Form CMS-2552-10
COST ALLOCATION -	GENERAL SERVICE COSTS		Provider CCN:	Period: From 07/01/201 To 06/30/201	Worksheet B 7 Part I 8 Date/Time Prepared: 11/30/2018 3:38 pm

						11/30/2018 3:	38 pm
				INTERNS &	RESI DENTS		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SEDVICES SALAD	SERVI CES-OTHER	PARAMED ED	
	cost center bescription	RECORDS &	SUCTAL SERVICE	Y & FRINGES	PRGM COSTS	PRGM	
		LI BRARY		APPRV	APPRV	i itom	
		16. 00	17. 00	21.00	22. 00	23. 00	
200.00	Cross Foot Adjustments			0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	8, 596, 162	5, 020, 832	3, 656	3, 957, 076	748, 798	202.00

	ALLOCATION - GENERAL SERVICE COSTS	UTHERAN HUSPITAL	Provider C	CN, 15 0017 D		Worksheet B
CUST	ALLUCATION - GENERAL SERVICE COSTS		Provider Co		eriod: fom 07/01/2017 o 06/30/2018	Part I
	Cost Center Description	PHARMACY RESI DENCY PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23. 01	24.00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS					
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMITTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
16. 00 17. 00 21. 00 22. 00 23. 00 23. 01	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) 02301 PHARMACY RESIDENCY PROGRAM	292, 736				16. 00 17. 00 21. 00 22. 00 23. 00 23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS		(0.570.070	0 505 077	50.040.400	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0 0	60, 573, 979 0		58, 048, 102 0	30. 00 31. 00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	Ö	2, 503, 604		2, 503, 604	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	o	7, 693, 045	1	7, 600, 474	31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT	0	31, 492, 050	1	31, 492, 050	31. 03
32. 00 40. 00	03200 CORONARY CARE UNIT 04000 SUBPROVI DER - I PF	0	10, 655, 109	0	10, 655, 109	32. 00 40. 00
43. 00	04300 NURSERY		592, 680		592, 680	43. 00
	ANCILLARY SERVICE COST CENTERS		,			
50.00	05000 OPERATING ROOM	0	45, 587, 203		45, 302, 877	50. 00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0 2, 716, 510	0	0 2, 716, 510	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		981, 832	1	981, 832	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	17, 349, 903	0	17, 349, 903	54.00
54. 01	05401 PET SCAN	0	311, 194	1	311, 194	54. 01
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	0	1, 252, 784 3, 804, 019		1, 252, 784 3, 804, 019	56. 00 57. 00
58. 00	05800 MRI		2, 609		2, 609	58.00
60.00	06000 LABORATORY	o	26, 258, 218		26, 258, 218	60. 00
65.00	06500 RESPI RATORY THERAPY	0	10, 056, 955	1	10, 056, 955	65. 00
66.00	06600 PHYSI CAL THERAPY	0	8, 648, 596		8, 648, 596	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		52, 823 589, 103		52, 823 589, 103	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	Ö	6, 319, 515	1	6, 319, 515	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	3, 442, 284	1	3, 442, 284	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	12, 146, 983	1	12, 146, 983 58, 441, 790	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	292, 736	58, 441, 790 55, 064, 078		55, 064, 078	73. 00
74.00	07400 RENAL DIALYSIS	o	4, 394, 368	1	4, 394, 368	74. 00
76. 00	03140 CARDIO CATH LAB	0	8, 041, 558	1	8, 041, 558	76. 00
76. 01 76. 02	03050 ENDOSCOPY 03950 CARDI AC REHAB	0	9, 756, 882 996, 985	1	9, 756, 882 996, 985	76. 01 76. 02
70.02	OUTPATIENT SERVICE COST CENTERS	U	770, 703	<u> </u>	770, 765	70.02
90.00	09000 CLI NI C	0	8, 511, 676	-595, 101	7, 916, 575	90.00
91. 00	09100 EMERGENCY	0	16, 174, 947	1	15, 712, 090	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			0		92. 00
95. 00	09500 AMBULANCE SERVICES	ol	8, 694, 744	lo	8, 694, 744	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	Ö	0	1	0	
	SPECIAL PURPOSE COST CENTERS	_				
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	2, 119, 453 789, 351		2, 119, 453 789, 351	105. 00 106. 00
118.00		292, 736	426, 016, 830		422, 056, 098	
	NONREI MBURSABLE COST CENTERS	2,2,,00	, 5.5, 650	5,755,752	, 550, 570	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	181, 464	1	181, 464	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	814, 214	0	814, 214	192. 00
	007950 CLOSED PSYCH UNIT 07951 MARKETING		0	0	0	194. 00 194. 01
	207952 SENIOR CIRCLE	o	100, 304	o o	100, 304	194. 02
194. 03	07953 OTHER NONREIMBURSABLE COST CENTERS	o	0	0	o	194. 03

Health Financial Systems					eu of Form CMS-2552-10	
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 07/01/2017 To 06/30/2018	Part I Date/Time Prep 11/30/2018 3:3	
Cost Center Description	PHARMACY	Subtotal	Intern &	Total		
	RESI DENCY		Residents Cos	t		
	PROGRAM		& Post			
			Stepdown			
			Adjustments			
	23. 01	24.00	25. 00	26.00		
200.00 Cross Foot Adjustments	0	0		0 0	[2	200. 00
201.00 Negative Cost Centers	0	0		0 0	[2	201. 00
202.00 TOTAL (sum lines 118 through 201)	292, 736	427, 112, 812	-3, 960, 73	423, 152, 080	2	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0017

					lo	06/30/2018	Date/lime Pre 11/30/2018 3:	
				CAPI TAL REI	LATED COSTS			
		Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Related Costs					
	CENED	AL SERVICE COST CENTERS	0	1.00	2.00	2A	4. 00	
1. 00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	391, 035		416, 806	416, 806	4. 00
5. 01		ADMITTING	0	325, 201		362, 491	17, 145	5. 01
5. 02 7. 00	1	OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	0	632, 132 3, 231, 508		10, 062, 199 3, 757, 253	25, 703 6, 247	5. 02 7. 00
8.00		LAUNDRY & LINEN SERVICE	o o	18, 750		18, 750	0, 217	8. 00
9.00	1	HOUSEKEEPI NG	0	62, 952		92, 543	4, 931	9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	0	605, 845 0		685, 319 0	0	10. 00 11. 00
13.00	1	NURSING ADMINISTRATION	0	143, 256	_	163, 460	11, 910	
14. 00		CENTRAL SERVICES & SUPPLY	o	261, 622		488, 664	7, 446	
15. 00		PHARMACY	0	149, 770		292, 527	22, 128	15. 00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	159, 959 107, 760		177, 753 107, 760	7, 432 8, 118	
21. 00		I &R SERVICES-SALARY & FRINGES APPRV	0	107, 700	1	107, 700	8, 118	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	o	0		Ō	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	60, 384	1	60, 671	615	23. 00
23. 01		PHARMACY RESIDENCY PROGRAM I ENT ROUTINE SERVICE COST CENTERS	0	0	0	0	577	23. 01
30. 00		ADULTS & PEDIATRICS	O	2, 081, 830	823, 662	2, 905, 492	61, 753	30. 00
31. 00		INTENSIVE CARE UNIT	O	0		0	0	31. 00
31. 01		PEDIATRIC INTENSIVE CARE UNIT	0	137, 702		167, 385	2, 565	
31. 02 31. 03		NEONATAL INTENSIVE CARE UNIT CARDIO INTENSIVE CARE UNIT	0	231, 096 825, 750		937, 175 1, 124, 589	8, 571 37, 705	31. 02 31. 03
32. 00		CORONARY CARE UNIT	o	321, 547		355, 823	14, 511	32. 00
40.00	04000	SUBPROVI DER - I PF	O	0		0	0	40. 00
43.00		NURSERY	0	11, 400	1, 082	12, 482	977	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	2, 207, 755	2, 163, 180	4, 370, 935	30, 819	50. 00
51. 00		RECOVERY ROOM	o	2,207,733		4, 370, 733	0 0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	4, 932	
53. 00	1	ANESTHESI OLOGY	0	1, 670		1, 670	286	53.00
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C PET SCAN	0	330, 880 36, 017		1, 892, 476 69, 504	21, 969 97	54. 00 54. 01
56. 00	1	RADI OI SOTOPE	o o	83, 895		129, 903	1, 728	
57. 00		CT SCAN	o	41, 488	89, 854	131, 342	3, 657	57. 00
58. 00	05800		0	252,020	0	704 943	14 171	58. 00
60. 00 65. 00		LABORATORY RESPI RATORY THERAPY	0	352, 929 119, 954		706, 862 297, 911	16, 171 15, 517	60. 00 65. 00
66. 00		PHYSI CAL THERAPY	Ö	253, 897		275, 115	15, 410	
67. 00		OCCUPATIONAL THERAPY	o	0		o	5	67. 00
68.00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	300 500	0,2,020	392, 523	7 544	
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	300, 500 31, 403		300, 500 376, 468	4, 042	69. 00 70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	0	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0 165, 785	2, 562	0 168, 347	0	73. 00 74. 00
76. 00		CARDIO CATH LAB	0	135, 133		919, 889	5, 379	
76. 01		ENDOSCOPY	0	145, 239		968, 265	10, 580	
76. 02		CARDI AC REHAB	0	0	16, 127	16, 127	1, 871	76. 02
90. 00		TIENT SERVICE COST CENTERS CLINIC	O	426, 614	46, 024	472, 638	9, 385	90. 00
91. 00		EMERGENCY	o o	421, 206		671, 718	18, 797	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
05 00		REIMBURSABLE COST CENTERS		0 / 1/	702 022	702 (70	0.07/	05.00
95. 00 96. 00		AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	0	9, 646 0		792, 679 0	8, 276 0	
70. 00		AL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u></u>		70.00
		KIDNEY ACQUISITION	0	54, 016	0	54, 016		105. 00
		HEART ACQUISITION	0	14 077 524	0	0		106.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	ı O	14, 877, 526	20, 320, 504	35, 198, 030	416, 639	1110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	50, 195	0	50, 195	0	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	o	0		165, 450		192. 00
		CLOSED PSYCH UNIT MARKETING	0	0	0	0		194. 00 194. 01
		SENIOR CIRCLE	0	0	-	0		194. 01
	1	1	<u>, </u>		. 9	٩		

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B		
				From 07/01/2017 To 06/30/2018	Part II Date/Time Pre 11/30/2018 3:		
		CAPITAL REI	LATED COSTS				
Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS		
	Capi tal Rel ated Costs				DEPARTMENT		
	0	1. 00	2.00	2A	4. 00		
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	194. 03	
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0		201. 00	
202.00 TOTAL (sum lines 118 through 201)	0	14, 927, 721	20, 485, 95	4 35, 413, 675	416, 806	202. 00	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2017 Part II
To 06/30/2018 Date/Time Prepared: 11/30/2018 3:38 pm

				00/30/2010	11/30/2018 3:	
Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE		
	5. 01	5. 02	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	070 (0)					4.00
5. 01 00540 ADMITTING 5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	379, 636 0	l				5. 01 5. 02
7.00 OO700 OPERATION OF PLANT	0	10, 087, 902 494, 094				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	52, 301	7, 715			8.00
9. 00 00900 HOUSEKEEPI NG	0	91, 329			214, 705	9. 00
10. 00 01000 DI ETARY	0	86, 180		0	12, 671	10.00
11. 00 01100 CAFETERI A	0	131, 102	0	0	0	11. 00
13.00 O1300 NURSING ADMINISTRATION	0	145, 003	58, 942	0	2, 996	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	274, 100		0	5, 472	14. 00
15. 00 01500 PHARMACY	0	263, 346		0	3, 132	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	191, 565		0	3, 345	16.00
17. 00 01700 SOCIAL SERVICE 21. 00 02100 &R SERVICES-SALARY & FRINGES APPRV	0	110, 071 85	44, 338 0	0	2, 254 0	17. 00 21. 00
22. 00 02200 I &R SERVI CES-SALARI & FRINGES APPRV	0	93, 462	•	0	0	22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0		•	248	1, 263	
23. 01 02301 PHARMACY RESI DENCY PROGRAM	0			0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	-	91		-1		
30. 00 03000 ADULTS & PEDIATRICS	17, 169	1, 045, 878	856, 563	30, 189	43, 539	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	331	34, 566		5, 344	2, 880	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	2, 028	l		322	4, 833	
31. 03 03101 CARDIO INTENSIVE CARE UNIT	10, 290	l	339, 753		17, 270	31. 03
32. 00 03200 CORONARY CARE UNIT	3, 632	201, 491	132, 300	3, 139	6, 725	32.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	0 220	12, 271	0 4, 691	0	0 238	40. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	220	12, 271	4, 091	U	230	43.00
50. 00 05000 OPERATING ROOM	64, 960	810, 695	908, 373	14, 092	46, 170	50.00
51. 00 05100 RECOVERY ROOM	01,700	010,070	0	0	0, 170	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 112	61, 666	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	8, 383	15, 240	687	0	35	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 773	359, 957	136, 140	3, 708	6, 920	54.00
54. 01 05401 PET SCAN	781	3, 666		0	753	54. 01
56. 00 05600 RADI 01 SOTOPE	4, 993	19, 919			1, 755	56. 00
57. 00 05700 CT SCAN	16, 205	l		1, 388	868	57. 00
58. 00 05800 MRI	20. 71.4	58	•	0	7 201	58.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	29, 714	536, 634		22	7, 381	60. 00 65. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	11, 729 3, 908	l		277 0	2, 509 5, 310	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 700	1, 247		0	5, 310	67.00
68. 00 06800 SPEECH PATHOLOGY	362	l		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	11, 520			0	6, 285	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 465	l		0	657	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 795	234, 884	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	34, 941	1, 199, 043	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	65, 975			0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	1, 710	1		245	3, 467	74. 00
76. 00 03140 CARDI O CATH LAB	13, 824	l			2, 826	76. 00
76. 01 03050 ENDOSCOPY	8, 311	212, 487		2, 262	3, 038	76. 01
76. 02 03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	556	22, 225	0	0	0	76. 02
90. 00 09000 CLINIC	494	150, 943	175, 529	1, 342	8, 922	90.00
91. 00 09100 EMERGENCY	18, 479				8, 809	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 477	275, 272	173, 304	7, 070	0,007	92.00
OTHER REIMBURSABLE COST CENTERS						/2.00
95. 00 09500 AMBULANCE SERVICES	1, 221	197, 366	3, 969	0	202	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	231			0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	520			12		106. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	379, 636	10, 069, 001	4, 236, 941	78, 766	213, 655	118. 00
NONREI MBURSABLE COST CENTERS	^	1 400	20 /52		1 050	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			0		190. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 194. 00 07950 CLOSED PSYCH UNIT	0			0		194. 00
194. 00 07950 CLOSED PSYCH UNIT	0	· -		٥		194. 00
194. 02 07952 SENI OR CI RCLE	0	2, 293	1 0	0		194. 01
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	l	Ö	o		194. 03
200.00 Cross Foot Adjustments	· ·			ا	· ·	200. 00
201.00 Negative Cost Centers	0	0	0	О	0	201. 00

Health Financial Systems LUTHERAN HOSPITAL OF INDIANA In I				In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 07/01/2017 o 06/30/2018	Part II Date/Time Pre	nared:
					11/30/2018 3:	
Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE		
		AND GENERAL				
	5. 01	5. 02	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118 through 201)	379, 636	10, 087, 902	4, 257, 594	78, 766	214, 705	202. 00

			10	06/30/2018	Date/lime Pre 11/30/2018 3:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	рш
			ADMI NI STRATI ON	SERVICES &		
	10.00	11. 00	13.00	SUPPLY 14.00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00540 ADMI TTI NG						5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING						8. 00 9. 00
10. 00 01000 DI ETARY	1, 033, 443		•			10.00
11. 00 01100 CAFETERI A	1, 033, 443	131, 102				11. 00
13. 00 01300 NURSING ADMINISTRATION	o	8, 639	1			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	4, 217	0	887, 543		14.00
15. 00 01500 PHARMACY	0	5, 887	8, 370	16, 773	673, 785	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	2, 319	1	125	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	2, 380	0	0	0	17. 00
21. 00 02100 1&R SERVI CES-SALARY & FRINGES APPRV	0	1	0	0	0	21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	100	0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) 23. 01 02301 PHARMACY RESIDENCY PROGRAM	0	190 197		23	0	23. 00 23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	17/	l o	<u> </u>	0	23.01
30. 00 03000 ADULTS & PEDI ATRI CS	682, 116	26, 045	110, 662	26, 943	0	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0	0	31. 00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	О	803	24, 994	4, 626	0	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	200, 197	2, 604		0	0	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	62, 794	12, 648	77, 019	22, 370	0	31. 03
32. 00 03200 CORONARY CARE UNIT	53, 694	4, 322	30, 214	6, 979	0	32.00
40. 00 04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	0	308	0	691	0	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	ol	15, 175	58, 602	89, 902	0	50. 00
51. 00 05100 RECOVERY ROOM	0	15, 175	0	07, 702	0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 554		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	o	222	1	1, 634	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	7, 860	1	10, 168	0	54.00
54. 01 05401 PET SCAN	0	973	0	0	0	54. 01
56. 00 05600 RADI OI SOTOPE	0	498	414	0	0	56.00
57. 00 05700 CT SCAN	0	1, 325	0	2, 309	0	57. 00
58. 00 05800 MRI	0	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0	5, 716		94, 029	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	5, 792	1	14, 629	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	4, 680	0	724	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		345	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	9, 475	2, 430	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0	0	4, 513	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	o	88, 826	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	459, 051	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	673, 785	73.00
74. 00 07400 RENAL DI ALYSI S	0	1	0	713	0	74.00
76. 00 03140 CARDI O CATH LAB	0	716		17, 115	0	76. 00
76. 01 03050 ENDOSCOPY	0	762		1, 119	0	76. 01
76. 02 03950 CARDI AC REHAB	0	853	0	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	2 112	12 020	4 471	0	90. 00
91. 00 09100 EMERGENCY	0	3, 112 7, 137		4, 671 14, 792	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o _l	7, 137	42,010	14, 772	U	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	0	3, 437	5, 562	2, 038	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	О	0	0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	495	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	153		0		106. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	998, 801	131, 021	390, 950	887, 538	673, 785	118. 00
NONREI MBURSABLE COST CENTERS	ما					
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 CLOSED PSYCH UNIT	34, 642	6		0		192. 00 194. 00
194. 00 07950 CLOSED PSYCH UNIT	0	0		0		194. 00 194. 01
194. 02 07952 SENI OR CI RCLE	0	75		5		194. 01
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	73		0		194. 02
200.00 Cross Foot Adjustments	J	O		Ĭ	O	200. 00
201.00 Negative Cost Centers	0	0	О	o	0	201. 00
				·		

Health Financial Systems	LUTHERAN HOSPITA	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
			F	rom 07/01/2017	Part II	
			1	To 06/30/2018		
					11/30/2018 3:	38 pm_
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
202.00 TOTAL (sum lines 118 through 201)	1, 033, 443	131, 102	390, 950	887, 543	673, 785	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0017

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 07/01/2017 Part II | To 06/30/2018 Date/Time Prepared: 11/30/2018 3: 38 pm

					0 00/30/2010	11/30/2018 3:	
				I NTERNS &	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	
G	ENERAL SERVICE COST CENTERS	10.00	17.00	21.00	22.00	23.00	
1	O100 CAP REL COSTS-BLDG & FIXT						1.00
1	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT 0540 ADMITTING						4. 00 5. 01
	0560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
	0700 OPERATION OF PLANT						7. 00
	0800 LAUNDRY & LINEN SERVICE						8. 00
	0900 HOUSEKEEPI NG 1000 DI ETARY						9. 00 10. 00
	1100 CAFETERI A						11.00
	1300 NURSING ADMINISTRATION						13. 00
	1400 CENTRAL SERVICES & SUPPLY						14. 00
	1500 PHARMACY	440.254					15.00
1	1600 MEDICAL RECORDS & LIBRARY 1700 SOCIAL SERVICE	448, 354 0	274, 921				16. 00 17. 00
1	2100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	94			21.00
1	2200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		93, 462		22. 00
1	2300 PARAMED ED PRGM-(SPECIFY)	0	0			101, 738	•
	2301 PHARMACY RESIDENCY PROGRAM	0	0				23. 01
	NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS	20, 207	12, 415				30.00
	3100 I NTENSI VE CARE UNI T	0	0				31.00
1	2080 PEDIATRIC INTENSIVE CARE UNIT	390	239	•			31. 01
1	2060 NEONATAL INTENSIVE CARE UNIT	2, 387	1, 466				31. 02
4	3101 CARDIO INTENSIVE CARE UNIT 3200 CORONARY CARE UNIT	12, 111 4, 275	7, 441 2, 626				31. 03 32. 00
	4000 SUBPROVI DER - I PF	0	0				40.00
	4300 NURSERY	259	159				43. 00
	NCILLARY SERVICE COST CENTERS	7/ 452	4/ 071	I	I I		
1	5000 OPERATING ROOM 5100 RECOVERY ROOM	76, 453 0	46, 971 0				50. 00 51. 00
1	5200 DELIVERY ROOM & LABOR ROOM	1, 309	804	•			52.00
	5300 ANESTHESI OLOGY	9, 866	6, 061				53. 00
	5400 RADI OLOGY-DI AGNOSTI C	20, 917	12, 851				54.00
	5401 PET SCAN 5600 RADI OI SOTOPE	919 5, 876	564 3, 610				54. 01 56. 00
	5700 CT SCAN	19, 072	11, 717				57. 00
	5800 MRI	5	3				58. 00
	6000 LABORATORY	34, 971	21, 485				60.00
1	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	13, 804 4, 599	8, 481 2, 826				65. 00 66. 00
1	6700 OCCUPATIONAL THERAPY	1, 377	0	1			67. 00
1	6800 SPEECH PATHOLOGY	426	262				68. 00
1	6900 ELECTROCARDI OLOGY	13, 558					69. 00
	7000 ELECTROENCEPHALOGRAPHY 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 724 31, 535					70. 00 71. 00
4	7200 IMPL. DEV. CHARGED TO PATIENTS	41, 122	25, 265				72.00
4	7300 DRUGS CHARGED TO PATIENTS	79, 201	48, 123				73. 00
	7400 RENAL DIALYSIS	2, 012					74. 00
	3140 CARDI O CATH LAB 3050 ENDOSCOPY	16, 270 9, 781	9, 996 6, 009				76. 00 76. 01
4	3950 CARDI AC REHAB	654	402				76. 01
	UTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	581	357	•			90.00
	9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT PART	21, 748	13, 362				91. 00 92. 00
	THER REIMBURSABLE COST CENTERS						92.00
	9500 AMBULANCE SERVICES	1, 437	883				95. 00
	9600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96. 00
	PECIAL PURPOSE COST CENTERS 0500 KIDNEY ACQUISITION	272	167	I			105. 00
	0600 HEART ACQUISITION	612					105.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	448, 354	274, 921		О	0	118. 00
_	ONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	9200 PHYSICIANS' PRIVATE OFFICES 7950 CLOSED PSYCH UNIT	0) 0 n				192. 00 194. 00
194. 01 0	7951 MARKETI NG	0	Ö				194. 01
	7952 SENI OR CI RCLE	0					194. 02
194. 03 0	7953 OTHER NONREIMBURSABLE COST CENTERS	0	0	1			194. 03

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-00	17

						11/30/2018 3:	38 pm
				INTERNS &	RESI DENTS		
		MEDICAL	COOLAL CEDVILOE	CEDITION CALAB	CEDVI OEC OTHER	DADAMED ED	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVICES-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			94	93, 462	101, 738	200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	448, 354	274, 921	94	93, 462	101, 738	202. 00

	•	LUTHERAN HUSPITA		CN 15 0017 5		U OF FORM CMS-2552-11
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der Co	F	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/30/2018 3:38 pm
	Cost Center Description	PHARMACY RESI DENCY PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23. 01	24. 00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS			1		4 00
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMITTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA					1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00
13. 00 14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	7, 491				13. 00 14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			1		
30. 00 31. 00 31. 01	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02080 PEDIATRIC INTENSIVE CARE UNIT		5, 838, 971 0 300, 780	1	0	30. 00 31. 00 31. 01
31. 02	1 1		1, 392, 221			31. 02
31. 03	+ I		2, 351, 037	c	_, _,,	31. 03
32.00	03200 CORONARY CARE UNIT		819, 731	C		32.00
40. 00 43. 00	+ I		32, 296	C		40.00
10.00	ANCI LLARY SERVI CE COST CENTERS	1	02,270	1	02,270	10.00
50.00	1 1		6, 533, 147	i		50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM		0 71, 377			51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		44, 084	l .		53.00
54. 00	1		2, 496, 125	l .		54.00
54. 01	05401 PET SCAN		92, 076	l .	, , , , , , ,	54. 01
56.00			203, 214	1	203, 214	56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI		275, 701 70	C		57. 00 58. 00
60.00	06000 LABORATORY		1, 601, 892	l .		60.00
65. 00	06500 RESPI RATORY THERAPY		629, 974	1		65. 00
66. 00			598, 626			66. 00
67.00			1, 253			67. 00
68. 00 69. 00	1 1		407, 412 600, 964		407, 412 600, 964	68. 00 69. 00
70. 00			479, 634		479, 634	70.00
71. 00			401, 415	1		71.00
72.00	1 1		1, 759, 422	1	.,,	72.00
73. 00 74. 00	1 1		1, 817, 730 338, 446	1	1, 817, 730 338, 446	73. 00 74. 00
76. 00			1, 206, 005			76. 00
76. 01	03050 ENDOSCOPY		1, 282, 372			76. 01
76. 02	03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS		42, 688	(<u>)</u>	42, 688	76. 02
90. 00			841, 913		841, 913	90.00
91. 00	1 1		1, 295, 726	l .		91. 00
92. 00	`			<u> </u>)	92.00
95. 00	OTHER REIMBURSABLE COST CENTERS		1 017 070		1 017 070	95. 00
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED SPECI AL PURPOSE COST CENTERS		1, 017, 070 0			
	10500 KIDNEY ACQUISITION		126, 199			105. 00
106. 00 118. 00	·	0	20, 175 34, 919, 746	l .		
100.0	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		72 22/		72 224	100.00
	0 19000 GIFI, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES		73, 326 215, 288	1		190. 00 192. 00
	07950 CLOSED PSYCH UNIT		213, 200		0	194. 00
194.0	1 07951 MARKETI NG		0	C	0	194. 01
	2 07952 SENI OR CI RCLE		2, 530	1		194. 02
194. ()	3 07953 OTHER NONREIMBURSABLE COST CENTERS	1	0	() C	ار (۱	194. 03

Health Financial Systems	LUTHERAN HOSPITA	AL OF INDIANA		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 07/01/2017	Part II	
				To 06/30/2018	Date/Time Pre 11/30/2018 3:	pared: 38 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	7, 491	202, 785		0 202, 785		200. 00
201.00 Negative Cost Centers	0	0		0		201. 00
202.00 TOTAL (sum lines 118 through 201)	7, 491	35, 413, 675		0 35, 413, 675		202. 00

		LUTHERAN HOSPITA				u of Form CMS-2	
COST A	ILLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 07/01/2017	Worksheet B-1	
				Т	o 06/30/2018	Date/Time Pre 11/30/2018 3:	pared: 38 pm
		CAPITAL REL	ATED COSTS			117 007 2010 0.	рш
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	Reconciliation	
	cost center bescriptron		(DOLLAR VALUE)	BENEFITS	(GROSS CHAR	Recording to	
				DEPARTMENT	GES)		
				(GROSS SALARI ES)			
		1.00	2. 00	4. 00	5. 01	5A. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	714, 940	40 -000				1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT	18, 728	13, 505, 593 16, 990	129, 428, 112			2. 00 4. 00
5. 01	00540 ADMI TTI NG	15, 575	24, 584		2, 923, 820, 029		5. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	30, 275	6, 216, 879			-72, 526, 797	5. 02
7.00	00700 OPERATION OF PLANT	154, 768	346, 603	1, 940, 114		0	
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	898 3, 015	19, 508	1, 531, 401	0	0	8. 00 9. 00
10.00	01000 DI ETARY	29, 016	52, 394		0	0	10.00
11.00	01100 CAFETERI A	0	0	0	0	0	11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	6, 861 12, 530	13, 320 149, 680	3, 698, 699 2, 312, 421	0	0	13. 00 14. 00
15. 00	01500 PHARMACY	7, 173	94, 114		0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	7, 661	11, 731	2, 308, 095	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	5, 161	0	2, 521, 107		0	17. 00
21. 00 22. 00	O2100 I &R SERVI CES-SALARY & FRINGES APPRV O2200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	2, 620 0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	2, 892	189	190, 883	0	0	1
23. 01	02301 PHARMACY RESIDENCY PROGRAM	0	0	179, 106	0	0	23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	99, 706	543, 008	19, 163, 294	132, 071, 063	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	6, 595	19, 569			0	
31. 02 31. 03	02060 NEONATAL INTENSIVE CARE UNIT 03101 CARDIO INTENSIVE CARE UNIT	11, 068	465, 490	2, 661, 925		0	31. 02 31. 03
32. 00	03200 CORONARY CARE UNIT	39, 548 15, 400	197, 013 22, 597	11, 709, 738 4, 506, 462		0	1
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	
43.00	04300 NURSERY	546	713	303, 274	1, 693, 639	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	105, 737	1, 426, 100	9, 570, 979	499, 692, 761	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0		0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1, 531, 624		0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	80 15, 847	0 1, 029, 499	88, 877 6, 822, 810		0	53. 00 54. 00
54. 01	05401 PET SCAN	1, 725	22, 077	30, 279		0	1
56.00	05600 RADI 0I SOTOPE	4, 018	30, 331	536, 558		0	00.00
57. 00	05700 CT SCAN	1, 987	59, 237	1, 135, 731		0	
58. 00 60. 00	05800 MRI	16, 903	233, 334	0 5, 021, 925		0	
65. 00	1 1	5, 745	117, 320			0	
66.00	06600 PHYSI CAL THERAPY	12, 160	13, 988			0	
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	0 258, 775	1, 444 0		0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	14, 392	230, 773	2, 343, 324		0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 504	227, 488	1, 255, 327		0	
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	206, 111, 805 268, 774, 145	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		511, 060, 003	0	73.00
74.00	07400 RENAL DIALYSIS	7, 940	1, 689	147	13, 151, 829	0	74. 00
76.00	03140 CARDIO CATH LAB	6, 472	517, 359			0	76.00
76. 01 76. 02	03050 ENDOSCOPY 03950 CARDI AC REHAB	6, 956 0	542, 589 10, 632	3, 285, 779 580, 991		0	
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	10, 032	300, 771	4, 274, 000	<u> </u>	70.02
90.00	09000 CLI NI C	20, 432	30, 342			0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	20, 173	165, 153	5, 837, 697	142, 146, 007	0	91. 00 92. 00
9 2.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	462	516, 223	2, 570, 135	9, 395, 006	0	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	2, 587	n	425, 490	1, 779, 720	0	105. 00
	10600 HEART ACQUISITION	2, 367	0	143, 001			106. 00
118.00		712, 536	13, 396, 518	129, 376, 024	2, 923, 820, 029	-72, 526, 797	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 404	0	^	0	0	190. 00
	19000 PHYSI CLANS' PRI VATE OFFICES	2, 404	109, 075	3, 228	_		190.00
194.00	07950 CLOSED PSYCH UNIT	0	0	0	0	0	194. 00
194. 01	07951 MARKETI NG	0	0	0	0	0	194. 01

Health Financial Systems	LUTHERAN HOSPITAL	OF INDIANA		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od: From 07/01/2017	Worksheet B-1	
				To 06/30/2018	Date/Time Prep 11/30/2018 3:3	
	CAPITAL RELAT	ED COSTS				·
Cook Cooker Doorsinting	DLDC 0 FLVT M	VIDLE FOLLID	TMDL OVEE	ADMITTING	ln ! ! ! ! !	

						11/30/2018 3:	38 pm
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMITTING	Reconciliation	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	(GROSS CHAR		
				DEPARTMENT	GES)		
				(GROSS			
				SALARI ES)			
		1. 00	2. 00	4. 00	5. 01	5A. 02	
	07952 SENI OR CI RCLE	0	0	48, 860	0		194. 02
194. 03	07953 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194. 03
200.00	,						200. 00
201.00	Negative Cost Centers						201. 00
202.00		14, 927, 721	20, 485, 954	22, 093, 806	12, 313, 066		202. 00
	Part I)						
203.00		20. 879684	1. 516850				203. 00
204.00				416, 806	379, 636		204. 00
	Part II)						
205.00				0. 003220	0. 000130		205. 00
	[11]						
206. 00	, ,						206. 00
	(per Wkst. B-2)						
207. 00							207. 00
	Parts III and IV)					1	

				1	0 00/30/2016	Date/lime Pre 11/30/2018 3:	
	Cost Center Description	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (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 & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	OO540 ADMITTING OO560 OTHER ADMINISTRATIVE AND GENERAL	354, 586, 015					5. 01 5. 02
7. 00	00700 OPERATION OF PLANT	17, 367, 085	ł				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 838, 339	l	1			8. 00
9.00	00900 HOUSEKEEPI NG	3, 210, 164	3, 015	0	491, 681		9. 00
10.00	01000 DI ETARY	3, 029, 175	l	0	29, 016		10.00
11.00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	4, 608, 156	l e	0	0	0 0	11.00
13. 00 14. 00	01400 CENTRAL SERVICES & SUPPLY	5, 096, 782 9, 634, 429	l	0	6, 861 12, 530	0	13. 00 14. 00
15. 00	01500 PHARMACY	9, 256, 465	l	1	7, 173	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 733, 386	l	I	7, 661	0	16. 00
17. 00	01700 SOCIAL SERVICE	3, 868, 935	5, 161	0	5, 161	0	17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	2, 983	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	3, 285, 137	0	0	0	0	22. 00
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PHARMACY RESI DENCY PROGRAM	487, 972 236, 093	2, 892	1	2, 892	0 0	23. 00 23. 01
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	250, 075		1	J		25.01
30.00	03000 ADULTS & PEDI ATRI CS	36, 761, 966	99, 706	784, 129	99, 706	184, 777	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	1, 214, 967	6, 595	l		0	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	4, 834, 936		1	11, 068	54, 231	31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT	21, 835, 171	39, 548		39, 548		31. 03
32. 00 40. 00	03200 CORONARY CARE UNIT 04000 SUBPROVI DER - I PF	7, 082, 296	15, 400	81, 525 0	15, 400	14, 545 0	32. 00 40. 00
43. 00	04300 NURSERY	431, 327	546	_	546	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	28, 495, 415	105, 737	366, 054	105, 737	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 167, 521	0	0	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	535, 693 12, 652, 278	80 15, 847	1	80 15, 847	0 0	53. 00 54. 00
54. 00	05400 RADI OLOGI - DI AGNOSTI C	12, 652, 276	l	1	1, 725	0	54. 00
56. 00	05600 RADI OI SOTOPE	700, 126	l		4, 018	Ö	56. 00
57.00	05700 CT SCAN	2, 486, 763	l	1		0	57. 00
58. 00	05800 MRI	2, 034	0	0	0	0	58. 00
60.00	06000 LABORATORY	18, 862, 365			16, 903	0	60.00
65. 00	06500 RESPI RATORY THERAPY	7, 380, 306		1		0	65. 00 66. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 382, 733 43, 840	l	1	12, 160	0 0	67.00
68. 00	06800 SPEECH PATHOLOGY	474, 308	l	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 136, 371	14, 392	Ö	14, 392	Ö	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 698, 944				0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 256, 039	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	42, 148, 054	l	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	33, 414, 620		0	0	0	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03140 CARDI O CATH LAB	3, 251, 421 5, 754, 673	7, 940 6, 472	l			74. 00 76. 00
76. 00	03050 ENDOSCOPY	7, 468, 787		l			76. 00
76. 01	03950 CARDI AC REHAB	7, 400, 707	0, 730	0	0, 730	Ö	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	5, 305, 558	l	l			90. 00
91.00	09100 EMERGENCY	10, 379, 345	20, 173	251, 194	20, 173	0	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	6, 937, 306	462	0	462	0	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0, 757, 500	i e	1	0	Ö	96. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	1, 627, 183	2, 587		2, 587		105. 00
	10600 HEART ACQUISITION	634, 176		1			106. 00
118. 00	9 /	353, 921, 667	493, 190	2, 045, 965	489, 277	270, 563	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	50, 195	2, 404	1 0	2, 404	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	533, 562	l	l o	2, 404		190.00
	07950 CLOSED PSYCH UNIT	0	, o	Ö	0	0	194. 00
194. 01	07951 MARKETI NG	0	0	0	0	0	194. 01
	07952 SENI OR CIRCLE	80, 591	0	0	0	0	194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 03
200.00	Cross Foot Adjustments			l			200. 00

Heal th Fi	nancial Systems	UTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provider Co		eri od:	Worksheet B-1	
					rom 07/01/2017 o 06/30/2018	Date/Time Pre	narod:
				'	0 00/30/2018	11/30/2018 3:	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		AND GENERAL	(SQUARE FEET)	(POUNDS OF			
		(ACCUM. COST)		LAUNDRY)			
		5. 02	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	72, 526, 797	20, 919, 331	2, 252, 256	3, 994, 033	5, 109, 245	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 204539	42. 210622	1. 100828	8. 123220	18. 250758	203. 00
204.00	Cost to be allocated (per Wkst. B,	10, 087, 902	4, 257, 594	78, 766	214, 705	1, 033, 443	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 028450	8. 590891	0. 038498	0. 436675	3. 691567	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Control Cont			_UTHERAN HOSPIT				eu of Form CMS-:	
Cost Center Description	COST A	LLOCATION - STATISTICAL BASIS		Provi der CC			Worksheet B-1	
Cost Center Description							Date/Time Pre	pared:
CERTIF 5 DOWN ASTRATION STRVICTS STR			CAFETERIA	NUDCING	CENTRAL	DUADMACY		38 pm
Company Comp		Cost Center Description						
COUNTRY STRINGE COST CENTERS COST CENTERS COST CENTERS COST CENTERS 1.00 15.00 16.00 16.00 17.00 15.00 16.00 17.00			(112 3)	ADMINI STRATION				
				(DI RECT NRS		,		
College Coll								
1.00		OFNEDAL CERVILOE COST OFNITERS	11. 00	13.00	14. 00	15. 00	16. 00	
2.00 02000 CAR REL COSTS-MINELE EQUIP	1 00		T				Γ	1 00
4.00 ODADIO INDEPENDENT IS DEPARTMENT A. DE CHEMEN		1 1						1
5.01 DOSAIG JOURNET ALMA INSTRATIVE AND GENERAL 7.00 DOSAIG JOURNET ALMA INSTRATIVE AND GENERAL 7.00 DOSAIG JOURNET ALMA INSTRATIVE SERVICE 8.00 DOSAIG JOURNET ALMA INSTRATION 1.0.0 10.00 DOSAIG JOURNET ALMA INSTRATION 1.1.500 10.00 DOSAIG JOURNET ALMA INSTRATION 1.0.00 10.00 DOSAIG JOURNET ALMA INSTRATION 1.0								
7. 00 00700 GERATION OF PLANT 100 001000 CALEFERIA 7. 00		00540 ADMITTING						5. 01
BOOD ODGOOD LAMINENY & LIFEN SERVICE	5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
9.00 00000 INJECTION		1 1						1
10.00 101000 DIETARY								
11.00 0 10100 CAFETERIA 175, 429 11.00 0 10100 CAFETERIA 11.00 11.00 0 10100 CAFTERIA SERVICES & SUPPLY 5, 443 0.00 10.00 10.00 10.00 10.00 10.00 11.00 10.00 10.00 11.00 10.00 10.00 11.00								1
13.00 01300 NURSI NO ADMINI STRATION 11, 500 50, 005, 228 1, 521, 398 31, 261, 687 1, 600 161, 100 101400 PUNRACKY 7, 878 1, 1083, 459 1, 521, 398 31, 261, 687 1, 600 161, 100 PUNRACKY 7, 878 1, 1083, 459 1, 521, 398 31, 261, 687 1, 600 161, 100 PUNRACKY 7, 878 1, 1083, 459 1, 521, 398 31, 261, 687 1, 600 161, 100 1, 600 PUNRACKY 7, 878 1, 1083, 459 1, 521, 398 31, 261, 687 1, 600			175. 429					
15.00 01500 PIAMANCY 7,878 1,083,459 1,521,389 31,261,687 0 15.00 17.00								
16.00 16-00 MEDICAL RECORDS & LIBRARY 3, 103 0 11, 327 0 2, 923, 820, 029 16, 00 17, 00 1700 017000 01700 01700 01700 01700 01700 01700 01700 01	14.00		5, 643	0				
17.00 0.1700 SOCIAL SERVICE 3.185 0 0 0 17.00 22.00 2								
21.00 02.00 12.00 12.00 0.0			1			0		1
22.00 02200 ARS SERVICES-OTHER PROKI COSTS APPRV 0 0 0 0 0 0 0 22.00 23.00 023000 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300			1		0	0	·	1
23.00			0	0	0	0		1
IMPART ENT ROUTI NE SERVICE COST CENTERS 34,850 14,322,355 2,443,815 0 132,071,03 30,00 30,00 00 00 0 0 0 0 0 0		1 1	254	l o	2, 091	Ö	1	
30.00 30.00 ADULTIS & PEDIATRICS 34,650 14,322,355 2,443,815 0 122,071,063 30.00 31.00 31.00 03.00 01.00 05.00 0 0 0 31.00 31.00 31.00 03.00	23. 01		264	0		0	0	23. 01
31.00 03100 INTENSIVE CARE UNIT 0,0 0 0,310,0 311,0 02000 DEDIATIC INTENSIVE CARE UNIT 1,075 3,255,483 419,636 0,0 2,546,394 31.01 31.02 02000 REDIATICI INTENSIVE CARE UNIT 1,075 3,255,483 419,636 0,0 2,546,394 31.01 31.02 02000 REDIATICI INTENSIVE CARE UNIT 1,075 3,284 9,970.056 2,028,987 0,0 79,155,946 31.03 32.00 03200 CORROMARY CARE UNIT 5,783 3,911,194 633,026 0,27938,747 32.00 040,00 0								
31.01 0.2080 PEDIATRIC INTENSIVE CARE UNIT 1,075 3,225,483 419,636 0 2,546,349 31.01 31.02 0.2080 DENORATAL INTENSIVE CARE UNIT 16,924 9,970,058 2,028,987 0 77,155,946 31.03 31.02 0.2080 0.008 0		1 1	1					
31.02 02000 NEONATAL INTENSIVE CARE UNIT 16,924 9,790,058 2,028,987 079,155,946 31.02 32.00 03200 CORDONARY CARE UNIT 16,724 9,790,058 2,028,987 079,155,946 31.02 32.00 03200 CORDONARY CARE UNIT 5,783 3,911,194 633,026 0 27,938,747 32.00 32.00 03000 SUBRPOVI DEE : IPF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	1	-		_		
31.03 (3010) CARDIO I NITENSIVE CARE UNIT		1 1	1		419,030 0	_		1
32.00 03200 CORDINARY CARE UNIT 5,783 3,911,194 633,026 0 27,938,741 32.00 43.00 04000 SUBRONU DER - IPF 0 0 0 0 0 0 43.00 04000 SUBRONU DER - IPF 0 0 0 0 0 0 43.00 04000 SUBRONU DER - IPF 0 0 0 0 0 45.00 05000 OFERATING ROOM 0 0 0 0 50.00 05000 OFERATING ROOM 20,000 7,585,979 8.154,374 0 499,692,761 50.00 50.00 05000 DELL VERY ROOM & LABOR ROOM 2,080 0 0 0 0 51.00 50.00 05000 DELL VERY ROOM & LABOR ROOM 2,080 0 0 0 0 6.00 54.00 05400 MESTHESI OLOY 297 0 148,206 0 64,481,483 53.00 54.00 05400 RADI OLOY-DI AKNOSTI C 10,518 697,178 922,233 0 136,712,801 54.00 56.00 05600 RADI OLSTOPE 667 53,588 0 0 0 6,004,749 54.00 56.00 05600 RADI OLSTOPE 667 53,588 0 0 38,405,422 56.00 56.00 05600 RADI OLSTOPE 7,748 478,289 8,528,694 0 228,566,996 60.00 56.00 05600 RESPIRATORY THERAPY 7,750 0 1,326,896 0 90,222,233 65.00 56.00 05600 RESPIRATORY THERAPY 7,750 0 1,326,896 0 90,222,233 65.00 56.00 05600 RESPIRATORY THERAPY 7,750 0 1,326,896 0 90,222,233 65.00 56.00 05600 RESPIRATORY THERAPY 7,750 0 1,326,896 0 90,222,233 65.00 56.00 05600 RESPIRATORY THERAPY 7,750 0 1,326,896 0 90,222,233 65.00 56.00 05600 RESPIRATORY THERAPY 7,750 0 1,326,896 0 90,222,233 65.00 56.00 05600 RESPIRATORY THERAPY 7,750 0 0 0 0 0 0 56.00 05600 RESPIRATORY THERAPY 7,750 0 0 0 0 0 0 56.00 05600 RESPIRATORY THERAPY 0 0 0 0 0 0 0 56.00 05600 RESPIRATORY THERAPY 0 0 0 0 0 0 0 56.00 05600 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 56.00 05600 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 56.00 05600 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 56.00 05600 RESPIRATORY THERAPY 0 0 0 0 0 0 0			1		2. 028. 987	_		
			1			0		
MOLILLARY SERVICE COST CENTERS	40.00		0			0	0	40. 00
50.00	43. 00		412	0	62, 653	0	1, 693, 639	43. 00
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 51.00 52.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2.080 0 0 0 8.553,370 52.00 53.00 05200 DELIVERY ROOM & LABOR ROOM 2.977 0 14.8, 266 0 6.4, 481, 483 53.00 0 0 0 0 0 0 0 0 0	EO 00		20.204	7 505 070	0 154 274	0	400 402 741	E0 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 2.080 0 0 0 8,553,370 52.00			1					
53.00 05300 ANESTHESI OLOGY 297 0 148, 206 0 64, 481, 483 33. 00 54. 01 05401 PET SCAN 1.302 0 0 0 0 6, 004, 749 54. 01 54. 0			· ·	1 9			l	1
54.01 05401 PET SCAN			1	1	148, 206	0		1
56.00 OSGO RADIO I SOTOPE 667 53,588 0 0 38,405,942 56.00 0 50.00 57.00 CT SCAN 1,773 0 209,455 0 124,651,434 57.00 58.00 0 0 0 0 0 0 0 0 0	54.00		10, 518	697, 178	922, 233	0	136, 712, 801	
57.00 GS700 CT SCAN 1,773 0 209,455 0 124,651,434 57.00		l l				_		
58. 00 05800 MR								
60. 00 00000 LABORATORY 7, 648 478, 289 8, 528, 694 0 228, 566, 996 60. 00 00 00 00 00 00 00			1, //3	0	209, 455	_		
65.00 05.00 05.00 RESPIRATORY THERAPY 7,750 0 1,326,896 0 99,222,33 65.00		l l	7.648	478, 289	8, 528, 694	_		
67. 00 06700 05CUPATI ONAL THERAPY 0 0 0 0 3, 326 67. 00 68. 00 06800 06800 SPEECH PATHOLOGY 0 0 31, 251 0 2, 783, 348 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1, 226, 522 220, 364 0 88, 614, 347 70. 00 07000 ELECTROCARDI OLOGY 0 1, 226, 522 220, 364 0 88, 614, 347 70. 00 07000 ELECTROCARDI OLOGY 0 1, 226, 522 220, 364 0 88, 614, 347 70. 00 07000 ELECTROCARDI OLOGY 0 1, 266, 591 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 409, 386 0 11, 266, 591 70. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 41, 639, 072 0 268, 774, 145 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 31, 261, 687 511, 060, 003 73. 00 74. 00 07400 RENALD I JALYSI S 1 0 0 64, 679 0 13, 151, 829 74. 00 07400 RENALD I JALYSI S 1 1 0 0 64, 679 0 106, 339, 168 76. 00 76. 01 03050 ENDOSCOPY 1, 020 0 101, 475 0 63, 929, 742 76. 01 76. 02 03950 CARDI AC REHAB 1, 141 0 0 0 0 42, 74, 600 79. 00 09100 EMERGENCY 9, 550 5, 516, 880 1, 341, 714 0 142, 146, 007 79. 00 09200 DSSERVATI ON BEDS (NON-DISTINCT PART			1					1
68. 00 06900 SPEECH PATHOLOGY 0 0 31, 251 0 2, 783, 348 68. 00 6900 06900 ELECTROCARDIOLOGY 0 1, 226, 522 220, 364 0 88, 614, 347 70. 00 7000 ELECTROCENCEPHALOGRAPHY 0 0 409, 386 0 11, 266, 597 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 0 0 0 8, 056, 750 0 206, 111, 805 71. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 0 0 0 8, 056, 750 0 206, 111, 805 71. 00 70.	66.00	06600 PHYSI CAL THERAPY	6, 263	0	65, 647	0	30, 061, 527	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 1, 226, 522 220, 364 0 88, 614, 347 69, 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 409, 386 0 11, 266, 510 00 70. 00			0	0		_		
70. 00 070000 070000 070000 070000 070000 07000 070000 070000 070000 070000 070000 0700000 070000 0700000 0700000000			0	0		_		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 8,056,750 0 206,111,805 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 41,639,072 0 268,774,145 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 31,261,687 511,060,003 73.00 74.00			0	1, 226, 522		_		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 41, 639, 072 0 268, 774, 145 72. 00 7300 DRUGS CHARGED TO PATIENTS 0 0 0 31, 261, 687 511, 060, 003 73. 00 74. 00 7400 RENAL DIALYSIS 1 1 0 0 64, 679 0 131, 151, 829 74. 00 74. 00 7400 RENAL DIALYSIS 1 1 0 0 64, 679 0 131, 151, 829 74. 00 74. 00 7400 RENAL DIALYSIS 1 1 0 0 64, 679 0 131, 151, 829 74. 00 76. 00 10 0 100, 339, 168 76. 00 76. 00 10 0 10, 475 0 63, 929, 742 76. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 31, 261, 687 511, 060, 003 73. 00 74. 0		1 1		o		0		
76. 00 03140 CARDI O CATH LAB 958 0 1,552,367 0 106,339,168 76. 00 76. 01 03050 ENDOSCOPY 1,020 0 101,475 0 63,929,742 76. 01 76. 02 03950 CARDI AC REHAB 1,141 0 0 0 0 4,274,660 76. 02 00 00 0 4,274,660 76. 02 00 00 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	0	o	0	31, 261, 687	511, 060, 003	73. 00
76. 01 03050 ENDOSCOPY 1, 020 0 101, 475 0 63, 929, 742 76. 01 76. 02 03950 CARDI AC REHAB 1, 141 0 0 0 0 0 0 4, 274, 660 76. 02 017PATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 4, 164 1, 804, 395 423, 681 0 3, 796, 973 90. 00 9000 EMERGENCY 9, 550 5, 516, 880 1, 341, 714 0 142, 146, 007 91. 00 9200 BERVATI ON BEDS (NON-DI STI NCT PART 95. 00 9500 AMBULANCE SERVI CES 4, 599 719, 948 184, 865 0 9, 395, 006 96. 00 9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 9, 395, 006 96. 00 9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0, 3, 999, 160 106. 00 10500 KI DNEY ACQUI SI TI ON 662 0 0 0 0 1, 779, 720 105. 00 1800 BERVAT ACQUI SI TI ON 662 0 0 0 0 3, 999, 160 106. 00 SUBTOTALS (SUM OF LINES 1 through 117) 175, 321 50, 605, 328 80, 504, 042 31, 261, 687 2, 923, 820, 029 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8 0 0 0 0 0 0 0 0 192. 00 194. 01 194. 01 194. 02 07952 SENI OR CI RCLE 100 0 0 0 0 0 0 0 0 0 0 194. 02 194. 02 194. 02 07952 SENI OR CI RCLE 100 0 0 0 0 0 0 0 0 0 194. 02 194. 02 194. 02 07952 SENI OR CI RCLE			1	0	· ·	0		
76. 02 03950 CARDIAC REHAB 1, 141 0 0 0 0 4, 274, 660 76. 02 00 1 1, 274, 660 00 00 00 00 00 00 00 00 00 00 00 00			1					
OUTPATI ENT SERVI CE COST CENTERS			1	1				
90. 00	76.02		1, 141	l O	0	0	4, 274, 000	70.02
91. 00 09100 EMERGENCY 9,550 5,516,880 1,341,714 0 142,146,007 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 09500 OBSERVATI ON BEDS (NON-DISTINCT PART 09500 OBSERVATI ON BEDS (NON-DISTINCT PART 09500 OBSERVATI ON BEDS (NON-DISTINCT PART 09500 OBSERVATION BEDS (NON-DISTINCT P	90. 00		4, 164	1, 804, 395	423, 681	0	3, 796, 973	90.00
OTHER REI MBURSABLE COST CENTERS	91.00	09100 EMERGENCY	1			0		
95. 00	92. 00							92. 00
96. 00			1	740.040	101.015			
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 105. 00 105.00 105.00 105.00 106.00 10			1					1
105. 00 105.00 105.00 KI DNEY ACQUI SI TI ON 662 0 0 0 0 0 1,779,720 105. 00 106	96.00		U	l O		0	0	96.00
106. 00	105 00		662	0	0	0	1 779 720	105 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8 0 0 0 0 192.00 194.00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194.00 194.01 07951 MARKETI NG 0 0 0 0 0 194.01 194.02 07952 SENI OR CI RCLE 100 0 420 0 0 194.02								
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8 0 0 0 0 192. 00 194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 194. 00 194. 01 07951 MARKETI NG 0 0 0 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 100 0 420 0 0 194. 02		SUBTOTALS (SUM OF LINES 1 through 117)	4		80, 504, 042	31, 261, 687		
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8 0 0 0 192.00 194.00 07950 CLOSED PSYCH UNI T 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 100 0 420 0 0 194.02								
194. 00 07950 CLOSED PSYCH UNIT 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 100 0 420 0 0 194. 02			0	1		_	l	1
194. 01 07951 MARKETI NG 0 0 0 194. 01 194. 02 07952 SENI OR CI RCLE 100 0 420 0 0 194. 02			8	0	0	0		
194. 02 07952 SENIOR CIRCLE 100 0 420 0 0 194. 02					0	0		
			100		_	0	l	
			1					

Health Fin	ancial Systems	LUTHERAN HOSPIT	TAL OF INDIANA		In Lie	eu of Form CMS-	2552-10
COST ALLOC	TATION - STATISTICAL BASIS		Provi der CC	CN: 15-0017	Peri od: From 07/01/2017	Worksheet B-1	
					To 06/30/2018	Date/Time Pre 11/30/2018 3:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTE' S)	ADMI NI STRATI ON		(COSTED	RECORDS &	
			(DIRECT NRS	SUPPLY (COSTED	REQUIS.)	LI BRARY (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)	5, 550, 704	6, 850, 380	12, 414, 27	7 12, 141, 360	8, 596, 162	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	31. 640744	0. 135369	0. 15420	0. 388378	0. 002940	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	131, 102	390, 950	887, 54	.3 673, 785	448, 354	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 747322	0. 007725	0. 01102	0. 021553	0. 000153	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

5.01 0.0540 AMULTING 5.01		FINANCIAL SYSTEMS		UTHERAN HUSPITA		CN 15 0017 5		U OF FORM CMS	
INTERIS A BESIDENTS COST CENTER COST C	COST A	ALLUCATION - STATISTICAL BAST:	5		Provider Co			worksneet B-1	
COST Center Description COST Center Description									
Cold Center Description					INTERNS &	RESIDENTS		11/30/2018 3:	38 pm
						MEGI BENTO			
CEMERAL SERVICE COST CENTERS		Cost Center Descriptio	n	SOCIAL SERVICE					
CEST CONTROL				(CDOCC CHAD					
SHEBBL SERVICE ORT CENTERS				,					
CHERNEL SERVICE COST CENTERS				020)			11 ME)		
1.00				17. 00	21.00	22. 00	23. 00	23. 01	
2 00 000000 CAP REL DOSTS - MYELE EQUIP	1 00								1 00
4.00 00000 DEPLOYEE BEREFITS DEPARTMENT		1							
5.02 00560 OTHER ARMIN ISTRATIVE AND CENERAL									4.00
7.00 00 7000 DEREATION OF FLANT 8.00 00900 HUJBERCEPH NG 9.00 00900 HUJBERCEPH NG 11.00 01 1000 DETECH NG 11.00 01 000 DETECH NG 11.00 DETECH NG 11.00 DETECH NG 11.00 DETECH NG 11.00 DETECH NG 11	5. 01	00540 ADMITTING							
8.00 00000 LAURONY & LINEN SERVICE 9.00 00000 IDENTARY 1.100			ND GENERAL						
9.00 00000 NUISEKEEP ING 0.00 11.00			г						
10.00 01000 DETARY			<u>C</u>						
13.00 01300 MURSING ADMINISTRATION 14.00 01400 01500 PHARMACY 15.00 PHARMACY 15.									10.00
14.00 01400 CENTRAL SERVICES & SUPPLY 16.00 01500 MEDICAL RECORDS & LIBRARY 15.00 01500 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 18K SERVICES-SALEIR REMIX COSTS APPRY 0 29,950 29,950 21.00 220									11. 00
15.00 1500 PHARMACY									13.00
16.00 1000 MEDICAL RECORDS & LIBRARY 2, 923, 820, 029 29, 950 27, 100 170, 00 1700			PLY						1
17.00			ARY						1
22.00 02200 148 SERVICES-OTHER PROXI COSTS APPRV 0 102,747 12,000 230 102,000 230 102,000 230 102,000 230 102,000 230 102,000 230 102,000 230				2, 923, 820, 029					17. 00
23.00				0	29, 950				21. 00
				- I		29, 950	1		1
INPATI ENT ROUTINE SERVICE COST CENTERS 132,071,063 19,100 19,100 65,782 0 30.00 30.00 30.00 MUITS & PEDIATRIC ST. 100 179,100 65,782 0 30.00 31.00 32				- I			102, 747	10,000	1
30.00	23.01			<u> </u>		l	1	10, 000	23.01
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT 2, 546, 349 0 0 934 0 31.01	30.00			132, 071, 063	19, 100	19, 100	65, 782	0	30.00
31.02 02000 NEOMATAL INTENSIVE CARE UNIT				0	0		1		
31.03 03101 CARDIO INTERSIVE CARE UNIT 79, 155, 946 0 0 21, 428 0 31.03 0310 0320.0 03200 CROMARY CARE UNIT 27, 938, 747 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		l	ū			ŭ	
32.00 03200 COROMARY CARE UNIT 27, 98, 747 0 0 7, 369 0 32.00					700			_	
40.00 04000 SUBPROVI DER - I PF			OIVI I		0			J	1
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50. 00	43. 00		-DC	1, 693, 639	0	<u> </u>	2, 067	0	43.00
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54. 00 05400 RADI OLOGY - DI AGNOSTI C 136, 712, 801 0 0 0 0 54, 00 56. 00 054. 01 05401 PET SCAN 66, 004, 749 0 0 0 0 0 0 54. 01 56. 00 05700 CT SCAN 124,651, 434 0 0 0 0 0 0 0 55. 00 05800 MRI 34, 120 0 0 0 0 0 0 0 0 0		1 1	ROOM	· · · · · · · · · · · · · · · · · · ·	0		l l	0	
54.01 OS401 PET SCAN					0	•	l l	-	1
56. 00 05000 CADIO I SOTOPE 38. 405, 942 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 124,651,434 0 0 0 0 0 57. 00 58. 00 05800 MRI 34,120 0 0 0 0 0 57. 00 60. 00 06000 LABORATORY 228,566,996 0 0 0 0 0 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 90,222,233 0 0 0 0 0 0 65. 00 66. 00 06600 PAYSI CAL THERAPY 30,661,527 0 0 0 0 0 0 66. 00 67. 00 06700 CCUPATI ONAL THERAPY 30,661,527 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 2,783,348 0 0 0 0 0 0 68. 00 69. 00 06900 LECTROCARDI OLOGY 88,614,347 0 0 0 0 0 0 69. 00 71. 00 07000 LECTROCARDI OLOGY 88,614,347 0 0 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 206,111,805 0 0 0 0 0 0 0 0 72. 00 07200 IMPL DEV CHARGED TO PATIENT 266,171,185 0 0 0 0 0 0 0 0 74. 00 07400 REVAL DIALYSIS 13,151,829 0 0 0 0 0 0 0 0 76. 00 07400 CARDI OLATH LAB 106,339,168 0 0 0 0 0 0 0 0 76. 01 03050 ENDOSCOPY 63,929,742 0 0 0 0 0 0 0 0 70. 00 09000 LINIC 3,796,973 4,500 4,500 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTES 7,460 0 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTES 7,7720 0 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTED 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTED 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTED 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTED 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTED 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTED 0 0 0 0 0 70. 00 09000 DIRABLE MEDICAL EQUIP PRINTED 0 0 0 0 0 70. 00 09000 09000 09000 09000 09000 09000 09000 09000 70. 00 09000 09000 09000 09000					0		1	-	
57. 00 05700 CT SCAN 124,651,434 0 0 0 0 0 57. 00 58. 00 05800 MRI 34,120 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 228,566,996 0 0 0 0 0 0 65. 00 65. 00 065000 05800 RESPI RATORY THERAPY 90,222,233 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CLA THERAPY 90,222,233 0 0 0 0 0 0 65. 00 67. 00 06700 0CCUPATI ONAL THERAPY 33,26 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 2,783,348 0 0 0 0 0 0 68. 00 69. 00 06900 SPEECH PATHOLOGY 2,783,348 0 0 0 0 0 0 69. 00 70. 00 07000 ELECTROCARDI 0LOGY 88,614,347 0 0 0 0 0 0 0 0 70. 00 07000 ELECTROCARDI 0LOGY 88,614,347 0 0 0 0 0 0 0 71. 00 07100 MDI CAL SUPPLIES CHARGED TO PATI ENT 206,111,805 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 268,774,145 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 511,060,003 0 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 13,151,829 0 0 0 0 0 0 76. 01 03950 CARDI AC REHAB 106,339,168 0 0 0 0 0 0 76. 01 03950 CARDI AC REHAB 4,274,660 0 0 0 0 0 76. 01 03950 CARDI AC REHAB 4,274,660 0 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0 79. 00 09000 OVERALE TO REHAB 4,274,660 0 0 0 0					0	•	l l		1
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66. 00 06600 PHYSICAL THERAPY 30, 061, 527 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 3, 325 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 2, 783, 348 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 88, 614, 347 0 0 0 0 0 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 88, 614, 347 0 0 0 0 0 0 0 71. 00 070. 00 070.00 070.00 070.00 71. 00 071.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 206, 111, 805 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 268, 774, 145 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 511, 060, 003 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 13, 151, 829 0 0 0 0 0 0 76. 01 03050 ENDOSCOPY 63, 929, 742 0 0 0 0 0 0 76. 01 03050 ENDOSCOPY 63, 929, 742 0 0 0 0 0 0 76. 02 03950 CARDI A C REHAB 4, 274, 660 0 0 0 0 0 71. 00 09000 CLINI C 3, 796, 973 4, 500 4, 500 0 0 71. 00 09000 CLINI C 3, 796, 973 4, 500 4, 500 0 0 75. 00 09000 DURBALE COST CENTERS 75. 00 09500 AMBULANCE SERVI CES 9, 395, 006 0 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 75. 00 09600 DURBALE MEDI CAL EQUI P-RENTED 0 0 0 0 0 75. 00 09600 09600 09600 09600 09600 09				i i	0	C	0		1
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68. 00 06800 SPECH PATHOLOGY 2, 783, 348 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 88, 614, 347 0 0 0 0 0 70. 00 07000 ELECTROCENCEPHALOGRAPHY 11, 266, 591 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 206, 111, 805 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 268, 774, 145 0 0 0 0 0 0 73. 00 07300 DRIGS CHARGED TO PATIENTS 511, 060, 003 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 13, 151, 829 0 0 0 0 0 76. 01 03305 ENDOSCOPY 63, 929, 742 0 0 0 0 0 76. 02 03950 CARDIA CREHAB 4, 274, 660 0 0 0 0 76. 02 09000 CLINI C CONSOCOPY 142, 146, 007 3, 500 3, 500 0 0 76. 02 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 142, 146, 007 3, 500 3, 500 0 0 76. 00 09400 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 0 76. 00 09500 AMBULANCE SERVI CES 9, 395, 006 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 76. 00 09600 00 0 0 0 77. 00 00 00 00 0 78. 00 09600 00 00 0 0 79. 00 09600 00 00 0 0 79. 00 09600 00 00 0 0 79. 00 09600 00 00 0 0 79. 00 09600 00 00 00 0 79. 00 09600 00 00 00 0 79. 00 09600 00 00 00 00 79. 00 09600 00 00 00 00 00 79. 00 00 00 00 00 00 79. 00 00 00 00 00 00 79. 00 00 00 00 00 7					0	•	1	-	
70. 00 07000 ELECTROENCEPHALOGRAPHY 11, 266, 591 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 206, 111, 805 0 0 0 0 0 0 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 7					0	C	o	0	1
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72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 268, 774, 145 0 0 0 0 0 72. 00 73. 00 73. 00 DRUGS CHARGED TO PATIENTS 511, 060, 003 0 0 0 0 0 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 0. 0 0 0 0 0 0 0 0					0	C		_	
73. 00					0			-	
74. 00					0			-	
76. 01 03050 ENDOSCOPY 63, 929, 742 0 0 0 0 0 76. 01 76. 02 03950 CARDI AC REHAB 4, 274, 660 0 0 0 0 0 76. 02 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 3, 796, 973 4, 500 4, 500 0 0 91. 00 91. 00 09100 EMERGENCY 142, 146, 007 3, 500 3, 500 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 95. 00 09500 AMBULANCE SERVI CES 9, 395, 006 0 0 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 K I DNEY ACQUI SI TI ON 1, 779, 720 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 3, 999, 160 0 0 0 0 0 106. 00 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 2, 923, 820, 029 29, 950 29, 950 102, 747 10, 000 118. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 192. 00 194. 00 07950 CLOSED PSYCH UNI T 0 0 0 0 0 0 0 194. 00	74.00			13, 151, 829	0	C	0	0	74. 00
76. 02 03950 CARDI AC REHAB					0	C	0		
OUTPATIENT SERVICE COST CENTERS OUTP					0		1		
90. 00	70.02		FRS	4, 274, 660	0	1	ıl Ol	0	76.02
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART		09000 CLI NI C		3, 796, 973			0	0	90.00
OTHER REIMBURSABLE COST CENTERS 9, 395, 006 0 0 0 0 0 0 0 0 0				142, 146, 007	3, 500	3, 500	0	0	
95. 00	92.00								92.00
96. 00	95. 00		LIG	9, 395, 006	0	C	o	0	95. 00
105. 00	96. 00			0	0	C		0	
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NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 194. 00			S 1 through 117)		29, 950		· ·		
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194.00 07950 CLOSED PSYCH UNIT 0 0 0 0 0 0 194.00				0	0		l l		
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Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0017	Period: Worksheet B-1 From 07/01/2017
		To 06/30/2018 Date/Time Prepared:

				10	06/30/2018	11/30/2018 3:	
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PHARMACY RESI DENCY	
		(GROSS CHAR	APPRV	APPRV	(ASSI GNED	PROGRAM	
		GES)	(ASSI GNED	(ASSI GNED	TIME)	(ASSI GNED	
		17.00	TIME)	TIME)	22.00	TIME)	
104 00 0705	CENTOD OF DOLE	17. 00	21. 00	22. 00	23. 00	23. 01	104 00
	SENI OR CI RCLE	0	0	0	0		194. 02 194. 03
	OTHER NONREIMBURSABLE COST CENTERS	٩	U	U	U	U	
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	F 000 000	0 (5)	0.057.07/	740 700		201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	5, 020, 832	3, 656	3, 957, 076	748, 798	292, 736	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 001717	0. 122070	132. 122738	7. 287785	29. 273600	
204. 00	Cost to be allocated (per Wkst. B, Part II)	274, 921	94	93, 462	101, 738	7, 491	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000094	0. 003139	3. 120601	0. 990180	0. 749100	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0	0	206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000	0.000000	207. 00
'			,	'	·		•

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0017	Peri od:	Worksheet C

				From 07/01/2017 To 06/30/2018	Part I Date/Time Pre 11/30/2018 3:	
		Titl∈	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)					
LUDATI ENT. DOUTLING OFFICE COOT OFFITEDO	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	50.040.400	ı	50.040.40		50.040.400	
30. 00 03000 ADULTS & PEDI ATRI CS	58, 048, 102		58, 048, 10		58, 048, 102	
31. 00 03100 INTENSIVE CARE UNIT	0		0.500.40	٦ ١	0	31.00
31. 01 02080 PEDI ATRI C INTENSI VE CARE UNI T	2, 503, 604		2, 503, 60		2, 503, 604	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	7, 600, 474		7, 600, 47		7, 600, 474	
31. 03 03101 CARDIO INTENSIVE CARE UNIT	31, 492, 050		31, 492, 050		31, 492, 050	
32. 00 03200 CORONARY CARE UNIT	10, 655, 109		10, 655, 10		10, 655, 109	
40. 00 04000 SUBPROVI DER - PF	0	1		0	0	40.00
43. 00 04300 NURSERY	592, 680		592, 680	0	592, 680	43. 00
ANCILLARY SERVICE COST CENTERS	45 202 077	I	I 45 202 07	7 0	45 202 077	FO 00
50. 00 05000 OPERATING ROOM	45, 302, 877		45, 302, 87			50.00
51. 00 05100 RECOVERY ROOM	0 71/ 510		1	0	0 717 510	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 716, 510	l e	2, 716, 510		2, 716, 510	1
53. 00 05300 ANESTHESI OLOGY	981, 832		981, 83		981, 832	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 349, 903		17, 349, 90		17, 349, 903	
54. 01 05401 PET SCAN	311, 194		311, 19		311, 194	
56. 00 05600 RADI 0I SOTOPE	1, 252, 784		1, 252, 78		1, 252, 784	
57. 00 05700 CT SCAN 58. 00 05800 MRI	3, 804, 019		3, 804, 019		3, 804, 019 2, 609	57. 00 58. 00
60. 00 06000 LABORATORY	2,609		2, 60			
	26, 258, 218		26, 258, 21		26, 258, 218	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	10, 056, 955 8, 648, 596				10, 056, 955 8, 648, 596	
67. 00 06700 OCCUPATIONAL THERAPY	52, 823		52, 82		52, 823	1
68. 00 06800 SPEECH PATHOLOGY	589, 103		1		52, 623 589, 103	
69. 00 06900 SPEECH PATHOLOGY	6, 319, 515		6, 319, 51		6, 319, 515	
70. 00 07000 ELECTROEARD OLOGT	3, 442, 284		3, 442, 28		3, 442, 284	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 146, 983	•	12, 146, 98		12, 146, 983	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	58, 441, 790		58, 441, 79		58, 441, 790	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	55, 064, 078		55, 064, 07		55, 064, 078	
74. 00 07400 RENAL DIALYSIS	4, 394, 368	ł .	4, 394, 36		4, 394, 368	1
76. 00 03140 CARDI O CATH LAB	8, 041, 558		8, 041, 55		8, 041, 558	
76. 01 03050 ENDOSCOPY	9, 756, 882		9, 756, 88		9, 756, 882	76. 01
76. 02 03950 CARDI AC REHAB	996, 985		996, 98		996, 985	
OUTPATIENT SERVICE COST CENTERS	770,700		770,70	<u> </u>	770, 700	70.02
90. 00 09000 CLINI C	7, 916, 575		7, 916, 57	5 0	7, 916, 575	90.00
91. 00 09100 EMERGENCY	15, 712, 090		15, 712, 09		15, 712, 090	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	523, 863		523, 86		523, 863	
OTHER REIMBURSABLE COST CENTERS	120,000		,	-1	220, 222	
95. 00 09500 AMBULANCE SERVI CES	8, 694, 744		8, 694, 74	1 0	8, 694, 744	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			o		96.00
SPECIAL PURPOSE COST CENTERS				-)		
105. 00 10500 KIDNEY ACQUISITION	2, 119, 453		2, 119, 45	3	2, 119, 453	105. 00
106. 00 10600 HEART ACQUISITION	789, 351		789, 35		789, 351	
200.00 Subtotal (see instructions)	422, 579, 961	l c			422, 579, 961	
201.00 Less Observation Beds	523, 863		523, 86		523, 863	
202.00 Total (see instructions)	422, 056, 098	o	1			

COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider Co	F	reniod: From 07/01/2017 To 06/30/2018	Part I Date/Time Pre 11/30/2018 3:	epared: 38 pm
				XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Rati o	TEFRA I npati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	96, 311, 432		96, 311, 432	2		30.00
31. 00	03100 INTENSIVE CARE UNIT	0		(31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 546, 349		2, 546, 349			31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	15, 601, 039		15, 601, 039			31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT	79, 155, 946		79, 155, 94 <i>6</i>	j		31. 03
32. 00	03200 CORONARY CARE UNIT	27, 938, 747		27, 938, 747	'		32.00
40. 00	04000 SUBPROVIDER - IPF	0		(40.00
43.00	04300 NURSERY	1, 693, 639		1, 693, 639			43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	302, 454, 278	197, 238, 483	499, 692, 761	0. 090661	0. 000000	50. 00
51. 00	05100 RECOVERY ROOM	o	0	(0. 000000	0.000000	51.00
	05200 DELIVERY ROOM & LABOR ROOM	8, 402, 337	151, 033	8, 553, 370	0. 317595	0.000000	52.00
53. 00	05300 ANESTHESI OLOGY	38, 285, 730	26, 195, 753	64, 481, 483	0. 015227	0.000000	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	53, 646, 230	83, 066, 571	136, 712, 801	0. 126908	0.000000	
54. 01	05401 PET SCAN	51, 016	5, 953, 733	6, 004, 749	0. 051825	0.000000	54. 01
56. 00	05600 RADI 0I SOTOPE	6, 705, 497	31, 700, 445	38, 405, 942		0.000000	56.00
	05700 CT SCAN	49, 442, 558	75, 208, 876			0.000000	1
	05800 MRI	0	34, 120	34, 120		0.000000	
	06000 LABORATORY	139, 641, 931	88, 925, 065	228, 566, 996		0.000000	
	06500 RESPI RATORY THERAPY	85, 935, 459	4, 286, 774	90, 222, 233		0.000000	1
	06600 PHYSI CAL THERAPY	20, 397, 622	9, 663, 905	30, 061, 527		0. 000000	1
	06700 OCCUPATI ONAL THERAPY	3, 326	0	3, 326		0. 000000	1
	06800 SPEECH PATHOLOGY	1, 447	2, 781, 901	2, 783, 348		0. 000000	1
	06900 ELECTROCARDI OLOGY	56, 659, 407	31, 954, 940	88, 614, 347		0. 000000	1
	07000 ELECTROENCEPHALOGRAPHY	1, 400, 623	9, 865, 968	11, 266, 591		0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	130, 020, 899	76, 090, 906			0. 000000	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	199, 512, 028	69, 262, 117	268, 774, 145		0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	322, 930, 670	188, 129, 333	511, 060, 003		0. 000000	
	07400 RENAL DIALYSIS	12, 717, 392	434, 437	13, 151, 829		0. 000000	
	03140 CARDIO CATH LAB	47, 264, 957	59, 074, 211	106, 339, 168		0. 000000	
	03050 ENDOSCOPY	10, 697, 965	53, 231, 777	63, 929, 742		0. 000000	
	03950 CARDI AC REHAB	2, 792, 126	1, 482, 534			0. 000000	
	OUTPATIENT SERVICE COST CENTERS	2, 772, 120	1, 402, 334	4, 214, 000	0. 200201	0.00000	70.02
	09000 CLINIC	99, 803	3, 697, 170	3, 796, 973	2. 084970	0. 000000	90.00
	09100 EMERGENCY	44, 757, 868	97, 388, 139			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 231, 380	32, 528, 251	35, 759, 631		0. 000000	1
	OTHER REIMBURSABLE COST CENTERS	3, 231, 360	32, 320, 231	35, 757, 03	0.014030	0.000000	72.00
	09500 AMBULANCE SERVICES	8, 151	9, 386, 855	9, 395, 006	0. 925464	0. 000000	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0, 131	9, 380, 833	9, 393, 000		0. 000000	1
	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		0.000000	0.000000	70.00
	10500 KIDNEY ACQUISITION	1, 779, 720	0	1, 779, 720			105. 00
	10600 HEART ACQUISITION	3, 999, 160	0	3, 999, 160			106.00
200.00	Subtotal (see instructions)		1, 157, 733, 297				200. 00
200.00	Less Observation Beds	1, 700, 000, 732	1, 101, 100, 291	2, 723, 020, 029	ή		200.00
201.00	l	1, 766, 086, 732	1 157 722 207	2 923 920 020			201.00
202.00	Total (See That detiblis)	1, 100, 000, 132	1, 101, 100, 291	1 2, 723, 020, 025	η Ι		1202.00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0017	Peri od: Worksheet C Part I Date/Time Prepared: 1/20/2019 2:38 pm

					11/30/2018 3: 38	8 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31. 00	03100 INTENSIVE CARE UNIT					31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT					31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT					31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT					31. 03
32.00	03200 CORONARY CARE UNIT					32.00
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. 090661				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 317595				52.00
53.00	05300 ANESTHESI OLOGY	0. 015227				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 126908				54.00
54.01	05401 PET SCAN	0. 051825				54.01
56.00	05600 RADI OI SOTOPE	0. 032620				56.00
57.00	05700 CT SCAN	0. 030517				57.00
58.00	05800 MRI	0. 076465				58.00
60.00	06000 LABORATORY	0. 114882				60.00
65.00	06500 RESPI RATORY THERAPY	0. 111469				65.00
66.00	06600 PHYSI CAL THERAPY	0. 287696				66.00
67.00	06700 OCCUPATI ONAL THERAPY	15. 881840				67.00
68.00	06800 SPEECH PATHOLOGY	0. 211653				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 071315				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 305530				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 058934				71.00
72. 00	1 1	0. 217438			l l	72.00
73. 00		0. 107745				73.00
74.00	1 1	0. 334126				74.00
76. 00	03140 CARDIO CATH LAB	0. 075622				76.00
76. 01	03050 ENDOSCOPY	0. 152619				76. 01
76. 02	03950 CARDI AC REHAB	0. 233231				76. 02
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
90.00		2. 084970				90.00
91.00	09100 EMERGENCY	0. 110535				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 014650				92.00
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVICES	0. 925464				95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			l l	96.00
	SPECIAL PURPOSE COST CENTERS	1 2:22222				
105. 00	10500 KIDNEY ACQUISITION				1	105. 00
	010600 HEART ACQUISITION				l l	106. 00
200.00	1					200. 00
201. 00						201. 00
202. 00	1				· · · · · · · · · · · · · · · · · · ·	202. 00
		. !				

					rom 07/01/2017 o 06/30/2018	Part I Date/Time Pre	
			Ti +1	e XIX	Hospi tal	11/30/2018 3: PPS	38 pm
			1111	e Al A	Costs	PP3	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	Total Costs	
		Part I, col.	Auj .		Di Sai i Owance		
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00	03000 ADULTS & PEDI ATRI CS	58, 048, 102		58, 048, 102	ol	58, 048, 102	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	00,010,102		00,010,102	o	0	31. 00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 503, 604	l	2, 503, 604	o	2, 503, 604	31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	7, 600, 474		7, 600, 474	o	7, 600, 474	31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT	31, 492, 050	ł	31, 492, 050	ol	31, 492, 050	
32. 00	03200 CORONARY CARE UNIT	10, 655, 109		10, 655, 109	ol	10, 655, 109	
40. 00	04000 SUBPROVI DER - I PF	0		0	o	0	40.00
43.00	04300 NURSERY	592, 680		592, 680	ol	592, 680	43.00
	ANCILLARY SERVICE COST CENTERS		ļ.	,	·		
50.00	05000 OPERATI NG ROOM	45, 302, 877		45, 302, 877	0	45, 302, 877	50.00
51.00	05100 RECOVERY ROOM	0		0	o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 716, 510		2, 716, 510	o	2, 716, 510	52.00
53.00	05300 ANESTHESI OLOGY	981, 832		981, 832	o	981, 832	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 349, 903		17, 349, 903	o	17, 349, 903	54.00
54. 01	05401 PET SCAN	311, 194		311, 194	o	311, 194	54. 01
56.00	05600 RADI OI SOTOPE	1, 252, 784		1, 252, 784	o	1, 252, 784	56. 00
57.00	05700 CT SCAN	3, 804, 019		3, 804, 019	o	3, 804, 019	57. 00
58.00	05800 MRI	2, 609		2, 609	o	2, 609	58. 00
60.00	06000 LABORATORY	26, 258, 218		26, 258, 218	o	26, 258, 218	60.00
65.00	06500 RESPI RATORY THERAPY	10, 056, 955	0	10, 056, 955	o	10, 056, 955	65. 00
66.00	06600 PHYSI CAL THERAPY	8, 648, 596	0	8, 648, 596	o	8, 648, 596	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	52, 823	0	52, 823	o	52, 823	67. 00
68.00	06800 SPEECH PATHOLOGY	589, 103	0	589, 103	0	589, 103	68. 00
69.00	06900 ELECTROCARDI OLOGY	6, 319, 515		6, 319, 515	0	6, 319, 515	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 442, 284		3, 442, 284	0	3, 442, 284	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 146, 983		12, 146, 983	0	12, 146, 983	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	58, 441, 790		58, 441, 790	0	58, 441, 790	
73.00	07300 DRUGS CHARGED TO PATIENTS	55, 064, 078	l e	55, 064, 078	0	55, 064, 078	
74. 00	07400 RENAL DIALYSIS	4, 394, 368	l e	4, 394, 368	0	4, 394, 368	
76. 00	03140 CARDIO CATH LAB	8, 041, 558		8, 041, 558	0	8, 041, 558	
76. 01	03050 ENDOSCOPY	9, 756, 882	ł	9, 756, 882	0	9, 756, 882	76. 01
76. 02	03950 CARDI AC REHAB	996, 985		996, 985	0	996, 985	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	7, 916, 575	l e	7, 916, 575	0	7, 916, 575	90. 00
91. 00	09100 EMERGENCY	15, 712, 090		15, 712, 090	0	15, 712, 090	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	523, 863		523, 863		523, 863	92. 00
	OTHER REIMBURSABLE COST CENTERS	T	Г				
95. 00	09500 AMBULANCE SERVICES	8, 694, 744	l .	8, 694, 744	0	8, 694, 744	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00
405	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	2, 119, 453		2, 119, 453		2, 119, 453	
	10600 HEART ACQUISITION	789, 351	_	789, 351	_	789, 351	
200.00	()	422, 579, 961	0	422, 579, 961	0	422, 579, 961	
201.00	1 1	523, 863	l .	523, 863		523, 863	
202.00	Total (see instructions)	422, 056, 098	0	422, 056, 098	0	422, 056, 098	1202.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 07/01/2017 Fo 06/30/2018	Worksheet C Part Date/Time Pre	pared:
			T: +1	o VIV	Hooni tal	11/30/2018 3: PPS	38 pm
			Charges	e XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		
30. 00	03000 ADULTS & PEDI ATRI CS	96, 311, 432		96, 311, 432	1		30. 00
31. 00	03100 INTENSIVE CARE UNIT	0					31. 00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT	2, 546, 349		2, 546, 349			31. 01
31. 02	02060 NEONATAL INTENSIVE CARE UNIT	15, 601, 039		15, 601, 039			31. 02
31. 03	03101 CARDIO INTENSIVE CARE UNIT	79, 155, 946		79, 155, 946	I		31. 03
32. 00 40. 00	03200 CORONARY CARE UNIT	27, 938, 747		27, 938, 74			32.00
40.00	04000 SUBPROVI DER - I PF 04300 NURSERY	1 (02 (20		1	1		40. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 693, 639		1, 693, 639	7		43.00
50. 00	05000 OPERATING ROOM	302, 454, 278	197, 238, 483	499, 692, 76	0. 090661	0. 000000	50. 00
51. 00	05100 RECOVERY ROOM	302, 434, 270	177, 230, 403	477, 072, 70	1	0. 000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	8, 402, 337	151, 033	8, 553, 370		0. 000000	
53. 00	05300 ANESTHESI OLOGY	38, 285, 730	26, 195, 753	64, 481, 483		0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	53, 646, 230	83, 066, 571	136, 712, 80		0. 000000	
54. 01	05401 PET SCAN	51, 016	5, 953, 733	6, 004, 749		0.000000	
56. 00	05600 RADI OI SOTOPE	6, 705, 497	31, 700, 445	38, 405, 942		0.000000	
57.00	05700 CT SCAN	49, 442, 558	75, 208, 876	124, 651, 434	0. 030517	0.000000	57. 00
58.00	05800 MRI	o	34, 120	34, 120	0. 076465	0.000000	58. 00
60.00	06000 LABORATORY	139, 641, 931	88, 925, 065	228, 566, 996	0. 114882	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	85, 935, 459	4, 286, 774	90, 222, 233	0. 111469	0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	20, 397, 622	9, 663, 905	30, 061, 52		0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	3, 326	0	3, 320		0.000000	1
68. 00	06800 SPEECH PATHOLOGY	1, 447	2, 781, 901	2, 783, 348		0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	56, 659, 407	31, 954, 940	88, 614, 34		0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 400, 623	9, 865, 968	11, 266, 59		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	130, 020, 899	76, 090, 906	206, 111, 80		0. 000000	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	199, 512, 028	69, 262, 117	268, 774, 14!		0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	322, 930, 670	188, 129, 333	511, 060, 003		0. 000000	
74.00	07400 RENAL DIALYSIS	12, 717, 392	434, 437	13, 151, 829		0.000000	
76.00	03140 CARDI O CATH LAB	47, 264, 957	59, 074, 211	106, 339, 168	I	0.000000	1
76. 01 76. 02	03050 ENDOSCOPY 03950 CARDI AC REHAB	10, 697, 965 2, 792, 126	53, 231, 777	63, 929, 742 4, 274, 660		0. 000000 0. 000000	
76. 02	OUTPATIENT SERVICE COST CENTERS	2, 192, 120	1, 482, 534	4, 274, 000	0. 233231	0.000000	76.02
90. 00	09000 CLINIC	99, 803	3, 697, 170	3, 796, 973	2. 084970	0. 000000	90.00
91. 00	09100 EMERGENCY	44, 757, 868	97, 388, 139	142, 146, 00		0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 231, 380	32, 528, 251	35, 759, 63°		0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	3, 231, 300	32, 320, 231	33, 737, 03	0.014030	0.000000	72.00
95. 00	09500 AMBULANCE SERVICES	8, 151	9, 386, 855	9, 395, 000	0. 925464	0. 000000	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0,131	0		0. 000000	0. 000000	
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
105.00	10500 KIDNEY ACQUISITION	1, 779, 720	0	1, 779, 720			105. 00
106.00	10600 HEART ACQUISITION	3, 999, 160	0	3, 999, 160			106. 00
200.00	Subtotal (see instructions)	1, 766, 086, 732	1, 157, 733, 297	2, 923, 820, 029)		200. 00
201.00							201. 00
202.00	Total (see instructions)	1, 766, 086, 732	1, 157, 733, 297	2, 923, 820, 029	9		202. 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0017	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared:

					11/30/2018 3:38 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				30.00
31. 00	03100 INTENSIVE CARE UNIT				31.00
31. 01	02080 PEDIATRIC INTENSIVE CARE UNIT				31. 01
	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. 090661			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 317595			52. 00
53.00	05300 ANESTHESI OLOGY	0. 015227			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 126908			54.00
54. 01	05401 PET SCAN	0. 051825			54. 01
56.00	05600 RADI OI SOTOPE	0. 032620			56. 00
57.00	05700 CT SCAN	0. 030517			57. 00
58.00	05800 MRI	0. 076465			58. 00
60.00	06000 LABORATORY	0. 114882			60.00
65.00	06500 RESPI RATORY THERAPY	0. 111469			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 287696			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	15. 881840			67. 00
68.00	06800 SPEECH PATHOLOGY	0. 211653			68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 071315			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 305530			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 058934			71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 217438			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 107745			73. 00
74.00	07400 RENAL DI ALYSI S	0. 334126			74. 00
76.00	03140 CARDIO CATH LAB	0. 075622			76. 00
76. 01	03050 ENDOSCOPY	0. 152619			76. 01
76. 02	03950 CARDI AC REHAB	0. 233231			76. 02
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	2. 084970			90.00
91.00	09100 EMERGENCY	0. 110535			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 014650			92. 00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0. 925464			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

REDUCTIONS FOR WEDICALD ONE!			T	06/30/2018	Date/Time Pre 11/30/2018 3:	
		Ti tl	e XIX	Hospi tal	PPS	оо р
Cost Center Description	Total Cost		Operating Cost	Capi tal	Operating Cost	
	(Wkst. B, Part			Reducti on	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						
50.00 05000 OPERATING ROOM	45, 302, 877	6, 533, 147		0	0	
51.00 05100 RECOVERY ROOM	0	0	_	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 716, 510	71, 377		0	0	
53. 00 05300 ANESTHESI OLOGY	981, 832	44, 084	·	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 349, 903	2, 496, 125		0	0	
54. 01 05401 PET SCAN	311, 194	92, 076		0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	1, 252, 784	203, 214		0	0	
57. 00 05700 CT SCAN	3, 804, 019	275, 701	3, 528, 318	0	0	57. 00
58. 00 05800 MRI	2, 609	70		0	0	58. 00
60. 00 06000 LABORATORY	26, 258, 218	1, 601, 892	24, 656, 326	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	10, 056, 955	629, 974	9, 426, 981	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	8, 648, 596	598, 626	8, 049, 970	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	52, 823	1, 253	51, 570	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	589, 103	407, 412	181, 691	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 319, 515	600, 964	5, 718, 551	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 442, 284	479, 634	2, 962, 650	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 146, 983	401, 415	11, 745, 568	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	58, 441, 790	1, 759, 422	56, 682, 368	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	55, 064, 078	1, 817, 730	53, 246, 348	0	0	73. 00
74.00 07400 RENAL DIALYSIS	4, 394, 368	338, 446	4, 055, 922	0	0	74. 00
76. 00 03140 CARDI O CATH LAB	8, 041, 558	1, 206, 005	6, 835, 553	0	0	76. 00
76. 01 03050 ENDOSCOPY	9, 756, 882	1, 282, 372	8, 474, 510	0	0	76. 01
76. 02 03950 CARDI AC REHAB	996, 985	42, 688	954, 297	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	7, 916, 575	841, 913	7, 074, 662	0	0	90.00
91. 00 09100 EMERGENCY	15, 712, 090	1, 295, 726	14, 416, 364	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	523, 863	52, 694	471, 169	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	8, 694, 744	1, 017, 070	7, 677, 674	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	2, 119, 453	126, 199	1, 993, 254	0	0	105. 00
106.00 10600 HEART ACQUISITION	789, 351	20, 175	769, 176	0		106. 00
200.00 Subtotal (sum of lines 50 thru 199)	311, 687, 942	24, 237, 404	287, 450, 538	0		200. 00
201.00 Less Observation Beds	523, 863	52, 694	471, 169	0		201. 00
202.00 Total (line 200 minus line 201)	311, 164, 079	24, 184, 710	286, 979, 369	0	0	202. 00

Title XIX						10	00/30/2016	11/30/2018 3:	
Capital and Operating Cost Part 1, column Ratio (col. 6 Reduction Reductio							Hospi tal		
Capital and Operating Cost Part 1, column Ratio (col. 6 Reduction Reductio		Cost Center Description	Cost Net of	Total Charges	Outpati ent				
Reduction 8)		·		(Worksheet C,	Cost to Charg				
ANCILLARY SERVICE COST CENTERS			Operating Cost	Part I, column	Ratio (col.	6			
ANCI LLARY SERVICE COST CENTERS			Reducti on	8)	/ col. 7)				
50. 00			6.00	7. 00	8. 00				
51.00 05100 RECOVERY ROOM & LABOR ROOM 2.716, 510 8.553, 370 0.3175955 52.00		ANCILLARY SERVICE COST CENTERS							
52.00 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 0530	50.00	05000 OPERATING ROOM	45, 302, 877	499, 692, 761	0. 09066	51			50.00
53. 00 05300 ARSTHESI OLOGY 981, 832 64, 481, 483 0. 015227 53. 00	51.00	05100 RECOVERY ROOM	0	0	0.00000	00			51. 00
54. 00 05400 RADIO LOGY_DI AGNOSTI C 17, 349, 903 136, 712, 801 0, 126908 54. 00 05401 PET SCAN 311, 194 6, 004, 749 0, 051825 54. 01 56. 00 05600 RADI OI SOTOPE 1, 252, 784 38, 405, 942 0, 032620 56. 00 05700 CT SCAN 3, 804, 019 124, 651, 434 0, 030517 57. 00 58. 00 05800 MR 2, 609 34, 120 0, 076465 58. 00 06. 00 06800 LABORATORY 26, 258, 218 228, 566, 996 0, 114882 60. 00 06. 00 06500 PHYSI CAL THERAPY 10, 056, 955 90, 222, 233 0, 111469 65. 00 06. 00 06600 PHYSI CAL THERAPY 52, 823 3, 326 15, 881840 67. 00 06700 0CCUPATI ONAL THERAPY 58, 848, 596 30, 061, 527 0, 287696 66. 00 06. 00 06600 PHYSI CAL THERAPY 58, 823 3, 326 15, 881840 67. 00 06900 ELECTROCARDIOLOGY 589, 103 2, 278, 348 0, 211653 68. 00 06900 ELECTROCARDIOLOGY 589, 103 2, 278, 348 0, 211653 68. 00 06900 ELECTROCARDIOLOGY 589, 103 2, 278, 348 0, 211653 69. 00 07000 ELECTROCARDIOLOGY 6, 319, 515 88, 614, 347 0, 071315 69. 00 07000 ELECTROCREPHALOGRAPHY 3, 442, 284 11, 266, 591 0, 305530 70. 00 07000 ELECTROCREPHALOGRAPHY 3, 442, 284 11, 266, 591 0, 305530 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 58, 441, 790 268, 774, 145 0, 217438 72, 00 07200 ELECTROCARDIOLOGY 8, 441, 790 268, 774, 145 0, 217438 72, 00 07200 EMBALDIALSIS 4, 394, 368 13, 151, 829 0, 334126 74, 00 07400 RENAL DIALYSIS 4, 394, 368 13, 151, 829 0, 334126 74, 00 07400 RENAL DIALYSIS 4, 394, 368 13, 151, 829 0, 334126 74, 00 07400 RENAL DIALYSIS 7, 00 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07	52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 716, 510	8, 553, 370	0. 31759	95			52. 00
54. 01 05401 PET SCAN 311, 194 6, 004, 749 0. 051825 54. 01	53.00	05300 ANESTHESI OLOGY	981, 832	64, 481, 483	0. 01522	27			53.00
56. 00 0500 0500 05700 CT SCAN 3, 804, 019 124, 651, 434 0, 030517 57. 00 57. 00 05700 CT SCAN 3, 804, 019 124, 651, 434 0, 030517 57. 00 60. 00 06000 06000 LABORATORY 26, 699 34, 120 0, 076465 58. 00 60. 00 06000 06000 LABORATORY THERAPY 10, 056, 955 90, 222, 233 0, 111489 65. 00 66. 00 06600 PHYSI CAL THERAPY 8, 648, 596 30, 061, 527 0, 287696 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 8, 648, 596 30, 061, 527 0, 287696 66. 00 68. 00 06800 SPEECH PATHOLOGY 589, 103 2, 783, 348 0, 211653 68. 00 69. 00 06900 LECTROCARDIO LOGY 6, 319, 515 88, 614, 347 0, 071315 69. 00 70. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 12, 146, 983 206, 111, 805 0, 35530 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 55, 644, 078 511, 060, 003 0, 107745 73. 00 74. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 349, 903	136, 712, 801	0. 12690	80			54.00
57. 00 05700 CT SCAN 3, 804, 019 124, 651, 434 0, 030517 57. 00 58. 00 05800 MRI 2, 609 34, 120 0, 076465 58. 00 06000 LABORATORY 26, 258, 218 228, 566, 996 0, 114882 60. 00 65. 00 06500 RESPIRATORY THERAPY 10, 056, 955 90, 222, 233 0, 111469 65. 00 66. 00 06600 PHYSI CAL THERAPY 8, 648, 596 30, 061, 527 0, 287696 66. 00 66. 00 66. 00 06000 PHYSI CAL THERAPY 52, 823 3, 326 15, 881840 67. 00 68. 00 06000 SPEECH PATHOLOGY 589, 103 2, 783, 348 0, 211653 68. 00 6900 ELECTROCARDI OLOGY 6, 319, 515 88, 614, 347 0, 071315 69, 00 6900 ELECTROCARDI OLOGY 6, 319, 515 88, 614, 347 0, 071315 69, 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 12, 146, 983 206, 111, 805 0, 058934 71. 00 07200 IMPL. DE V. CHARGED TO PATI ENT 58, 441, 790 268, 774, 145 0, 217438 72. 00 73. 00 07300 RUGS CHARGED TO PATI ENTS 55, 064, 078 511, 060, 003 0, 107745 73. 00 07400 RUAS CHARGED TO PATI ENTS 55, 064, 078 511, 060, 003 0, 107745 73. 00 07400 RUAS CHARGED TO PATI ENTS 55, 064, 078 511, 060, 003 0, 107745 74. 00 07400 RUAS LIVIS 4, 394, 368 13, 151, 829 0, 334126 74. 00 07400 RUAS LIVIS 4, 394, 368 13, 151, 829 0, 334126 74. 00 07400 RUAS LIVIS 74. 000 09000 CLINIC 79, 756, 882 63, 929, 742 0, 152619 76. 00 09000 CLINIC 79, 756, 882 63, 929, 742 0, 152619 76. 00 09000 09000 CLINIC 79, 756, 755 79, 756, 757 75, 976, 973 2, 084970 90. 00 0900	54.01	05401 PET SCAN	311, 194	6, 004, 749	0. 05182	25			54. 01
58. 00 05800 MRI 2,609 34,120 0,076465 58,00 60. 00 06000 LABORATORY 26,258,218 228,566,996 0,114882 60,00 65. 00 06500 RESPIRATORY THERAPY 10,056,955 90,222,233 0,111469 65.00 66. 00 06600 PHYSI CAL THERAPY 8,648,596 30,061,527 0.287696 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 52,823 3,326 15,881840 67.00 68. 00 06800 SPEECH PATHOLOGY 589,103 2,783,348 0.211653 68.00 69. 00 06900 LECTROCARDIOLOGY 6,319,515 88,614,347 0.071315 69.00 71. 00 07000 ELECTROENCEPHALOGRAPHY 3,442,284 11,266,591 0.350530 70.00 71. 00 07100 MBDI CAL SUPPLIES CHARGED TO PATI ENT 12,146,983 206,111,805 0.058934 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 55, 064,078 511,060,003 0.107745 73.00 74. 00 07400 RENAL DI ALYSI S 4,394,368 13,151,829 0.334126 <td>56.00</td> <td>05600 RADI 0I S0T0PE</td> <td>1, 252, 784</td> <td>38, 405, 942</td> <td>0. 03262</td> <td>20</td> <td></td> <td></td> <td>56.00</td>	56.00	05600 RADI 0I S0T0PE	1, 252, 784	38, 405, 942	0. 03262	20			56.00
60. 00 06000 LABORATORY 26, 258, 218 228, 566, 996 0.114882 60. 00 65. 00 65. 00 665. 00 66500 RESPI RATORY THERAPY 8, 648, 596 30, 061, 527 0. 287696 66. 00 66. 00 6600 PHYSI CAL THERAPY 8, 648, 596 30, 061, 527 0. 287696 66. 00 67. 00 67. 00 06600 PHYSI CAL THERAPY 52, 823 3, 326 15, 881840 67. 00 68. 00 06800 SPECH PATHOLOGY 589, 103 2, 783, 348 0. 211653 69. 00 06900 ELECTROCARDI OLOGY 6, 319, 515 88, 614, 347 0. 071315 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 12, 146, 983 206, 111, 805 0. 058934 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 58, 441, 790 268, 774, 145 0. 217438 72. 00 73. 00 07300 RUGS CHARGED TO PATIENTS 55, 064, 078 511, 060, 003 0. 107745 73. 00 07400 RENAL DI ALYSIS 4, 394, 368 13, 151, 829 0. 334126 74. 00 07400 RENAL DI ALYSIS 996, 985 4, 274, 660 0. 233231 76. 02 07400 RENAL DI ALYSIS 996, 985 4, 274, 660 0. 233231 76. 02 07400 RENAL DI ALYSIS 77, 916, 575 77, 916, 575 77, 910, 9700 07400 RENEGNCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 09000 OLINIC 77, 916, 575 3, 796, 973 2. 084970 90. 00 00000 07400 RENEGNCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 09000 OLINIC 77, 916, 575 3, 796, 973 2. 084970 90. 00 00000 07400 RENEGNCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 000000 90. 000000 90. 0000000 90. 00000000 90. 00000000 90. 000000000 90. 0000000000	57.00	05700 CT SCAN	3, 804, 019	124, 651, 434	0. 03051	17			57.00
65. 00	58.00	05800 MRI	2, 609	34, 120	0. 07646	55			58. 00
65. 00 06500 RESPI RATORY THERAPY 10, 056, 955 90, 222, 233 0, 111469 66. 00 66	60.00	06000 LABORATORY	26, 258, 218	228, 566, 996	0. 11488	32			60.00
67. 00 06700 06700 0CCUPATI ONAL THERAPY 52, 823 3, 326 15, 881840 67, 00 68. 00 06800 SPEECH PATHOLOGY 589, 103 2, 783, 348 0, 211653 68. 00 69. 00 06900 ELECTROCARDI OLOGY 6, 319, 515 88, 614, 347 0, 071315 69. 00 07000 ELECTROCARDI OLOGY 3, 442, 284 11, 266, 591 0, 305530 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 12, 146, 983 206, 111, 805 0, 058934 71. 00 7200 MPL. DEV. CHARGED TO PATI ENT 58, 441, 790 268, 774, 145 0, 217438 72. 00 73. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 55, 064, 078 511, 060, 003 0, 107745 73. 00 74. 00 7400 RENAL DI ALYSI S 4, 394, 368 13, 151, 829 0, 334126 74. 00 76. 00 03140 CARDI 0 CATH LAB 8, 041, 558 106, 339, 168 0, 075622 76. 00 76. 01 03050 ENDOSCOPY 9, 756, 882 63, 929, 742 0, 152619 76. 01 03050 ENDOSCOPY 9, 756, 882 63, 929, 742 0, 152619 76. 01 03050 CARDI AC REHAB 996, 985 4, 274, 660 0, 233231 76. 02 009000 CLINIC COST CENTERS 90. 00 090000 EMERGENCY 15, 712, 090 142, 146, 007 0, 110535 91. 00 92. 00 09500 BSERVATI ON BEDS (NON-DI STINCT PART 523, 863 35, 759, 631 0, 014650 92. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0, 000000 96. 00 96. 00 97. 00	65.00	06500 RESPI RATORY THERAPY	10, 056, 955			59			65. 00
68. 00 06800 SPEECH PATHOLOGY 589, 103 2, 783, 348 0. 211653 68. 00 69. 00 06900 ELECTROCARDI OLOGY 6, 319, 515 88, 614, 347 0. 071315 69. 00 07000 ELECTROENCEPHALOGRAPHY 3, 442, 284 11, 266, 591 0. 305530 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 12, 146, 983 206, 111, 805 0. 058934 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 58, 441, 790 268, 774, 145 0. 217438 72. 00 73. 00 07400 RURGS CHARGED TO PATI ENTS 55, 064, 078 511, 060, 003 0. 107745 73. 00 07400 RENAL DI ALYSI S 4, 394, 368 13, 151, 829 0. 334126 74. 00 07400 RENAL DI ALYSI S 8, 041, 558 106, 339, 168 0. 075622 76. 00 03140 CARDI O CATH LAB 8, 041, 558 106, 339, 168 0. 075622 76. 00 0350 ENDOSCOPY 9, 756, 882 63, 929, 742 0. 152619 76. 01 03050 ENDOSCOPY 9, 756, 882 63, 929, 742 0. 152619 76. 01 03050 ENDOSCOPY 97, 56, 882 63, 929, 742 0. 152619 76. 01 00000 00000 000000 000000 000000	66.00	06600 PHYSI CAL THERAPY	8, 648, 596	30, 061, 527	0. 28769	96			66. 00
69. 00 66900 ELECTROCARDI OLOGY 6, 319, 515 88, 614, 347 0. 071315 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 3, 442, 284 11, 266, 591 0. 305530 70. 00 70. 00 70. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 12, 146, 983 206, 111, 805 0. 058934 71. 00 72. 00 72. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 58, 441, 790 268, 774, 145 0. 217438 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 55, 064, 078 511, 060, 003 0. 107745 73. 00 74. 00 07400 RENAL DI ALYSIS 4, 394, 368 13, 151, 829 0. 334126 74. 00 74.	67.00	06700 OCCUPATI ONAL THERAPY	52, 823	3, 326	15. 88184	10			67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 3, 442, 284 11, 266, 591 0. 305530 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 12, 146, 983 206, 111, 805 0. 058934 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 58, 441, 790 268, 774, 145 0. 217438 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 55, 064, 078 511, 060, 003 0. 107745 73. 00 74. 00 07400 RENAL DI ALYSI S 4, 394, 368 13, 151, 829 0. 334126 74. 00 76. 00 03140 CARDI O CATH LAB 8, 041, 558 106, 339, 168 0. 075622 76. 00 76. 01 03050 ENDOSCOPY 9, 756, 882 63, 929, 742 0. 152619 76. 01 76. 01 76. 02 03950 CARDI AC REHAB 996, 985 4, 274, 660 0. 233231 76. 01 76. 02 0010 EMERGENCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 09100 EMERGENCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 523, 863 35, 759, 631 0. 014650 92. 00 09500 AMBULANCE SERVI CES 8, 694, 744 9, 395, 006 0. 925464 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0. 0. 000000 96. 00 0. 000000 97. 00 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	68.00	06800 SPEECH PATHOLOGY	589, 103	2, 783, 348	0. 21165	53			68. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 3, 442, 284 11, 266, 591 0. 305530 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 12, 146, 983 206, 111, 805 0. 058934 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 58, 441, 790 268, 774, 145 0. 217438 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 55, 064, 078 511, 060, 003 0. 107745 73. 00 07400 RENAL DI ALYSI S 4, 394, 368 13, 151, 829 0. 334126 74. 00 76. 00 03140 CARDI LAB 8, 041, 558 106, 339, 168 0. 075622 76. 01 03050 ENDOSCOPY 9, 756, 882 63, 929, 742 0. 152619 76. 01 76. 02 03950 CARDI AC REHAB 996, 985 4, 274, 660 0. 233231 76. 02 001741 ENT SERVI CE COST CENTERS 15, 712, 090 142, 146, 007 0. 110535 91. 00 09100 EMERGENCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 523, 863 35, 759, 631 0. 014650 92. 00 09500 AMBULANCE SERVI CES 8, 694, 744 9, 395, 006 0. 925464 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0. 000000 0. 000000 96. 00 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 00000000	69.00	06900 ELECTROCARDI OLOGY	6, 319, 515	88, 614, 347	0. 07131	15			69. 00
71. 00	70.00	07000 ELECTROENCEPHALOGRAPHY							70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 58, 441, 790 268, 774, 145 0. 217438 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 55, 064, 078 511, 060, 003 0. 107745 73. 00 74. 00 07400 RENAL DIALYSIS 4, 394, 368 13, 151, 829 0. 334126 74. 00 07400 CARDI O CATH LAB 8, 041, 558 106, 339, 168 0. 075622 76. 00 03050 ENDOSCOPY 9, 756, 882 63, 929, 742 0. 152619 76. 01 03950 CARDI AC REHAB 996, 985 4, 274, 660 0. 233231 76. 02 000000000000000000000000000000000						34			71.00
74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 21743	38			72. 00
74. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	55, 064, 078	511, 060, 003	0. 10774	15			73.00
76. 00	74.00	07400 RENAL DIALYSIS				26			74.00
76. 01 03050 ENDOSCOPY 9, 756, 882 63, 929, 742 0. 152619 76. 01 76. 02 03950 CARDI AC REHAB 996, 985 4, 274, 660 0. 233231 76. 02 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 7, 916, 575 3, 796, 973 2. 084970 90. 00 91. 00 09100 EMERGENCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 523, 863 35, 759, 631 0. 014650 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 8, 694, 744 9, 395, 006 0. 925464 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0. 0. 0000000 96. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 2, 119, 453 1, 779, 720 1. 190891 105. 00 106. 00 10600 HEART ACQUI SI TI ON 789, 351 3, 999, 160 0. 197379 106. 00 200. 00 Subtotal (sum of lines 50 thru 199) 311, 687, 942 2, 700, 572, 877 200. 00 201. 00 Less Observati on Beds 523, 863 0									76. 00
76. 02 03950 CARDI AC REHAB 996, 985 4, 274, 660 0. 233231 76. 02 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 7, 916, 575 3, 796, 973 2. 084970 90. 00 91. 00 09100 EMERGENCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 092.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 523, 863 35, 759, 631 0. 014650 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0. 0000000 96. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10600 HEART ACQUI SI TI ON 789, 351 3, 999, 160 0. 197379 105. 00 200. 00 Subtotal (sum of lines 50 thru 199) 311, 687, 942 2, 700, 572, 877 201. 00 201. 00 Less Observati on Beds 523, 863 0 201.									
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 7,916,575 3,796,973 2.084970 90.00 91.00 09100 EMERGENCY 15,712,090 142,146,007 0.110535 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 523,863 35,759,631 0.014650 92.00 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 07000000 07000000 0700000000									76, 02
90. 00			,	., ., .,					
91. 00 09100 EMERGENCY 15, 712, 090 142, 146, 007 0. 110535 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 523, 863 35, 759, 631 0. 014650 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 8, 694, 744 9, 395, 006 0. 925464 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0. 000000 96. 00 OURABLE MEDI CAL EQUI STI TON 2, 119, 453 1, 779, 720 1. 190891 105. 00 10500 KI DNEY ACQUI SI TI ON 789, 351 3, 999, 160 0. 197379 106. 00 200. 00 Subtotal (sum of lines 50 thru 199) 311, 687, 942 2, 700, 572, 877 200. 00 201. 00 Less Observation Beds 523, 863 0 201. 00			7, 916, 575	3, 796, 973	2. 08497	70			90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 523, 863 35, 759, 631 0.014650 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 8, 694, 744 9, 395, 006 0.000000 96. 00 0.0000000 96. 00 0.00000000 96. 00 0.0000000 96. 00 0.0000000 96. 00 0.0000000 96. 00 0.0000000 96. 00 0.0000000 96. 00 0.0000000 96. 00 0.0000000 96. 00 0.0000000 96. 00 0.00000000 96. 00 0.00000000 96. 00 0.000000000 96. 00 0.000000000 96. 00 0.000000000 96. 00 0.000000000 96. 00 0.0000000000					l .				91.00
OTHER REIMBURSABLE COST CENTERS 8,694,744 9,395,006 0.925464 95.00					l .				92, 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0.0000000 96. 00									
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0.0000000 96. 00	95.00	09500 AMBULANCE SERVICES	8, 694, 744	9, 395, 006	0. 92546	54			95.00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 2, 119, 453 1, 779, 720 1. 190891 105.00 106.00 106.00 10600 HEART ACQUI SI TI ON 789, 351 3, 999, 160 0. 197379 106.00 200.00 Subtotal (sum of lines 50 thru 199) 311, 687, 942 2, 700, 572, 877 200.00 201.00 Less Observation Beds 523, 863 0 201.00	96.00	09600 DURABLE MEDICAL EQUIP-RENTED				00			96.00
106.00 106.00 10600 HEART ACQUISITION 789, 351 3,999, 160 0.197379 106.00 200.00 Subtotal (sum of lines 50 thru 199) 311,687,942 2,700,572,877 200.00 201.00 Less Observation Beds 523,863 0									1
106.00 106.00 10600 HEART ACQUISITION 789, 351 3,999, 160 0.197379 106.00 200.00 Subtotal (sum of lines 50 thru 199) 311,687,942 2,700,572,877 200.00 201.00 Less Observation Beds 523,863 0			2, 119, 453	1, 779, 720	1. 19089	91			105.00
200.00 Subtotal (sum of lines 50 thru 199) 311,687,942 2,700,572,877 201.00 Less Observation Beds 201.00 201.00			1 1		l .				
201.00 Less Observation Beds 523,863 0 201.00	200.00	Subtotal (sum of lines 50 thru 199)	311, 687, 942						200.00
202.00 Total (line 200 minus line 201) 311, 164, 079 2, 700, 572, 877 202.00	201.00								201.00
	202.00	Total (line 200 minus line 201)	311, 164, 079	2, 700, 572, 877					202.00

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		ln lie	eu of Form CMS-:	2552 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider C		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part I	pared:
-		Ti tl e	e XVIII	Hospi tal	PPS	00 piii
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost (col. 1 - col 2)	Total Patient Days		
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•		•	<u> </u>		
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 31.01 PEDIATRIC INTENSIVE CARE UNIT 31.02 NEONATAL INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 40.00 SUBPROVIDER - IPF 43.00 NURSERY 200.00 Total (lines 30 through 199) Cost Center Description	5,838,971 0 300,780 1,392,221 2,351,037 819,731 0 32,296 10,735,036 Inpatient Program days	C	300, 78 1, 392, 22 2, 351, 03 819, 73	0 0 535 1 4, 271 7 21, 115 1 6, 230 0 0 0 6 1, 644	0. 00 562. 21 325. 97 111. 34 131. 58 0. 00 19. 64	31. 00 31. 01 31. 02 31. 03 32. 00 40. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 31.01 PEDIATRIC INTENSIVE CARE UNIT 31.02 NEONATAL INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 40.00 SUBPROVIDER - IPF 43.00 NURSERY 200.00 Total (lines 30 through 199)	20, 658 0 2 0 7, 858 2, 635 0 0 31, 153	0 1, 124 0 874, 910 346, 713 0				30. 00 31. 00 31. 01 31. 02 31. 03 32. 00 40. 00 43. 00 200. 00

	<u> </u>	LUTHERAN HOSPIT		ON 45 0047		eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der C		Peri od: From 07/01/2017	Worksheet D Part II	
					To 06/30/2018	Date/Time Pre	pared:
			T: +1 a	. VVIII	Haani tal	11/30/2018 3: PPS	38 pm
	Cost Center Description	Capi tal	Total Charges	XVIII	Hospi tal t Inpati ent	Capital Costs	
	cost center bescription		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,				column 4)	
		Part II, col.	8)	2)	. Charges	Corumir 4)	
		26)		2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50.00	05000 OPERATI NG ROOM	6, 533, 147	499, 692, 761	0. 01307	90, 293, 463	1, 180, 497	50.00
51. 00	05100 RECOVERY ROOM	0,000,000		1			
52. 00	05200 DELIVERY ROOM & LABOR ROOM	71, 377	1				52.00
53.00	05300 ANESTHESI OLOGY	44, 084					53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 496, 125		0. 01825			54.00
54. 01	05401 PET SCAN	92, 076				0	54. 01
56.00	05600 RADI OI SOTOPE	203, 214				13, 995	56.00
57.00	05700 CT SCAN	275, 701					57.00
58. 00	05800 MRI	70					
60.00	06000 LABORATORY	1, 601, 892	228, 566, 996	0.00700	8 47, 757, 330	334, 683	60.00
65.00	06500 RESPIRATORY THERAPY	629, 974	90, 222, 233	0. 00698	28, 224, 778	197, 065	65.00
66.00	06600 PHYSI CAL THERAPY	598, 626			3 7, 746, 480	154, 256	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 253	3, 326	0. 37672	9 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	407, 412	2, 783, 348	0. 14637	5 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	600, 964	88, 614, 347	0. 00678	2 14, 562, 675	98, 764	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	479, 634	11, 266, 591	0. 04257	1 465, 565	19, 820	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	401, 415	206, 111, 805	0. 00194	8 44, 617, 104	86, 914	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 759, 422	268, 774, 145	0. 00654	6 66, 208, 855	433, 403	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 817, 730	511, 060, 003	0. 00355	7 106, 976, 983	380, 517	73.00
74.00	07400 RENAL DIALYSIS	338, 446	13, 151, 829	0. 02573	4 6, 736, 045	173, 345	74.00
76.00	03140 CARDIO CATH LAB	1, 206, 005	106, 339, 168	0. 01134	1 14, 892, 680	168, 898	76.00
76. 01	03050 ENDOSCOPY	1, 282, 372	63, 929, 742	0. 02005	9 3, 603, 764	72, 288	76. 01
76. 02	03950 CARDI AC REHAB	42, 688	4, 274, 660	0. 00998	1, 020, 866	10, 194	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	841, 913		0. 22173	3 25, 484	5, 651	90.00
91.00	09100 EMERGENCY	1, 295, 726	142, 146, 007	0. 00911	5 14, 137, 788	128, 866	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	52, 694	35, 759, 631	0. 00147	4 1, 176, 529	1, 734	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
96 00	09600 DURABLE MEDICAL FOULP-RENTED		ol o	0 00000	o lo	0	96 00

0 0 23, 073, 960 2, 685, 398, 991

0.000000

0 495, 493, 353

96.00 0 3, 825, 496 200. 00

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

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST		F	Period: From 07/01/2017 To 06/30/2018	11/30/2018 3:	pared: 38 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	2/1	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0		479, 404	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	Ö		0	o o	31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	0		6, 807	Ō	31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	0	O		37, 656	0	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	0	0	(156, 163	0	31. 03
32. 00 03200 CORONARY CARE UNIT	0	0	(53, 704	0	32. 00
40. 00 04000 SUBPROVI DER - PF	0	0	(0	0	40. 00
43. 00 04300 NURSERY	0	0	(15, 064	0	43.00
200.00 Total (lines 30 through 199)	0	0	(748, 798	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	1	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)		7 00		
LANDATI FAT DOUTLAS OFFICE OFFICE	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1	470 404	1 (0.07			
30. 00 03000 ADULTS & PEDI ATRI CS	0	479, 404	62, 274			
31. 00 03100 INTENSIVE CARE UNIT		(007		0.00	0	31.00
31. 01 02080 PEDI ATRI C I NTENSI VE CARE UNI T		6, 807	535		2	31. 01

31. 01 02000 1 EDITATIO TIVIENSI VE GAILE GIVI I		0,007	555	12. /2	2 31.01
31.02 02060 NEONATAL NTENSIVE CARE UNIT		37, 656	4, 271	8. 82	0 31.02
31.03 03101 CARDIO INTENSIVE CARE UNIT		156, 163	21, 115	7. 40	7, 858 31. 03
32. 00 03200 CORONARY CARE UNIT		53, 704	6, 230	8. 62	2, 635 32. 00
40. 00 04000 SUBPROVI DER - PF	0	00,701	0, 200	0.00	0 40.00
43. 00 04300 NURSERY	ď	15, 064	1, 644	9. 16	0 43.00
			·	9. 10	
200.00 Total (lines 30 through 199)		748, 798	96, 069		31, 153 200. 00
Cost Center Description	I npati ent				
	Program				
	Pass-Through				
	Cost (col. 7 x				
	col. 8)				
	9. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>				
30. 00 03000 ADULTS & PEDI ATRI CS	159, 067				30.00
31.00 03100 INTENSIVE CARE UNIT	0				31.00
31. 01 02080 PEDIATRIC INTENSIVE CARE UNIT	25				31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT	20				31. 02
	FO 140				
31. 03 03101 CARDIO INTENSIVE CARE UNIT	58, 149				31. 03
32. 00 03200 CORONARY CARE UNIT	22, 714				32. 00
40. 00 04000 SUBPROVI DER - 1 PF	0				40. 00
43. 00 04300 NURSERY	0				43.00
200.00 Total (lines 30 through 199)	239, 955				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: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared:

				'	0 00/30/2016	11/30/2018 3:	
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
54. 01	05401 PET SCAN	0	0	C	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	C	0	0	56.00
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58. 00	05800 MRI	o	0	C	0	0	58. 00
60.00	06000 LABORATORY	o	0	C	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	o	0	C	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	o	0	C	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	0	C	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	o	0	C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0	l c	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	C	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	C	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	C	0	292, 736	73. 00
74.00	07400 RENAL DIALYSIS	o	0	C	0	0	74. 00
76.00	03140 CARDIO CATH LAB	o	0	C	0	0	76. 00
76. 01	03050 ENDOSCOPY	o	0	C	0	0	76. 01
76. 02	03950 CARDI AC REHAB	o	0	C	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		1
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	o	0	l c	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o		l c		4, 327	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	l c	0	0	96. 00
200.00	Total (lines 50 through 199)	0	0	l c	0	297, 063	200. 00
				•			

Health Financial Systems	LUTHERAN HOSPI TAL	OF INDIANA	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/30/2018 3:38 pm
		T: +1 o V/////	Heeni tel	DDC

Cost Center Description All Other Medical Education Cost through col. 2, 3 and 4 11/30/2018 3:3 PPS Title XVIII Hospital PPS Total Cost (Sum of Cost (Sum of Part I, col.) (col. 5 ÷ col.) Total (from Wkst. C, to Charges (col. 2, 3 and 8) Total (col. 5 ÷ col.)	
Medical (sum of col 1 Outpatient (from Wkst. C, to Charges Education Cost through col. Cost (sum of Part I, col. (col. 5 ÷ col.	
Medical (sum of col 1 Outpatient (from Wkst. C, to Charges Education Cost through col. Cost (sum of Part I, col. (col. 5 ÷ col.	
4) col. 2, 3 and 8) 7)	
4)	
4.00 5.00 6.00 7.00 8.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0 0 499, 692, 761 0. 000000	50.00
51. 00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 8, 553, 370 0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY 0 0 64, 481, 483 0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 136, 712, 801 0. 000000	54.00
54. 01 05401 PET SCAN 0 0 6, 004, 749 0. 000000	54.01
56. 00 05600 RADI 01 SOTOPE 0 0 0 38, 405, 942 0. 000000	56.00
57. 00 05700 CT SCAN 0 0 0 124, 651, 434 0. 000000	57.00
58. 00 05800 MRI 0 0 0 34, 120 0. 000000	58.00
60. 00 06000 LABORATORY 0 0 228, 566, 996 0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY 0 0 90, 222, 233 0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0 30, 061, 527 0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 3, 326 0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0 2, 783, 348 0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 88, 614, 347 0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 11, 266, 591 0. 000000 0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 206, 111, 805 0.000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 268, 774, 145 0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 292, 736 292, 736 511, 060, 003 0. 000573	73.00
74.00 07400 RENAL DIALYSIS 0 0 13,151,829 0.000000	74.00
76. 00 03140 CARDI 0 CATH LAB 0 0 106, 339, 168 0. 000000	76.00
76. 01 03050 ENDOSCOPY 0 0 0 63, 929, 742 0. 000000	76. 01
76. 02 03950 CARDI AC REHAB 0 0 0 4, 274, 660 0. 000000	76. 02
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 0 0 3, 796, 973 0. 000000	90.00
91.00 09100 EMERGENCY 0 0 142,146,007 0.000000	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 4, 327 4, 327 35, 759, 631 0. 000121	92.00
OTHER REI MBURSABLE COST CENTERS	
95. 00 O9500 AMBULANCE SERVI CES	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0. 000000	96.00
200.00 Total (lines 50 through 199) 0 297,063 297,063 2,685,398,991	200.00

Health Financial Systems	LUTHERAN HOSPITA	_	45 0047		eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co		Peri od: From 07/01/2017	Worksheet D Part IV	
THROUGH COSTS				To 06/30/2018		nared.
				10 00/00/2010	11/30/2018 3:	38 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	90, 293, 463		0 46, 487, 883	l .	
51. 00 05100 RECOVERY ROOM	0. 000000	0		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	18, 094		0 2, 961	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	11, 038, 822		0 5, 727, 488	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	17, 645, 799		0 17, 279, 233	0	54. 00
54. 01 05401 PET SCAN	0. 000000	0		0 1, 123, 111	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	2, 645, 068		0 8, 689, 013	0	56.00
57. 00 05700 CT SCAN	0. 000000	15, 699, 181		0 14, 049, 734	0	57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58. 00
60. 00 06000 LABORATORY	0. 000000	47, 757, 330		0 12, 593, 760	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	28, 224, 778		0 873, 016	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	7, 746, 480		0 345, 147	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	14, 562, 675		0 13, 345, 170	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	465, 565		0 1, 801, 737	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	44, 617, 104		0 23, 986, 594	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	66, 208, 855		0 19, 452, 619	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000573	106, 976, 983	61, 29		20, 906	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	6, 736, 045		0 376, 369	0	74.00
76. 00 03140 CARDIO CATH LAB	0. 000000	14, 892, 680		0 17, 950, 618	0	
76. 01 03050 ENDOSCOPY	0. 000000	3, 603, 764		0 12, 073, 816	0	76. 01
76. 02 03950 CARDI AC REHAB	0. 000000	1, 020, 866		0 337, 347	o o	
OUTPATIENT SERVICE COST CENTERS		,				1
90. 00 09000 CLINIC	0. 000000	25, 484		0 536, 177	0	90.00
91. 00 09100 EMERGENCY	0. 000000	14, 137, 788		0 14, 358, 647	o o	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000121	1, 176, 529				
OTHER REIMBURSABLE COST CENTERS		, ., .,				1
95. 00 09500 AMBULANCE SERVICES						95.00

0. 000000

495, 493, 353

0 61, 440

0 250, 847, 869

95.00

96.00 0

21, 266 200. 00

95. 00 09500 AMBULANCE SERVICES

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

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE		Provi der CC		Peri od: From 07/01/2017	Worksheet D	pared:
		Title	XVIII	Hospi tal	PPS	
·			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		

			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
·	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 090661	46, 487, 883	0		4, 214, 638	
51.00 05100 RECOVERY ROOM	0. 000000		0		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 317595		0	0	940	
53. 00 05300 ANESTHESI OLOGY	0. 015227	5, 727, 488	0	_	87, 212	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 126908	17, 279, 233	0	0	2, 192, 873	
54.01 05401 PET SCAN	0. 051825	1, 123, 111	0	0	58, 205	54. 01
56. 00 05600 RADI OI SOTOPE	0. 032620	8, 689, 013	0	0	283, 436	56. 00
57. 00 05700 CT SCAN	0. 030517	14, 049, 734	0	0	428, 756	57. 00
58. 00 05800 MRI	0. 076465	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0. 114882	12, 593, 760	0	0	1, 446, 796	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 111469	873, 016	0	0	97, 314	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 287696	345, 147	0	0	99, 297	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	15. 881840	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 211653	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 071315	13, 345, 170	0	0	951, 711	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 305530	1, 801, 737	0	0	550, 485	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 058934	23, 986, 594	0	0	1, 413, 626	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 217438	19, 452, 619	0	0	4, 229, 739	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 107745	36, 485, 749	0	269, 328	3, 931, 157	73.00
74.00 07400 RENAL DIALYSIS	0. 334126	376, 369	0	0	125, 755	74.00
76.00 03140 CARDIO CATH LAB	0. 075622	17, 950, 618	0	0	1, 357, 462	76. 00
76. 01 03050 ENDOSCOPY	0. 152619	12, 073, 816	0	0	1, 842, 694	76. 01
76. 02 03950 CARDI AC REHAB	0. 233231	337, 347	0	0	78, 680	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	2. 084970	536, 177	158		1, 117, 913	90.00
91. 00 09100 EMERGENCY	0. 110535	14, 358, 647	938	0	1, 587, 133	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 014650	2, 971, 680	0	0	43, 535	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 925464		0			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	0	0	96. 00
200.00 Subtotal (see instructions)		250, 847, 869	1, 096	269, 328	26, 139, 357	200.00
201.00 Less PBP Clinic Lab. Services-Program			0	0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		250, 847, 869	1, 096	269, 328	26, 139, 357	202. 00

Health Financial Systems	LUTHERAN HOSPITAL	OF INDIANA		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der CC	CN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Pre 11/30/2018 3:3	
		Title	XVIII	Hospi tal	PPS	
	Costs					

					To 06/30/2018	Date/Time Pre 11/30/2018 3:	
			Title	XVIII	Hospi tal	PPS	
		Cos	ts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	0	0				50. 00
	05100 RECOVERY ROOM	0	0	1			51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
	05300 ANESTHESI OLOGY	0	0	1			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
	05401 PET SCAN	0	0)			54. 01
	05600 RADI OI SOTOPE	0	0)			56. 00
	05700 CT SCAN	0	0)			57. 00
	05800 MRI	0	0)			58. 00
	06000 LABORATORY	0	0)			60.00
	06500 RESPI RATORY THERAPY	0	0)			65. 00
	06600 PHYSI CAL THERAPY	0	0)			66. 00
	06700 OCCUPATI ONAL THERAPY	0	0)			67. 00
	06800 SPEECH PATHOLOGY	0	0)			68. 00
	06900 ELECTROCARDI OLOGY	0	0				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0)			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	29, 019	1			73. 00
74. 00	07400 RENAL DIALYSIS	0	0				74.00
	03140 CARDIO CATH LAB	0	0				76. 00
	03050 ENDOSCOPY	0	0				76. 01
	03950 CARDI AC REHAB	0	0				76. 02
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	329	0				90. 00
	09100 EMERGENCY	104	0				91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	1			96. 00
200.00	Subtotal (see instructions)	433	29, 019				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	433	29, 019	1			202. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS HOSPIT	Provider C		Peri od:	eu of Form CMS-: Worksheet D	2552-10
				From 07/01/2017		
				To 06/30/2018	Date/Time Pre 11/30/2018 3:	
			e 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) 1. 00	2.00	2) 3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	5, 838, 971	0	5, 838, 97	1 62, 274	93. 76	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	l .	31.00
31.01 PEDIATRIC INTENSIVE CARE UNIT	300, 780		300, 78	0 535	562. 21	31. 01
31.02 NEONATAL INTENSIVE CARE UNIT	1, 392, 221		1, 392, 22	1 4, 271	325. 97	31. 02
31.03 CARDIO INTENSIVE CARE UNIT	2, 351, 037		2, 351, 03	7 21, 115		
32. 00 CORONARY CARE UNIT	819, 731		819, 73	1 6, 230		
40. 00 SUBPROVI DER - I PF	0			0		
43. 00 NURSERY	32, 296		32, 29			
200.00 Total (lines 30 through 199)	10, 735, 036		10, 735, 03	6 96, 069		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		6)				
	6, 00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 427	133, 796				30. 00
31.00 INTENSIVE CARE UNIT	0	0				31.00
31.01 PEDIATRIC INTENSIVE CARE UNIT	87	48, 912				31. 01
31.02 NEONATAL INTENSIVE CARE UNIT	128					31. 02
31.03 CARDIO INTENSIVE CARE UNIT	430		1			31. 03
32. 00 CORONARY CARE UNIT	138	1	1			32. 00
40. 00 SUBPROVI DER - I PF	0		1			40.00
43. 00 NURSERY	25					43.00
200.00 Total (lines 30 through 199)	2, 235	290, 957	I			200. 00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Pre 11/30/2018 3:	pared: 38 pm
			e XIX	Hospi tal	PPS	•
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	6, 533, 147	499, 692, 761			58, 277	50.
I.00 05100 RECOVERY ROOM	0	C	0.0000		0	51. (
2.00 05200 DELIVERY ROOM & LABOR ROOM	71, 377	8, 553, 370			3, 554	52. (
3. 00 05300 ANESTHESI OLOGY	44, 084	64, 481, 483	0. 00068	4 554, 206	379	53. (
1. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 496, 125	136, 712, 801	0. 01825	8 1, 022, 088	18, 661	54. (
4. 01 05401 PET SCAN	92, 076	6, 004, 749	0. 01533		0	54.
5. 00 05600 RADI OI SOTOPE	203, 214	38, 405, 942			481	56. (
7.00 05700 CT SCAN	275, 701	124, 651, 434			2, 069	57. (
3. 00 05800 MRI	70				0	58.0
). 00 06000 LABORATORY	1, 601, 892	228, 566, 996		2, 869, 564	20, 110	
5. 00 06500 RESPI RATORY THERAPY	629, 974	90, 222, 233			18, 277	65. (
5. 00 06600 PHYSI CAL THERAPY	598, 626				6, 249	
7. 00 06700 OCCUPATI ONAL THERAPY	1, 253	3, 326	0. 37672	.9 0	0	67.
3.00 06800 SPEECH PATHOLOGY	407, 412	2, 783, 348	0. 14637	5 0	0	68.
P. 00 06900 ELECTROCARDI OLOGY	600, 964	88, 614, 347	0. 00678	2 497, 118	3, 371	69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	479, 634	11, 266, 591	0. 04257	1 42, 175	1, 795	70.
I.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	401, 415	206, 111, 805	0. 00194	8 1, 920, 915	3, 742	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 759, 422	268, 774, 145	0. 00654	6 1, 807, 625	11, 833	72.
3.00 07300 DRUGS CHARGED TO PATLENTS	1, 817, 730			7, 718, 264	27, 454	73.
1. 00 07400 RENAL DIALYSIS	338, 446		0. 02573	4 410, 728	10, 570	74.
5. 00 03140 CARDIO CATH LAB	1, 206, 005	106, 339, 168	0. 01134	1 157, 968	1, 792	76.
5. 01 03050 ENDOSCOPY	1, 282, 372	63, 929, 742	0. 02005	9 133, 504	2, 678	76.
5. 02 03950 CARDI AC REHAB	42, 688	4, 274, 660	0. 00998	6 19, 406	194	76. (
OUTPATIENT SERVICE COST CENTERS						
D. 00 09000 CLI NI C	841, 913	3, 796, 973	0. 22173	3 1, 594	353	90.
I. 00 09100 EMERGENCY	1, 295, 726	142, 146, 007	0. 00911	5 839, 907	7, 656	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	52, 694	35, 759, 631	0. 00147	4 53, 856	79	92. (
OTHER REIMBURSABLE COST CENTERS						I

0 0 23, 073, 960 2, 685, 398, 991

26, 890, 063

95.00

96.00 0

199, 574 200. 00

0.000000

95. 00 09500 AMBULANCE SERVICES

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

Health Financial Systems	LUTHERAN HOSPIT	AL (OF INDIANA		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS	Provider CC		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part III Date/Time Pre 11/30/2018 3:3	
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nurs	sing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		-	Post-Stepdowr	Cost	Medi cal	
	Adjustments			Adjustments		Education Cost	
	1A		1. 00	2A	2. 00	3. 00	
INDATI ENT DOUTINE CEDULAE ACCT ACRITEDO							

					11/30/2018 3:	38 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi na School	Nursing School	Allied Health	Allied Health	All Other	
, , , , , , , , , , , , , , , , , , ,	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	173	1.00	ZN	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	T 0	О	0	479, 404	0	30.00
		-		479, 404	0	
31. 00 03100 INTENSIVE CARE UNIT	0	1	· -	_	-	
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	0		6, 807	0	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	0	0	1	37, 656	0	
31.03 03101 CARDIO INTENSIVE CARE UNIT	0	0	0	156, 163	0	31. 03
32. 00 03200 CORONARY CARE UNIT	0	0	0	53, 704	0	32.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40.00
43. 00 04300 NURSERY	0	l 0	l 0	15, 064	0	43.00
200.00 Total (lines 30 through 199)	0	0	0	748, 798	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
oost contai boscii pti on	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Days	3 . coi . o)	l 110graiii bays	
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INDATIENT DOUTINE CEDVICE COCT CENTERS	4.00	5.00	6.00	7.00	8.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		470 404	1 (0.074	7.70	4 407	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	1, ,, ,, ,,			1, 427	30.00
31.00 03100 INTENSIVE CARE UNIT		0	0			
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT		6, 807	535		87	31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT		37, 656	4, 271		128	31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT		156, 163	21, 115	7. 40	430	31. 03
32. 00 03200 CORONARY CARE UNIT		53, 704	6, 230	8. 62	138	32.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0.00	0	40.00
43. 00 04300 NURSERY		15, 064	1, 644			43.00
200.00 Total (lines 30 through 199)		748, 798				200. 00
Cost Center Description	I npati ent	7 107 7 70	, 0, 00,		2,200	200.00
oost contai boscii pti on	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
INDATIONE DOUBLING CODYLOG COCT CONTEDC	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	10.000	1				
30. 00 03000 ADULTS & PEDI ATRI CS	10, 988	t e				30.00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
31.01 02080 PEDIATRIC INTENSIVE CARE UNIT	1, 107					31. 01
31.02 02060 NEONATAL INTENSIVE CARE UNIT	1, 129					31. 02
31.03 03101 CARDIO INTENSIVE CARE UNIT	3, 182					31. 03
32. 00 03200 CORONARY CARE UNIT	1, 190					32.00
40. 00 04000 SUBPROVI DER - 1 PF	0	t e				40.00
43. 00 04300 NURSERY	229	1				43. 00
200.00 Total (lines 30 through 199)	17, 825					200. 00
200.00 10tal (11163 30 till ough 177)	17,625	I				1200.00

Health Financial Systems	OF INDIANA	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared:

				Т	o 06/30/2018	Date/Time Pre 11/30/2018 3:	
			Ti tl	e XIX	Hospi tal	PPS	ос р
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	(0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0) C	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0) C	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0) C	0	0	54. 00
	05401 PET SCAN	0	0) C	0	0	54. 01
	05600 RADI OI SOTOPE	0	0) C	0	0	56. 00
57. 00	05700 CT SCAN	0	0) C	0	0	57. 00
58. 00	05800 MRI	0	0) C	0	0	58. 00
60.00	06000 LABORATORY	0	0) C	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0) C	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0) C	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0) C	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0) C	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0) C	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) C	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0) C	0	292, 736	73. 00
	07400 RENAL DI ALYSI S	0	0	C	0	0	74. 00
	03140 CARDIO CATH LAB	0	0) C	0	0	76. 00
	03050 ENDOSCOPY	0	0) C	0	0	76. 01
76. 02	03950 CARDI AC REHAB	0	0	<u> </u>	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	-			0	90.00
	09100 EMERGENCY	0	0) c	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		<u> </u>)	0	92.00
	OTHER REIMBURSABLE COST CENTERS	1		1			
95. 00	09500 AMBULANCE SERVICES					1	95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	1	0	0	96. 00
200.00	Total (lines 50 through 199)	0	0) C	0	292, 736	200. 00

Health Financial Systems	LUTHERAN HOSPI TAL	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/30/2018 3:38 pm

					0 06/30/2018	11/30/2018 3:	pared: 38 nm
-			Ti tl	e XIX	Hospi tal	PPS	ос р
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	0	(499, 692, 761	0.000000	
	100 RECOVERY ROOM	0	0	(0	0. 000000	
1	200 DELIVERY ROOM & LABOR ROOM	0	0	(8, 553, 370	0. 000000	
	300 ANESTHESI OLOGY	0	0	(64, 481, 483		53. 00
	6400 RADI OLOGY-DI AGNOSTI C	0	0	(136, 712, 801	0. 000000	54.00
	5401 PET SCAN	0	0	(6, 004, 749		
	6600 RADI OI SOTOPE	0	0	(38, 405, 942		
	5700 CT SCAN	0	0	(124, 651, 434		
	800 MRI	0	0	(34, 120		
	0000 LABORATORY	0	0	(228, 566, 996	0.000000	60.00
	5500 RESPI RATORY THERAPY	0	0	(65. 00
	6600 PHYSI CAL THERAPY	0	0	(30, 061, 527	0. 000000	66. 00
	700 OCCUPATI ONAL THERAPY	0	0	(3, 326		
	800 SPEECH PATHOLOGY	0	0	(2, 783, 348	0.000000	68. 00
	900 ELECTROCARDI OLOGY	0	0	(88, 614, 347	0. 000000	
	'000 ELECTROENCEPHALOGRAPHY	0	0	(11, 266, 591	0.000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(206, 111, 805	0. 000000	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(268, 774, 145		72. 00
	300 DRUGS CHARGED TO PATIENTS	0	292, 736	292, 736			73. 00
	400 RENAL DI ALYSI S	0	0	(13, 151, 829		
	3140 CARDIO CATH LAB	0	0	(106, 339, 168		76. 00
76. 01 03	8050 ENDOSCOPY	0	0	(63, 929, 742	0.000000	76. 01
	950 CARDI AC REHAB	0	0	(4, 274, 660	0.000000	76. 02
	ITPATIENT SERVICE COST CENTERS						
	2000 CLI NI C	0	0	(
91.00 09	2100 EMERGENCY	0	0	(142, 146, 007	0.000000	91. 00
	2200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(35, 759, 631	0.000000	92. 00
	HER REIMBURSABLE COST CENTERS						
1	2500 AMBULANCE SERVICES						95. 00
	2600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0	0. 000000	
200. 00	Total (lines 50 through 199)	0	292, 736	292, 736	2, 685, 398, 991		200. 00

Health Financial Systems	LUTHERAN HOSPITA	L OF INDIANA		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS	RVICE OTHER PASS	Provi der CO	F	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Pre 11/30/2018 3:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col . 6 ÷ col .		Costs (col. 8		Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col . 12)	
ANCILLARY SERVICE COST CENTERS	9. 00	10.00	11. 00	12. 00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	4, 457, 481) 0	0	50.00
51. 00 05100 RECOVERY ROOM	0.000000	4, 457, 461 N		,	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	425, 882			0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	554, 206			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 022, 088			, O	54.00
54. 01 05401 PET SCAN	0. 000000	0.022			, O	54. 01
56. 00 05600 RADI 01 SOTOPE	0. 000000	90, 947		0	o o	56.00
57. 00 05700 CT SCAN	0. 000000	935, 298	ĺ	o o	Ō	57. 00
58. 00 05800 MRI	0. 000000	0		0	0	58. 00
60. 00 06000 LABORATORY	0. 000000	2, 869, 564	d	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2, 617, 720		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	313, 817		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	497, 118		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	42, 175	(0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 920, 915	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 807, 625	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000573	7, 718, 264	4, 423	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	410, 728		0	0	74. 00
76. 00 03140 CARDIO CATH LAB	0. 000000	157, 968	C	0	0	76. 00
76. 01 03050 ENDOSCOPY	0. 000000	133, 504		0	0	76. 01
76. 02 03950 CARDI AC REHAB	0. 000000	19, 406	(0	0	76. 02
OUTPATIENT SERVICE COST CENTERS	1		ı			
90 00 109000 CLINIC	0 000000	1 504	1) 0	l n	

0. 000000 0. 000000

0. 000000

1, 594 839, 907 53, 856

26, 890, 063

0 0

0 4, 423 0

0

90.00

91. 00 92. 00

95.00

0 96.00 0 200.00

0

0

0

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 through 199)

91. 00 09100 EMERGENCY

Health Financial Systems	LUTHERAN HOSPITAL C	OF INDIANA	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST		Peri od: From 07/01/2017	Worksheet D Part V

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C	CN: 15-0017	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Pre 11/30/2018 3:	
			Titl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins			
		1.00		(see inst.)	(see inst.)		
	ANOULL ARV CERVI OF COCT OFNITERS	1.00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS	0.000//4		0.400.00	20		F0 00
50.00	05000 OPERATI NG ROOM	0. 090661	0	_,,		-	
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	-	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 317595	Ü	11, 34		0	
53. 00	05300 ANESTHESI OLOGY	0. 015227	0	312, 72		, and the second se	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 126908	0	943, 90		0	
54. 01	05401 PET SCAN	0. 051825	0	74, 20		Ĭ	
56. 00	05600 RADI OI SOTOPE	0. 032620	0	122, 78		_	
57. 00	05700 CT SCAN	0. 030517	0	977, 26		0	
58. 00	05800 MRI	0. 076465	0		0	0	
60.00	06000 LABORATORY	0. 114882	0	1, 237, 63	35 0	0	
65.00	06500 RESPI RATORY THERAPY	0. 111469	0	77, 02		0	
66.00	06600 PHYSI CAL THERAPY	0. 287696	0	415, 40	0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	15. 881840	0		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 211653	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 071315	0	368, 81	5 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 305530	0	132, 88		0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 058934	0	521, 96	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 217438	0	421, 86	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 107745	0	3, 848, 57	0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 334126	0	4, 58	39 0	0	74. 00
76.00	03140 CARDIO CATH LAB	0. 075622	0	159, 13	39 0	0	76. 00
76. 01	03050 ENDOSCOPY	0. 152619	0	352, 67	77 0	0	76. 01
76. 02	03950 CARDI AC REHAB	0. 233231	0	36	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	2. 084970	0	115, 83	39 0	0	90. 00
91.00	09100 EMERGENCY	0. 110535	0	2, 160, 03	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 014650	0	358, 13	36 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 925464	C	240, 59	97		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96. 00
200.00	Subtotal (see instructions)		0	15, 055, 86	0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	15, 055, 86	0	0	202. 00

Health Financial Systems	LUTHERAN HOSPI TAL	OF INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0017	Peri od: From 07/01/2017	Worksheet D Part V

06/30/2018 Date/Time Prepared: 11/30/2018 3:38 pm Title XIX Hospi tal Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 199, 281 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 3.603 0 52 00 05300 ANESTHESI OLOGY 0 53.00 4,762 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 119, 789 54.00 0 54. 01 05401 PET SCAN 3.846 54.01 0 05600 RADI OI SOTOPE 56.00 4,005 56.00 57.00 05700 CT SCAN 29, 823 0 57.00 05800 MRI 0 58.00 58.00 06000 LABORATORY 0 60 00 142 182 60 00 65.00 06500 RESPIRATORY THERAPY 8,586 0 65.00 66.00 06600 PHYSI CAL THERAPY 119, 511 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 26, 302 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 40, 601 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 30, 761 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 91, 729 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 414, 664 0 73.00 74.00 07400 RENAL DIALYSIS 1,533 0 74.00 03140 CARDIO CATH LAB 0 76.00 12,034 76.00 03050 ENDOSCOPY 0 76.01 53,825 76.01 76.02 03950 CARDI AC REHAB 85 0 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 241, 521 0 09100 EMERGENCY 91.00 238, 759 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 5, 247 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 222, 664 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 200.00 0 200. 00 Subtotal (see instructions) 2, 015, 113 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 - line 201) 202.00 2, 015, 113 0 202.00

Heal th	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0017	Peri od: From 07/01/2017	Worksheet D-1	namad.	
			To 06/30/2018	Date/Time Pre 11/30/2018 3:	38 pm	
	Cook Cooking Doorwinking	Title XVIII	Hospi tal	PPS		
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	e eveluding newborn)		62, 274	1. 00	
2.00	Inpatient days (including private room days and swing-bed days) Inpatient days (including private room days, excluding swing-			62, 274	2.00	
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00	
4 00	do not complete this line.	- d - d \		/1 710	4 00	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation by Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	61, 712 0	4. 00 5. 00	
5.00	reporting period	on days) thi ough becember	31 of the cost	0	3.00	
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December :	31 of the cost	0	6. 00	
7 00	reporting period (if calendar year, enter 0 on this line)		24 -6	0	7.00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)	<i>3</i> ,				
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	20, 658	9. 00	
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	alv (including private r	nom days)	0	10.00	
	through December 31 of the cost reporting period (see instruc		Join day J		10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	0	11. 00			
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) O Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)					
12.00	through December 31 of the cost reporting period	0	12. 00			
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	0	13. 00			
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	uays)	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 service reporting period	es through December 31 o	f the cost	0.00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00	
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00	
20.00	reporting period	3 di tel becember 31 di ti	10 0031	0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions	,		58, 048, 102	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	n period (line 6	0	23. 00	
23.00	x line 18)	or the cost reporting	g perrou (Trie o		25.00	
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00	
25 00	7 x line 19)	21 of the cost reporting	nominal (line O	0	25.00	
25. 00	Swing-bed cost applicable to NF type services after December $x = 20$	31 of the cost reporting	perrod (Title 8	0	25. 00	
26.00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		58, 048, 102	27. 00	
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observetion had the	argos)	^	20 00	
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed cha	arges)	0	28. 00 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 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nue lina 33)/eoo inetruo	tions)		33. 00 34. 00	
J4. UU	paverage per urem private room charge urrierentrar (IIIIE 32 IIII	ins tille sollate that the	u onaj	0.00	ı →. ∪∪	

		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
00	Inpatient days (including private room days and swing-bed days, excluding newborn)	62, 274	
00	Inpatient days (including private room days, excluding swing-bed and newborn days)	62, 274	-
00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	
	do not complete this line.		
00	Semi-private room days (excluding swing-bed and observation bed days)	61, 712	2
00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	
-	report in a peri od	ŭ	
00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0)
50	reporting period (if calendar year, enter 0 on this line)	O	Ί
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	,
50		U	Ί
20	reporting period	0	
00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	U)
20	reporting period (if calendar year, enter 0 on this line)	20 (50	.
00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	20, 658	3
	newborn days)		
00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0) 1
	through December 31 of the cost reporting period (see instructions)		
00		0) 1
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0) 1
	through December 31 of the cost reporting period		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0) 1
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0) 1
00	Total nursery days (title V or XIX only)	0) 1
00	Nursery days (title V or XIX only)	0) 1
	SWING BED ADJUSTMENT		
00		0.00	ī 1
-	report in a peri od	0.00	1
00		0. 00	1
00	report in a peri od	0.00	Ί.
00	1 31	0.00	1 1
00	reporting period	0.00	Ί.
00		0. 00	ر ار
00	reporting period	0.00	′ ′
00	Total general inpatient routine service cost (see instructions)	58, 048, 102	2 2
00	, , ,	0	
UU		U	′ ′
00	5 x line 17) Swing had east applicable to SNE type complete December 31 of the cost reporting period (line (0	
. 00		0) 2
	x line 18)		
. 00		0) 2
	7 x line 19)	_	
. 00		0) 2
	x line 20)		
. 00		0	
00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	58, 048, 102	2
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0) 2
00	Private room charges (excluding swing-bed charges)	0) 2
00		o) 3
00		0.000000	
00		0. 00	
00		0.00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		
00		0.00	
00		0.00	
00	Private room cost differential adjustment (line 3 x line 35)	0	1 1
00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	58, 048, 102	2 3
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
. 00	Adjusted general inpatient routine service cost per diem (see instructions)	932. 14] 3
. 00		19, 256, 148	
			1 ~
. 00		0) 4
. 00 . 00		0 19, 256, 148	

Heal th	Financial Systems	LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0017	Period: From 07/01/2017	Worksheet D-1	
				To 06/30/2018		
			Title XVIII	Hospi tal	11/30/2018 3: 3 PPS	36 piii
	Cost Center Description	Total	Total Average		Program Cost	
		inpatient costiin	patient DaysDiem (col. col. 2		(col. 3 x col. 4)	
10.00	Indiana in the second of the s	1.00	2.00 3.00	4. 00	5. 00	10.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	42. 00
43. 00	INTENSIVE CARE UNIT	0	0	0.00 0	0	43. 00
43. 01	PEDIATRIC INTENSIVE CARE UNIT	2, 503, 604		79. 63	9, 359	
43. 02 43. 03	NEONATAL INTENSIVE CARE UNIT CARDIO INTENSIVE CARE UNIT	7, 600, 474 31, 492, 050		79. 55 0 91. 45 7, 858	0 11, 719, 814	43. 02 43. 03
44. 00	CORONARY CARE UNIT	10, 655, 109		10. 29 2, 635		
45. 00	BURN INTENSIVE CARE UNIT					45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)					46. 00 47. 00
47.00	Cost Center Description					47.00
40.00	Drogram i mosti ent ancil lany comi co cost (WIII	rot D 2 and 2	Line 200)		1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				57, 556, 868 93, 048, 803	
	PASS THROUGH COST ADJUSTMENTS	, , , , , , , , , , , , , , , , , , ,	,		, ,	
50. 00	Pass through costs applicable to Program inp	atient routine se	rvices (from Wkst. D,	sum of Parts I and	3, 399, 596	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	oatient ancillary	services (from Wkst. [), sum of Parts II	3, 886, 936	51.00
52.00	Total Program excludable cost (sum of lines				7, 286, 532	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ted, non-physician and	esthetist, and	85, 762, 271	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)				
54.00	Program di scharges				0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)				0. 00 0	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and targ	et amount (line 56 mir	nus line 53)	Ö	57. 00
58. 00	Bonus payment (see instructions)	morting ported on	ding 100/ undoted and	d compounded by the	0 0. 00	58. 00 59. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	portring perrou en	urng 1996, upuateu and	compounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year				0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that				0	61. 00
	amount (line 56), otherwise enter zero (see		(g		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	nant (saa instruct	i one)		0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see mstruct	10113)		0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Decemb	er 31 of the cost repo	orting period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the cost report	ting period (See	0	65. 00
	instructions)(title XVIII only)					,, ,,
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	plus line 65)(title)	(VIII only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through D	ecember 31 of the cost	reporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ne costs after Dec	ember 31 of the cost i	reporting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III – SKILLED NURSING FACILITY, OTHER N				0	69. 00
70. 00	Skilled nursing facility/other nursing facil			37)		70. 00
71.00	Adjusted general inpatient routine service of		e 70 ÷ line 2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	line 14 x line 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv					74. 00
75. 00	Capital-related cost allocated to inpatient	routine service c	osts (from Worksheet E	B, Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				76. 00
77. 00	Program capital -related costs (line 9 x line					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		vider records)			78. 00 79. 00
80. 00	Total Program routine service costs for comp	· ·		minus line 79)		80.00
81.00	Inpatient routine service cost per diem limi					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)				84. 00
85.00	Utilization review - physician compensation					85.00
oo. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ugil oo)			86. 00
87. 00	Total observation bed days (see instructions	5)			562	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		rne 2)		932. 14 523, 863	
57.00	(30)				320,000	07.00

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 838, 971	58, 048, 102	0. 10058	8 523, 863	52, 694	90.00
91.00 Nursing School cost	0	58, 048, 102	0.00000	523, 863	0	91.00
92.00 Allied health cost	479, 404	58, 048, 102	0.00825	9 523, 863	4, 327	92.00
93 00 All other Medical Education	. 0	58 048 102	0 00000	523 863	0	93 00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Pre	
		Title XIX	Hospi tal	11/30/2018 3: PPS	
	Cost Center Description		, neep tu	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s oveluding newborn)		62, 274	1.00
2. 00	Inpatient days (including private room days, excluding swing-			62, 274	
3. 00	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	3. 00
00	do not complete this line.	- d - d\		/1 710	4 00
. 00 . 00	Semi-private room days (excluding swing-bed and observation by Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	61, 712 0	4. 00 5. 00
. 00	reporting period	om days) tri odgi becembe	31 01 01 110 0031	G	0.00
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
00	reporting period	ii days) tiii odgii becembei	31 01 1110 0031	O	7.00
00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8. 00
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (eveluding	s swing bod and	1, 427	9.00
00	newborn days)	o the Frogram (excruding	g swifig-bed and	1,427	9.00
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10.00
	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII of		soom days) after	0	11. 00
1. 00	December 31 of the cost reporting period (if calendar year, e		dolli days) arter	U	11.00
. 00	Swing-bed NF type inpatient days applicable to titles V or XII		te room days)	0	12. 00
	through December 31 of the cost reporting period	V only (including privat	to room dovo)	0	12 00
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar year)			U	13. 00
1. 00	Medically necessary private room days applicable to the Progra			0	14. 00
5.00	Total nursery days (title V or XIX only)			1, 644	
6. 00	Nursery days (title V or XLX only) SWLNG BED ADJUSTMENT			25	16. 00
7. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0.00	17. 00
	reporting period	CL D L 04 C			40.00
3. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
9. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0. 00	19. 00
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	the cost	0. 00	20. 00
1. 00	Total general inpatient routine service cost (see instructions	s)		58, 048, 102	21. 00
2. 00	Swing-bed cost applicable to SNF type services through December		ting period (line	0	22. 00
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	a poriod (lino 6	0	23. 00
3. 00	x line 18)	31 of the cost reportin	ig perrou (Trile 6	U	23.00
4. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
E 00	7 x line 19) Swing had cost applicable to NE type sorvices after December:	21 of the cost reporting	a ported (line 9	0	25 00
5. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	g perrod (irne 8	U	25. 00
6. 00	Total swing-bed cost (see instructions)			0	26. 00
7. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		58, 048, 102	27. 00
8. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	narges)	0	28. 00
9. 00	Private room charges (excluding swing-bed charges)	a ana observation bed ti	iai gc <i>s)</i>	0	
0.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
1. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3. 00 4. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mil	nus line 33)/eaa instru	rtions)	0. 00 0. 00	
5. 00	Average per diem private room cost differential (line 34 x li		aci olis)	0.00	1
6. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
7. 00	General inpatient routine service cost net of swing-bed cost		ee	58, 048, 102	1 07 00

Semi-private room days (excluding swing-bed and observation bed days) 0.00 1 1 1 1 1 1 1 1 1	3.00	do not complete this line.	0	3.00
1.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Poporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Poporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Poporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.11 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 1.12 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 1.13 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 1.14 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 1.15 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 1.16 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 1.16 Swing-bed SNF type inpatient days applicable to services after December 31 of the cost of the cost reporting period (including private room days) 1.17 Swing-bed SNF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 1.18 Swing-bed SNF type inpatient r	4 00		61 712	4. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 SW ing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newton days) 10.00 SW ing-bed SW type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SW type inpatient days applicable to titles XV or XX only (including private room days) 10.00 Swing-bed Not type inpatient days applicable to titles XV or XX only (including private room days) 10.00 Swing-bed SW type services applicable to the Program (excluding swing-bed days) 10.00 Swing-bed SW type services applicable to services through December 31 of the cost reporting period (including private room days) 10.00 Swing-bed cost applicable to SW type services applicable to services after December 31 of the cost reporting period (line S X I including swing-bed cost applicable to SW type services after Dec				
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)	5.00		U	5.00
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7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period to a wing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) to the Program (excluding swing-bed and 1,427 total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,427 through December 31 of the cost reporting period (see Instructions) through December 31 of the cost reporting period (see Instructions) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost (if calendar year, enter 0 on this line) December 31 of the cost (if calendar year, enter 0 on this line) December 31 of the cost (if calendar year, enter 0 on this line) December 31 of the cost (if calendar unsery days (title V or XIX only) (including private room days) December 31 of the cost (if calendar unser) December 31 of the cost (if calendar unser) December 31 of the cost (if calendar period (if calendar are for swing-bed SNF services applicable to services after December 31 of the cost (if calendar are for swing-bed NF services applicable to services after December 31 of the cost (if calendar are for swing-bed NF services applicable to services after December 31 of the cost reporting period (if calendar period (if calendar period (if calendar period (if calendar p	6.00		U	6. 00
reporting period Note that swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) The period of the period of the cost reporting period (including private room days) Note of the period of the period of the period of the program (excluding swing-bed and newtorn days) Note of the period of the p	7.00			7 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if realendar year, enter 0 on this line)	7.00		0	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 1. 427 newborn days) 1. 00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 1. 00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 1. 00 Swing-bed SNT 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) 1. 00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 00 Swing-bed SNT type SWING S				
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8. 00		0	8. 00
newborn days) 10.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if callendar year, enter 0 on this line) 10.00 Sing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if callendar year, enter 0 on this line) 10.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 11.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Sing-bed NF type inpatient days applicable to title and the program (excluding sprivate room days) 13.00 Sing-bed NF type inpatient days applicable to the program (excluding sprivate room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Including private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 x IIIne 18) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x IIne 18) 21.10 Swing-bed cost applicable to SNF typ				
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31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 58, 048, 102 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Average per diem private room cost differential (line 58, 048, 102 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Average per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 1, 330, 164 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	30.00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 58, 048, 102) 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) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	31. 00		0. 000000	31. 00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 58, 048, 102) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 58, 048, 102) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 58, 048, 102 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 58, 048, 102 37 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		Average per urein private room charge urrierentral (Trie 32 initias Trie 33) (See Tristructions)		
37.00 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 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 339.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 1, 330, 164 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0	37. 00		58, 048, 102	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 3 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 4		27 minus line 36)		
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.14 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,330,164 3	38.00		932. 14	38. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
				40. 00
1 1,000,101				
		1	., 555, 101	

		UTHERAN HOSPITA				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	UN: 15-001/	Peri od: From 07/01/2017	Worksheet D-1	
					To 06/30/2018	Date/Time Pre 11/30/2018 3:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	inpatient bays	col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	592, 680	1, 644	360. 5	51 25	9, 013	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	ol	0	0.0	00 0	0	43. 00
43. 01	PEDIATRIC INTENSIVE CARE UNIT	2, 503, 604	535			1	l
43. 02	NEONATAL INTENSIVE CARE UNIT	7, 600, 474	4, 271				1
43. 03 44. 00	CARDIO INTENSIVE CARE UNIT	31, 492, 050 10, 655, 109	21, 115 6, 230				1
45. 00	BURN INTENSIVE CARE UNIT	10,000,107	0, 200	1,710.2	100	200, 020	45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1.00	
	, , ,					3, 078, 005	
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)(see instructio	ins)		5, 929, 436	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	308, 782	50.00
E4 00					6.5		
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	203, 997	51. 00
52.00	Total Program excludable cost (sum of lines !	50 and 51)				512, 779	52. 00
53. 00	Total Program inpatient operating cost exclud		lated, non-phy	sician anesth	etist, and	5, 416, 657	53. 00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54.00	Program di scharges					0	54.00
55. 00	Target amount per discharge					l	55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	raet amount (L	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	g	. g (.			0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, u	pdated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the less	er of 50% of		0	61. 00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mher 31 of the	cost renorti	na period (See	0	64. 00
0 11 00	instructions)(title XVIII only)	Ü		·			0 11 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
	CAH (see instructions)				-		
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
(0.00	(line 13 x line 20)		l: /7 l:	(0)			(0.00
69. 00	Total title V or XIX swing-bed NF inpatient i PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service c	ost (line 37)			70. 00
71.00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 1		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Medically necessary private room cost applica	,	(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi						74. 00
75. 00	Capital-related cost allocated to inpatient (26. line 45)	routine service	costs (from W	lorksheet B, F	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 75 + line 75 Per diem capital-related costs (line 75 + line 75 +	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	le)			78. 00 79. 00
80. 00	Total Program routine service costs for compa			· .	us line 79)		80.00
81. 00	Inpatient routine service cost per diem limit		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins		~ <i>,</i>				84. 00
85. 00	Utilization review - physician compensation	•					85. 00
გ 6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86. 00
87. 00	Total observation bed days (see instructions)					l	87. 00
88. 00	Adjusted general inpatient routine cost per of		line 2)			932.14	1
09.00	Observation bed cost (line 87 x line 88) (see	= instructions)				523, 863	I 07. UU

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/30/2018 3:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 838, 971	58, 048, 102	0. 10058	8 523, 863	52, 694	90.00
91.00 Nursing School cost	0	58, 048, 102	0.00000	523, 863	0	91.00
92.00 Allied health cost	479, 404	58, 048, 102	0.00825	9 523, 863	4, 327	92.00
93 00 All other Medical Education	1 0	58 048 102	0 00000	523 863	0	93 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 07/01/2017 To 06/30/2018	Date/Time Pre	nared:
			10 00/30/2018	11/30/2018 3:	38 pm
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	•	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		4.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3. 00	
10.00 03000 ADULTS & PEDIATRICS			35, 698, 302		30.0
B1. 00 03100 NTENSIVE CARE UNIT			33, 040, 302		31. 0
1. 01 02080 PEDIATRIC INTENSIVE CARE UNIT			6, 928		31.0
1. 02 02060 NEONATAL INTENSIVE CARE UNIT			0, 720		31.0
1. 03 03101 CARDIO INTENSIVE CARE UNIT			29, 272, 640		31.0
2. 00 03200 CORONARY CARE UNIT			11, 264, 519		32. 0
0. 00 04000 SUBPROVI DER - PF			0		40.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS			-		1
O. OO O5OOO OPERATING ROOM		0. 09066	90, 293, 463	8, 186, 096	50.0
1.00 05100 RECOVERY ROOM		0. 00000	00	0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 31759	18, 094	5, 747	52.0
3. 00 05300 ANESTHESI OLOGY		0. 01522		168, 088	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12690		2, 239, 393	
4. 01 05401 PET SCAN		0. 05182		0	54.0
6. 00 05600 RADI 0I SOTOPE		0. 03262			56. C
7. 00 05700 CT SCAN		0. 03051		479, 092	1
8. 00 05800 MRI		0. 07646		0	58.0
0. 00 06000 LABORATORY		0. 11488			
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY		0. 11146			1
6. 00 06600 PHYSI CAL THERAPY 7. 00 06700 OCCUPATI ONAL THERAPY		0. 28769 15. 88184			66. C
8.00 06800 SPEECH PATHOLOGY		0. 21165		0	68.0
9. 00 06900 ELECTROCARDI OLOGY		0. 07131			69.0
0. 00 07000 ELECTROCARD OLOGY		0. 30553			70. C
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 05893		2, 629, 464	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 21743			72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 10774			1
4. 00 07400 RENAL DI ALYSI S		0. 33412			
6. 00 03140 CARDI O CATH LAB		0. 07562			
6. 01 03050 ENDOSCOPY		0. 15261			1
6. 02 03950 CARDI AC REHAB		0. 23323	1, 020, 866	238, 098	76. C
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLI NI C		2. 08497			
1. 00 09100 EMERGENCY		0. 11053			
02 OO 09200 OBSERVATION BEDS (NON-DISTINCT PART		0 01465	1 176 529	17 236	92 0

0.014650

0.000000

1, 176, 529

495, 493, 353

495, 493, 353

92.00

95. 00

96.00

201. 00

202. 00

17, 236

0

57, 556, 868 200. 00

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

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

OTHER REIMBURSABLE COST CENTERS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

95. 00 09500 AMBULANCE SERVICES

Health Financial Systems LUTHERAN HOSPI	TAL OF INDIANA		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 07/01/2017	D-+- /T: D	
			To 06/30/2018	Date/Time Pre 11/30/2018 3:	
	Titl	e XIX	Hospi tal	PPS	30 piii
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			2, 009, 237		30.00
31. 00 03100 INTENSI VE CARE UNIT			0		31.00
31. 01 02080 PEDIATRI C INTENSIVE CARE UNIT			467, 798		31. 01
31. 02 02060 NEONATAL INTENSIVE CARE UNIT			1, 453, 611		31. 02
31. 03 03101 CARDIO INTENSIVE CARE UNIT			1, 834, 838		31. 03
32. 00 03200 CORONARY CARE UNIT			457, 835		32.00
40. 00 04000 SUBPROVI DER - PF			120 27/		40.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS			138, 376		43. 00
50. 00 05000 OPERATING ROOM		0. 09066	1 4, 457, 481	404, 120	50.00
51. 00 05100 RECOVERY ROOM		0. 00000		404, 120	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 31759		135, 258	
53. 00 05300 ANESTHESI OLOGY		0. 01522		8, 439	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 12690			
54. 01 05401 PET SCAN		0. 05182		0	54. 01
56. 00 05600 RADI 0I SOTOPE		0. 03262		2, 967	56.00
57. 00 05700 CT SCAN		0. 03051	· ·	28, 542	
58. 00 05800 MRI		0. 07646		0	58. 00
60. 00 06000 LABORATORY		0. 11488	2, 869, 564	329, 661	60.00
65. 00 06500 RESPIRATORY THERAPY		0. 11146	9 2, 617, 720	291, 795	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 28769	6 313, 817	90, 284	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		15. 88184	.0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 21165	3 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 07131	5 497, 118	35, 452	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 30553	0 42, 175	12, 886	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 05893	4 1, 920, 915	113, 207	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 21743		393, 046	
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 10774		831, 604	
74. 00 07400 RENAL DI ALYSI S		0. 33412			
76. 00 03140 CARDI O CATH LAB		0. 07562			
76. 01 03050 ENDOSCOPY		0. 15261			
76. 02 03950 CARDI AC REHAB		0. 23323	19, 406	4, 526	76. 02

3, 323

789

0

3, 078, 005 200. 00

92, 839

1, 594 839, 907 53, 856

26, 890, 063

26, 890, 063

2. 084970

0. 110535

0.014650

0.000000

90. 00 91. 00

92.00

95.00

96.00

201. 00

202. 00

90.00

91.00

92.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

09200 OBSERVATION BEDS (NON-DISTINCT PART

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

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

	Financial Systems ATION OF ORGAN ACQUISITION COSTS AND CHARGES	LUTHERAN HOSPIT		CN. 1F 0017	In Lie Period:	eu of Form CMS-2 Worksheet D-4	
	ATION OF ORGAN ACQUISITION COSTS AND CHARGES ARE CERTIFIED TRANSPLANT CENTERS	FUR HUSPITALS	Provi der C		From 07/01/2017		
	THE SERVICE TRANSPERSION		Component		To 06/30/2018		
			Vi.	dney	Hospi tal	11/30/2018 3: PPS	38 pm
	Cost Center Description	Worksheet D-1		Per Diem Cost		Cost (col. 2 x	
		Line Numbers	Routine Organ		Acqui si ti on	col . 3)	
			Charges	D-1, Part II		·	
		0	1.00	2.00	3.00	4. 00	
	PART I - COMPUTATION OF ORGAN ACQUISITION COS				CES)		
1.00	Computation of Inpatient Routine Service Cos ADULTS & PEDIATRICS	38. 00			1 1	932	1. 00
2.00	INTENSIVE CARE UNIT	43. 00	1	0.0			2.00
2. 01	PEDIATRIC INTENSIVE CARE UNIT	43. 01	6, 867			9, 359	2. 01
2.02	NEONATAL INTENSIVE CARE UNIT	43. 02	0	1, 779. 5			2. 02
2.03	CARDIO INTENSIVE CARE UNIT	43. 03	45, 296	1, 491. 4	5 13	19, 389	2. 03
3.00	CORONARY CARE UNIT	44. 00	ł	.,		_	3. 00
4.00	BURN INTENSIVE CARE UNIT	45. 00	0	0. 0		0	4. 00
5.00	SURGICAL INTENSIVE CARE UNIT	46.00	ł	0.0		_	5. 00
6. 00 7. 00	OTHER SPECIAL CARE (SPECIFY) TOTAL (sum of lines 1 through 6)	47. 00	0 55, 327	O. C	0 16	_	6. 00 7. 00
7.00	Cost Center Description		Worksheet C	Ratio of	0rgan	0rgan	7.00
	oost denter bescriptron		Line Numbers	Cost/Charges		Acquisition	
				(from Wkst. C		Ancillary	
					Charges	Costs	
			0	1.00	2. 00	3. 00	
8. 00	Computation of Ancillary Service Cost Applica OPERATING ROOM	nble to Urgan A	cquisition 50.00	0. 09066	781, 115	70, 817	8. 00
9. 00	RECOVERY ROOM		51.00				9. 00
10. 00	DELIVERY ROOM & LABOR ROOM		52.00	l .			10.00
11. 00	ANESTHESI OLOGY		53.00			1, 280	1
12. 00	RADI OLOGY-DI AGNOSTI C		54.00	0. 12690			1
12. 01	PET SCAN		54. 01	0. 05182	.5 0	0	12. 01
13.00	RADI OLOGY-THERAPEUTI C		55. 00			0	13. 00
14.00	RADI OI SOTOPE		56.00				1
15. 00 16. 00	CT SCAN MRI		57. 00 58. 00				15. 00 16. 00
17. 00	CARDI AC CATHETERI ZATI ON		59.00				17. 00
18. 00	LABORATORY		60.00	0. 11488			•
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. 00000	0 0	0	21. 00
22. 00	INTRAVENOUS THERAPY		64. 00			0	22. 00
23. 00	RESPI RATORY THERAPY		65.00				1
24. 00 25. 00	PHYSI CAL THERAPY		66. 00 67. 00	•		0	24. 00 25. 00
26. 00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY		68.00				26. 00
27. 00	ELECTROCARDI OLOGY		69.00	0. 07131			•
	ELECTROENCEPHALOGRAPHY		70. 00				1
	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0. 05893	193, 734	11, 418	29. 00
30.00	IMPL. DEV. CHARGED TO PATIENTS		72.00	0. 21743			1
31. 00	DRUGS CHARGED TO PATIENTS		73. 00				
32. 00	RENAL DIALYSIS		74.00			_	
33. 00	ASC (NON-DISTINCT PART)		75.00			_	1
34. 00 34. 01	CARDIO CATH LAB ENDOSCOPY		76. 00 76. 01			11, 442 9, 383	1
34. 01	CARDI AC REHAB		76.01			9, 303	34. 01
35. 00	RURAL HEALTH CLINIC		88. 00				35. 00
36. 00	FEDERALLY QUALIFIED HEALTH CENTER		89. 00			0	36. 00
	CLINIC		90. 00			170, 486	1
38. 00	EMERGENCY		91. 00			1, 238	
39. 00	OBSERVATION BEDS (NON-DISTINCT PART		92.00	0. 01465	11, 242	165	•
	OTHER OUTPATIENT SERVICE COST CENTER TOTAL (sum of lines 8 through 40)				5 202 224	EO/ /42	40.00
41.00	TIVIAL (Sum OF TITIES O LIMOUGH 40)		I	I	5, 392, 234	594, 463	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.

	ITAL OF INDIANA			eu of Form CMS-2	
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITAL WHICH ARE CERTIFIED TRANSPLANT CENTERS			Period: From 07/01/2017		
	Component	CCN:	Го 06/30/2018	Date/Time Pre 11/30/2018 3:	pared: 38 pm
		dney	Hospi tal	PPS	
Cost Center Description	Worksheet D-2,		0rgan	0rgan	
	Part I Line Numbers	Per Day (from Wkst. D-2,	Acquisition	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 T					_
Computation of the Cost of Inpatient Services of Interns 42.00 ADULTS & PEDIATRICS	and Residents No			am O	42.00
43. 00 INTENSIVE CARE UNIT	3.00				
43. 01 PEDIATRIC INTENSIVE CARE UNIT	3. 01	1		0	43. 01
43.02 NEONATAL INTENSIVE CARE UNIT	3. 02	1		1	43. 02
43. 03 CARDIO INTENSIVE CARE UNIT	3. 03	1			43. 03
44. 00 CORONARY CARE UNIT	4.00	1			44.00
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT	5. 00 6. 00	1		0	45. 00 46. 00
47. 00 OTHER SPECIAL CARE (SPECIFY)	7.00			0	47. 00
48.00 TOTAL (sum of lines 42 through 47)	1		16		
Cost Center Description	Worksheet D-2,		Ratio of Cost	0rgan	
	Part I Line	(see	To Charges	Acqui si ti on	
	Numbers	instructions)	from Wkst.	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	ot In Approve			
49.00 RURAL HEALTH CLINIC	21.00		0. 000000		
50. 00 FEDERALLY QUALIFIED HEALTH CENTER	22.00	•	0.000000	•	50.00
51. 00 CLINI C 52. 00 EMERGENCY	23. 00 24. 00	•			51. 00 52. 00
53. 00 OBSERVATION BEDS (NON-DISTINCT PART	25. 00	•			53.00
54. 00 OTHER OUTPATIENT SERVICE COST CENTER	26.00	•	0. 000000		54. 00
55.00 TOTAL (sum of lines 49 through 52)		104, 21	2	0	55. 00
		st		rges	
Cost Center Description	Part A	Part B	Part A	Part B	
<u> </u>					
Cost Center Description PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I	Part A	Part B 2.00	Part A	Part B	56. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient)	Part A 1.00	Part B 2.00	Part A 3.00	Part B 4.00	57. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient)	Part A 1.00	Part B 2.00	Part A 3. 00 5, 447, 561 0	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions)	Part A 1.00	Part B 2.00	Part A 3.00 5,447,561	Part B 4.00	57. 00 58. 00 59. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Fr.00 F	Part A 1.00	Part B 2.00	Part A 3. 00 5, 447, 561 0	Part B 4.00	57. 00 58. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions)	Part A 1.00	Part B 2.00	Part A 3. 00 5, 447, 561 0	Part B 4.00	57. 00 58. 00 59. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 1nterns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 10.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions)	Part A 1.00 624, 143 0 0 2, 119, 453	Part B 2.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions)	Part A 1.00 624, 143 0 0 2, 119, 453	Part B 2.00	Part A 3. 00 5, 447, 561 0 1, 633, 376 0 7, 080, 937	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs	Part A 1.00 624, 143 0 0 2, 119, 453	Part B 2.00	Part A 3. 00 5, 447, 561 0 1, 633, 376 0 7, 080, 937	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 0 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 70tal Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596	Part B 2.00	Part A 3.00 5,447,561 0 0 1,633,376 0 7,080,937	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions)	Part A 1.00 624, 143 0 0 2, 119, 453	Part B 2.00	Part A 3. 00 5, 447, 561 0 1, 633, 376 0 7, 080, 937	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
PART III - SUMMARY OF COSTS AND CHARGES Routine and Ancillary from Part I Interns and Residents (inpatient) 1 Interns and Residents (outpatient) 59.00 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)	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596	Part B 2.00	Part A 3.00 5,447,561 0 0 1,633,376 0 7,080,937	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 0 Organs Furnished Part B	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2.08 2.08 3 2 0.85294	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 17.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions)	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303	Part B 2.00 3 2.085294	Part A 3.00 5,447,561 0 1,633,376 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 1nterns and Residents (inpatient) 1nterns and Residents (outpatient) 1nterns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 0 Organs Furnished Part B	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2.08 2.08 85294	Part A 3.00 5,447,561 0 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 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
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2.085294	Part A 3.00 5,447,561 0 1,633,376 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621	Part B 4.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 17.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions)	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2.08 2.08 85294	Part A 3.00 5,447,561 0 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 d Cadaveric	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
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ± line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Excised in Provider (1) 71.00 Organs Purchased from Other Transplant Hospitals (2)	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2 0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 1 Cadaveri c 2.00	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Excised in Provider (1) 71.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Non-Transplant Hospitals	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2.0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 0 6,039,621 0 1 Cadaveric 2.00	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Non-Transplant Hospitals	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2.0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 1 Cadaveri c 2.00 12 0 0 0 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 70. 00 71. 00 72. 00 73. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Excised in Provider (1) 71.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Mon-Transplant Hospitals 73.00 Organs Purchased from OPOS 74.00 Total (sum of lines 70 through 73)	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2.0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 1 Cadaveric 2.00 12 0 0 0 13 25	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Non-Transplant Hospitals	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2.0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 1 Cadaveri c 2.00 12 0 0 0 13	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Excised in Provider (1) 71.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Non-Transplant Hospitals 73.00 Organs Purchased from OPOs 74.00 Total (sum of lines 70 through 73) 75.00 Organs Transplanted	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2 0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 1 Cadaveric 2.00 12 0 0 0 13 25	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) Interns and Residents (outpatient) 58.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from OPOs 74.00 Total (sum of lines 70 through 73) 75.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Other Hospitals 78.00 Organs Sold to Transplant Hospitals	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2 0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 d Cadaveric 2.00 712 0 0 0 0 13 0 13 0 13 0 15 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18	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 78. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from OPOs 74.00 Total (sum of lines 70 through 73) 75.00 Organs Transplanted 76.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Transplant Hospitals 78.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Military or VA Hospitals	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2 0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 d Cadaveric 2.00 712 0 0 0 0 13 0 13 0 13 0 15 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18	Part B 4.00 0 Revenue 3.00 61,303 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Non-Transplant Hospitals 73.00 Organs Transplanted 74.00 Total (sum of lines 70 through 73) 75.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Transplant Hospitals 78.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Military or VA Hospitals 79.00 Organs Sold Outside the U.S.	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2 0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 d Cadaveric 2.00 712 0 0 0 0 13 0 13 0 13 0 15 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00 79. 00 80. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I 57.00 Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 71.00 Organs Purchased from OPOs 72.00 Organs Purchased from OPOs 73.00 Organs Transplanted 76.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Transplant Hospitals 78.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Other Hospitals 79.00 Organs Sold to Other Hospitals 79.00 Organs Sold to Military or VA Hospitals 80.00 Organs Sold Outside the U.S. 81.00 Organs Sent Outside the U.S. (no revenue received)	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2 0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 1 Cadaveric 2.00 7 12 0 0 13 25 13 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 Revenue 3.00 61,303 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 79. 00 80. 00 80. 00 81. 00
PART III - SUMMARY OF COSTS AND CHARGES 56.00 Routine and Ancillary from Part I Interns and Residents (inpatient) 58.00 Interns and Residents (outpatient) 59.00 Direct Organ Acquisition (see instructions) 60.00 Cost of physicians' services in a teaching hospital (see intructions) 61.00 Total (sum of lines 56 thru 60) 62.00 Total Usable Organs (see instructions) 63.00 Medicare Usable Organs (see instructions) 64.00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65.00 Medicare Cost/Charges (see instructions) 66.00 Revenue for Organs Sold 67.00 Subtotal (line 65 minus line 66) 68.00 Organs Furnished Part B 69.00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70.00 Organs Purchased from Other Transplant Hospitals (2) 72.00 Organs Purchased from Non-Transplant Hospitals 73.00 Organs Transplanted 74.00 Total (sum of lines 70 through 73) 75.00 Organs Sold to Other Hospitals 77.00 Organs Sold to Transplant Hospitals 78.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Transplant Hospitals 79.00 Organs Sold to Military or VA Hospitals 79.00 Organs Sold Outside the U.S.	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2 0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 0 6,039,621 1 Cadaveric 2.00 7 12 0 0 13 25 13 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00 61,303 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00 79. 00 80. 00
PART III - SUMMARY OF COSTS AND CHARGES 56. 00 Routine and Ancillary from Part I Interns and Residents (inpatient) 57. 00 Interns and Residents (outpatient) 59. 00 Interns and Residents (outpatient) 59. 00 Direct Organ Acquisition (see instructions) 60. 00 Cost of physicians' services in a teaching hospital (see intructions) 61. 00 Total (sum of lines 56 thru 60) 62. 00 Total Usable Organs (see instructions) 63. 00 Medicare Usable Organs (see instructions) 64. 00 Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) 65. 00 Medicare Cost/Charges (see instructions) 66. 00 Revenue for Organs Sold 67. 00 Subtotal (line 65 minus line 66) 68. 00 Organs Furnished Part B 69. 00 Net Organ Acquisition Cost and Charges (see instructions) Cost Center Description PART IV - STATISTICS 70. 00 Organs Purchased from Other Transplant Hospitals (2) 72. 00 Organs Purchased from OPOs 74. 00 Total (sum of lines 70 through 73) 75. 00 Organs Sold to Other Hospitals 77. 00 Organs Sold to Other Hospitals 78. 00 Organs Sold to Other Hospitals 79. 00 Organs Sold to Transplant Hospitals 79. 00 Organs Sold to Military or VA Hospitals 80. 00 Organs Sold Outside the U. S. 81. 00 Organs Used for Research	Part A 1.00 624, 143 0 0 2, 119, 453 0 2, 743, 596 2, 340, 126 61, 303 2, 278, 823	Part B 2.00 3 2 0.85294 Li vi ng Rel ate 1.00	Part A 3.00 5,447,561 0 1,633,376 0 7,080,937 4 6,039,621 0 6,039,621 1 Cadaveric 2.00 7 12 0 0 13 0 13 0 13 0 14 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00 61,303 0 0 0	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 77. 00 78. 00 79. 00 81. 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.

	Financial Systems I TATION OF ORGAN ACQUISITION COSTS AND CHARGES	LUTHERAN HOSPIT	Provider C	CN: 15 0017	Period:	eu of Form CMS-3 Worksheet D-4	
	ARE CERTIFIED TRANSPLANT CENTERS	FUR HUSPITALS	Provider	CN. 13-0017	From 07/01/2017		
WIII OII	ARE GERTITED TRANSFERMI GERTERS		Component	CCN:	To 06/30/2018	Date/Time Pre	
						11/30/2018 3:	38 pm
	Cook Cooks Decoring to a	Wasaliahaat D 1		eart	Hospi tal	PPS	
	Cost Center Description	Worksheet D-1 Line Numbers	Inpatient Routine Organ	Per Diem Cost (from Wkst.	s Organ Acquisition	Cost (col. 2 x col. 3)	
		Little Numbers	Charges	D-1, Part II		(01.3)	
		0	1.00	2.00	3. 00	4.00	
	PART I - COMPUTATION OF ORGAN ACQUISITION COS					1	
	Computation of Inpatient Routine Service Cos	sts Applicable	to Organ Acqui	sition			
1.00	ADULTS & PEDI ATRI CS	38. 00		932. 1	4 C	0	1. 00
2.00	INTENSIVE CARE UNIT	43.00	0	0.0	00	0	2. 00
2.01	PEDIATRIC INTENSIVE CARE UNIT	43. 01	0	4, 679. 6	o3 C	0	2. 01
2.02	NEONATAL INTENSIVE CARE UNIT	43. 02	0	1, 779. 5	55 C	0	2. 02
2.03	CARDIO INTENSIVE CARE UNIT	43. 03				1	2. 03
3.00	CORONARY CARE UNIT	44. 00	•	.,		ή	
4.00	BURN INTENSIVE CARE UNIT	45. 00		1		1	
5.00	SURGICAL INTENSIVE CARE UNIT	46. 00	ł .	1		0	
6.00	OTHER SPECIAL CARE (SPECIFY)	47. 00				1	
7. 00	TOTAL (sum of lines 1 through 6)		Worksheet C	Ratio of	Organ	0 Organ	7. 00
	Cost Center Description		Line Numbers	Cost/Charges	Organ Acquisition	Acquisition	
			Little Number 3	(from Wkst. (Ancillary	
				(110m mor. c	Charges	Costs	
			0	1.00	2. 00	3.00	
	Computation of Ancillary Service Cost Applica	able to Organ A	cqui si ti on		•		
8.00	OPERATING ROOM		50.00	0. 09066	65, 959	5, 980	8. 00
9.00	RECOVERY ROOM		51.00	1	00	0	9. 00
10. 00	DELIVERY ROOM & LABOR ROOM		52.00	1		1	10. 00
11. 00	ANESTHESI OLOGY		53.00	1			1
12.00	RADI OLOGY-DI AGNOSTI C		54.00	1		1	12.00
12. 01	PET SCAN		54. 01	1			12. 01
13. 00 14. 00	RADI OLOGY-THERAPEUTI C RADI OI SOTOPE		55. 00 56. 00	1		_	13. 00 14. 00
15. 00	CT SCAN		57.00	1		1	1
16. 00	MRI		58.00	1	· ·	1	16. 00
17. 00	CARDI AC CATHETERI ZATI ON		59.00	1		_	17. 00
18. 00	LABORATORY		60.00	1			
19. 00	PBP CLINICAL LAB SERVICES-PRGM ONLY		61.00	1		1	1
20. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS		62.00	1		0	1
21.00	BLOOD STORING, PROCESSING & TRANS.		63.00	0. 00000	00	0	21. 00
22.00	INTRAVENOUS THERAPY		64.00	0.00000	00	0	22. 00
23.00	RESPI RATORY THERAPY		65.00	0. 11146	9 8, 530	951	23. 00
24. 00	PHYSI CAL THERAPY		66.00	1		_	24. 00
25. 00	OCCUPATIONAL THERAPY		67.00	1		_	25. 00
26. 00	SPEECH PATHOLOGY		68.00	1		0	26. 00
27. 00	ELECTROCARDI OLOGY		69.00	1		l e	27. 00
28. 00 29. 00	ELECTROENCEPHALOGRAPHY		70. 00 71. 00	1		1	
	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00			1	1
31. 00	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		73.00			1	
32. 00	RENAL DIALYSIS		74.00			2,012	32.00
33. 00	ASC (NON-DISTINCT PART)		75.00	1			ı
34. 00	CARDIO CATH LAB		76.00	1		1	1
34. 01	ENDOSCOPY		76. 01	1	·	0	ı
34. 02	CARDI AC REHAB		76. 02	1			1
35. 00	RURAL HEALTH CLINIC		88.00	1		0	
36.00	FEDERALLY QUALIFIED HEALTH CENTER		89. 00	0.00000	00 0	0	36. 00
37. 00	CLINIC		90.00				
38. 00	EMERGENCY		91.00			1	
39. 00	OBSERVATION BEDS (NON-DISTINCT PART		92.00	0. 01465	3, 710	54	1
	OTHER OUTPATIENT SERVICE COST CENTER				100		40.00
41.00	TOTAL (sum of lines 8 through 40)		l	I	192, 949	η 22, 911	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 C		eri od:	Worksheet D-4	10
WHI CH	ARE CERTIFIED TRANSPLANT CENTERS	Component		rom 07/01/2017 o 06/30/2018	Date/Time Pre	pared:
					11/30/2018 3:	
	Cost Center Description	Worksheet D-2,	art Average Cost	Hospi tal Organ	PPS Organ	
	oust defiter beserver on	Part I Line	Per Day (from	Acqui si ti on	Acqui si ti on	
		Numbers	Wkst. D-2,	·	Costs (col. 1	
			Part I, col. 4)		x col. 2)	
		0	1.00	2. 00	3. 00	
	PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THA					
42. 00	Computation of the Cost of Inpatient Services of Interns an ADULTS & PEDIATRICS	nd Residents No			am O	42. 00
43. 00	INTENSIVE CARE UNIT	3.00	1			43. 00
43. 01	PEDIATRIC INTENSIVE CARE UNIT	3. 01	1		0	43. 01
43. 02	NEONATAL INTENSIVE CARE UNIT	3.02	1		0	43. 02
43. 03 44. 00	CARDIO INTENSIVE CARE UNIT CORONARY CARE UNIT	3. 03 4. 00			0	43. 03 44. 00
45. 00	BURN INTENSIVE CARE UNIT	5. 00	l .		Ö	45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT	6. 00	1		0	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) TOTAL (sum of lines 42 through 47)	7.00	0.00	0	0	47. 00 48. 00
48. 00	Cost Center Description	Worksheet D-2,	Organ Charges	Ratio of Cost	0rgan	48.00
		Part I Line	(see	To Charges	Acqui si ti on	
		Numbers	instructions)	from Wkst. D-2, Part I,	Costs (col. 1 x col. 2)	
				col. 4	X COI. 2)	
		0	1.00	2. 00	3. 00	
49. 00	Computation of the Cost of Outpatient Services of Interns a RURAL HEALTH CLINIC	and Residents N 21.00				49. 00
50. 00	FEDERALLY QUALIFIED HEALTH CENTER	22. 00	1			50.00
51. 00	CLI NI C	23. 00				51. 00
52.00	EMERGENCY	24. 00 25. 00	1		0	52. 00 53. 00
53. 00 54. 00	OBSERVATION BEDS (NON-DISTINCT PART OTHER OUTPATIENT SERVICE COST CENTER	26.00		0. 000000		54. 00
55. 00	TOTAL (sum of lines 49 through 52)	20.00	7, 288		0	55. 00
			· · · +	Cha	rges	
	Cost Center Description		st Part B			
	Cost Center Description	Part A 1.00	Part B 2.00	Part A 3.00	Part B 4.00	
56.00	PART III - SUMMARY OF COSTS AND CHARGES	Part A 1.00	Part B 2.00	Part A 3.00	Part B	56.00
56. 00 57. 00	PART III - SUMMARY OF COSTS AND CHARGES Routine and Ancillary from Part I	Part A	Part B 2.00	Part A	Part B	56. 00 57. 00
56. 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)	Part A 1.00 22,911 0	Part B 2.00	Part A 3.00	Part B	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)	Part A 1.00 22,911 0 0 789,351	Part B 2.00	Part A 3.00	Part B	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	Part A 1.00 22,911 0	Part B 2.00	Part A 3.00 192,949 0	Part B	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) Total (sum of lines 56 thru 60)	Part A 1.00 22,911 0 0 789,351	Part B 2.00	Part A 3.00 192,949 0	Part B	57. 00 58. 00 59. 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)	Part A 1.00 22,911 0 0 789,351	Part B 2.00	Part A 3.00 192, 949 0 0 631, 071	Part B	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	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)	Part A 1.00 22,911 0 0 789,351	Part B 2.00	Part A 3.00 192, 949 0 0 631, 071 0 824, 020	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 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)	Part A 1.00 22,911 0 0 789,351	Part B 2.00	Part A 3.00 192, 949 0 0 631, 071 0 824, 020	Part B	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) Medicare Cost/Charges (see instructions)	Part A 1.00 22, 911 0 0 789, 351 0 812, 262	Part B 2.00	Part A 3.00 192, 949 0 0 631, 071 0 824, 020	Part B	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 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	Part A 1.00 22, 911 0 789, 351 0 812, 262	Part B 2.00	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869	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)	Part A 1.00 22, 911 0 789, 351 0 812, 262	Part B 2.00	Part A 3.00 192, 949 0 631, 071 0 824, 020 470, 869 0 470, 869	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 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)	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170	Part B 2.00 7 4 0.571429	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869 0 470, 869	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	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 0 Li vi ng Rel ated	Part A 3.00 192, 949 0 631, 071 0 824, 020 470, 869 0 470, 869 0 470, 869 Cadaveri c	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
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)	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869 0 470, 869	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 PART IV - STATISTICS Organs Excised in Provider (1)	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00	Part A 3.00 192, 949 0 631, 071 0 824, 020 470, 869 470, 869 0 470, 869 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
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)	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00	Part A 3.00 192, 949 0 631, 071 0 824, 020 470, 869 470, 869 0 470, 869 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 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	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)	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00	Part A 3.00 192, 949 0 631, 071 0 824, 020 470, 869 470, 869 0 470, 869 Cadaveri c 2.00	Part B 4.00 0 0 Revenue	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 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 Non-Transplant Hospitals Organs Purchased from OPOs Total (sum of lines 70 through 73)	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869 470, 869 Cadaveri c 2.00 3 0 4	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 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 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 through 73) Organs Transplanted	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00 0 0 0 0 0 0 0	Part A 3.00 192, 949 0 631, 071 0 824, 020 470, 869 470, 869 2.00 3 0 440, 869 470, 869 470, 869 470, 869 470, 869 470, 869	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 74. 00 75. 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 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 through 73) Organs Transplanted Organs Sold to Other Hospitals	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00 0 0 0 0 0 0 0	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869 470, 869 Cadaveri c 2.00 3 0 4	Part B	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 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 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 through 73) Organs Transplanted	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00 0 0 0 0 0 0 0	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869 0 470, 869 2.00 3 0 0 4 7 4 0 3 3	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 74. 00 75. 00 76. 00 77. 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 76. 00 77. 00 78. 00 79. 00 79. 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 through 73) Organs Transplanted Organs Sold to Other Hospitals Organs Sold to Transplant Hospitals Organs Sold to Transplant Hospitals	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869 470, 869 Cadaveri c 2.00 3 0 4 7 4 0 3 0 0 0 0	Part B 4.00 0 Revenue 3.00 11,980 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 69. 00 70. 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 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00	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 through 73) Organs Transplanted Organs Sold to Other Hospitals Organs Sold to Transplant Hospitals Organs Sold to Transplant Hospitals Organs Sold to Transplant Hospitals	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 192, 949 0 631, 071 0 824, 020 470, 869 0 470, 869 Cadaveric 2.00 3 0 47 4 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00	57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00 79. 00 80. 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 76. 00 77. 00 78. 00 79. 00 80. 00 81. 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) 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 Purchased from Other Transplant Hospitals (2) Organs Purchased from OPOs Total (sum of lines 70 through 73) Organs Transplanted Organs Sold to OPOs Organs Sold to Transplant Hospitals Organs Sold to OPOs Organs Sold to Military or VA Hospitals Organs Sold Outside the U.S. Organs Sent Outside the U.S. (no revenue received)	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 192, 949 0 631, 071 0 824, 020 470, 869 0 470, 869 Cadaveric 2.00 3 0 4 7 4 0 3 0 0 0 0 0 0 0 0	Part B 4.00 0 Revenue 3.00 11,980 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 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00
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) 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 through 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. (no revenue received) Organs Used for Research Unusable/Discarded Organs	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869 470, 869 Cadaveric 2.00 3 0 0 4 7 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00 11,980 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 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
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) 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) 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 through 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 Sent Outside the U.S. (no revenue received) Organs Used for Research	Part A 1.00 22, 911 0 789, 351 0 812, 262 464, 150 11, 980 452, 170 0	Part B 2.00 7 4 0.571429 Li vi ng Rel ated 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A 3.00 192, 949 0 0 631, 071 0 824, 020 470, 869 470, 869 Cadaveric 2.00 3 0 4 7 4 0 3 0 0 0 0 0 0 0 0 0 0 0 0	Part B 4.00 0 0 Revenue 3.00 11,980 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 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00

⁽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: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/30/2018 3:38 pm
	T1 11 30 (11)		550

		Title XVIII	Hospi tal	11/30/2018 3: PPS	38 pm
		II tile XVIII	nospi tai	FF3	
				1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurrir instructions)	g prior to October 1 (s	see	15, 954, 617	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	g on or after October í	l (see	45, 342, 871	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for 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			4, 389, 683 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0	2. 02
3.00	Managed Care Simulated Payments			37, 318, 953	3. 00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment			394. 46	
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)			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 ur ACA \S 5503 reduction amount to the IME cap as specified under 4			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79(1998), and 67 FR 50069 (August 1, 2002).			7.67	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slot report straddles July 1, 2011, see instructions.	s under § 5503 of the A	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slot under § 5506 of ACA. (see instructions)	s from a closed teachin	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines linstructions)	(8, 8,01 and 8,02) (s	see	17. 80	9. 00
	FTE count for allopathic and osteopathic programs in the currer FTE count for residents in dental and podiatric programs.	t year from your record	ds	23. 58 0. 00	11. 00
12.00	Current year allowable FTE (see instructions)			17. 80	•
14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on or after Sep	tember 30, 1997,	6. 42 6. 07	1
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.				15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	1
17. 00	Adjustment for residents displaced by program or hospital closu	re			17.00
18.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			10. 10 0. 025605	ł
20. 00	Prior year resident to bed ratio (see instructions)			0. 041105	1
	Enter the lesser of lines 19 or 20 (see instructions)			0. 025605	
22. 00	IME payment adjustment (see instructions)			851, 667	
22. 01	IME payment adjustment - Managed Care (see instructions)			518, 510	1
22.00	Indirect Medical Education Adjustment for the Add-on for § 422		-D 412 10F	2.00	22.00
23. 00	Number of additional allopathic and osteopathic IME FTE resider $(f)(1)(iv)(C)$.	it cap slots under 42 G	-R 412. 105		23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)				24.00
25. 00	If the amount on line 24 is greater than -O-, then enter the loinstructions)	wer of line 23 or line	24 (see	3. 00	
	Resident to bed ratio (divide line 25 by line 4)			0. 007605	•
	IME payments adjustment factor. (see instructions)			0. 002028	1
	IME add-on adjustment amount (see instructions)			124, 311	1
	IME add-on adjustment amount - Managed Care (see instructions)			75, 683	1
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			975, 978 594, 193	
	Di sproporti onate Share Adjustment			2,	1
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruct	tions)	4. 76	30.00
	Percentage of Medicaid patient days (see instructions)	, tale 1, 1, 20	´		31. 00
	Sum of lines 30 and 31			24. 37	1
	Allowable disproportionate share percentage (see instructions)				33. 00
	Di sproporti onate share adjustment (see instructions)			1, 428, 232	1
			'		

CALCUL	Financial Systems LUTHERAN HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0017	Peri od:	u of Form CMS-2 Worksheet E	_JJZ-1(
			From 07/01/2017	Part A	narad:
			To 06/30/2018	Date/Time Prep 11/30/2018 3:3	
		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)		0	0	35.00
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	
35. 02	Hospital uncompensated care payment (If line 34 is zero, entinstructions)	ter zero on this line) (se	e 3, 048, 511	3, 199, 930	35. 02
35. 03		mount (see instructions)	768, 392	2, 393, 372	35. 03
36. 00	·	,	3, 161, 764		36.00
40. 00	Additional payment for high percentage of ESRD beneficiary of Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46)		40.00
40.00	652, 682, 683, 684 and 685 (see instructions)	g discharges for M3-DNGS	0		40.00
			Before 1/1	On/After 1/1	
41 00	Tatal FCDD Madianas diaskanas austudias MC DDCs (F2 (02	/02 /04 /05 /	1.00	1. 01	41.00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	083, 084 an 685. (See	0		41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS	S-DRGs 652, 682, 683, 684	0	0	41. 01
	an 685. (see instructions)				
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6		0.00		42.00
43.00	instructions)	302, 003, 004 an 003. (3ee	0		45.00
44. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instruction	ne)	0.00	0.00	45. 00
46. 00	Total additional payment (line 45 times line 44 times line 4		0.00	0.00	46. 00
47. 00	Subtotal (see instructions)	,	71, 253, 145		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instruction	· ·		71, 847, 338	1
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a Exception payment for inpatient program capital (Wkst. L, Pt			5, 877, 210 0	1
52. 00	Direct graduate medical education payment (from Wkst. E-4, I	•		386, 808	
53. 00	Nursing and Allied Health Managed Care payment			333, 130	
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			4, 143 0	1
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		2, 730, 993	
56. 00	Cost of physicians' services in a teaching hospital (see int			0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	239, 955	
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, col. II line 200)		61, 440 81, 481, 017	
60.00	Primary payer payments			121, 354	
61. 00		us line 60)		81, 359, 663	
62.00	Deductibles billed to program beneficiaries			5, 141, 897	
64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			219, 166 388, 905	1
65. 00	Adjusted reimbursable bad debts (see instructions)			252, 788	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		154, 760	1
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	s anni achi a ta MC DDCa (a	aa imatmuatiana)	76, 251, 388	1
68. 00 69. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)			0 0	69.00
70. 00	MSP PASS THROUGH RECONCILIATION	, ,		3, 417	1
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	· •	instructions)	0	1
70. 87 70. 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	1		0	
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	structions)			70. 89
	HSP bonus payment HVBP adjustment amount (see instructions)	,		0	70. 90
	HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 91	Donall and Market Andreas and American Control				
70. 90 70. 91 70. 92 70. 93	· · · · · · · · · · · · · · · · · · ·			0 -345 433	
70. 91 70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-345, 433 -90, 357	70. 93

	Financial Systems LUTHERAN HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0017	Peri od:	u of Form CMS-2 Worksheet E	
MEGGE	ATTOM OF REIMBORGEMENT SETTEEMENT	Trovider 6	CIV. 13 0017	From 07/01/2017 To 06/30/2018	Part A Date/Time Pre	pared
					11/30/2018 3:	
		Titl∈	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
0. 96	Low volume adjustment for foderal figure voor (vana) (Enter i	n column O		0	1. 00	70
). 90	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n corullin o		U	U	70.
). 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.
	the corresponding federal year for the period ending on or af			Ü	· ·	' .
0. 98	Low Volume Payment-3	ĺ			0	70.
). 99	HAC adjustment amount (see instructions)				772, 929	70.
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			75, 046, 086	
I. 01	Sequestration adjustment (see instructions)				1, 500, 922	
1. 02	Demonstration payment adjustment amount after sequestration				0	
2. 00	Interim payments				72, 054, 912	
3. 00	Tentative settlement (for contractor use only)				0	
1. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0273)	2, 72, and			1, 490, 252	74.
. 00	Protested amounts (nonallowable cost report items) in accordal CMS Pub. 15-2, chapter 1, §115.2	nce with			3, 929, 396	75.
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			1
. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	90.
. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
. 00	Operating outlier reconciliation adjustment amount (see instru	ucti ons)			0	92
. 00	Capital outlier reconciliation adjustment amount (see instruc	,			0	
. 00	The rate used to calculate the time value of money (see instr	ucti ons)			0.00	
5. 00	Time value of money for operating expenses (see instructions)				0	
. 00	Time value of money for capital related expenses (see instruc	tions)		15.1 1.10/1	0	96.
				Prior to 10/1 1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
0. 00	HSP bonus amount (see instructions)			0	0	100.
	HVBP Adjustment for HSP Bonus Payment					
1. 00	HVBP adjustment factor (see instructions)			0.0000000000	0.000000000	101.
2.00	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102.
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	
4.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104.
	Rural Community Hospital Demonstration Project (§410A Demonstr					
00.00	Is this the first year of the current 5-year demonstration per	riod under t	the 21st			200.
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					201.
1 00	Medicana impatient comples costs (from What D.1 Dt. II. Line	~ 10)				1 .
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				
2. 00	Medicare discharges (see instructions)	e 49)				
2. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in		of the currer	nt 5-year demonst	ration	
2. 00 3. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)		of the currer	it 5-year demonst	ration	203.
)2. 00)3. 00)4. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount		of the currer	it 5-year demonst	rati on	202. 203. 204.
02. 00 03. 00 04. 00 05. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)		of the currer	it 5-year demonst	ration	203. 204. 205.
2. 00 3. 00 4. 00 5. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)		of the currer	it 5-year demonst	ration	203. 204.
2. 00 3. 00 4. 00 5. 00 6. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	first year	of the currer	it 5-year demonst	ration	203. 204. 205. 206.
2. 00 3. 00 4. 00 5. 00 6. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insti	first year	of the currer	t 5-year demonst	ration	204 205 206
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instimedicare Part A inpatient service costs (from Wkst. E, Pt. A,	first year	of the currer	nt 5-year demonst	ration	204 205 206 207 208
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see insti	first year	of the currer	ot 5-year demonst	ration	204 205 206

211. 00 Reserved for future use
211. 00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement
212. 00 Total adjustment to Medicare Part A IPPS payments (from line 211)
213. 00 Low-volume adjustment (see instructions)
218. 00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)
(line 212 minus line 213) (see instructions)

209. 00 210. 00 211. 00

212. 00 213. 00 218. 00

Provider CCN: 15-0017

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 07/01/2017 Part A Exhibit 5 Date/Time Prepared: 06/30/2018 11/30/2018 3:38 pm Title XVIII Hospi tal Period to Total (cols. 2 Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 15, 954, 617 1.01 1.01 15, 954, 617 15, 954, 617 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 45, 342, 871 1.02 1.02 45, 342, 871 45, 342, 871 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 1.03 C for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 4, 389, 683 892, 659 3, 497, 024 4, 389, 683 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 O O 2.01 **BPCI** Operating outlier reconciliation 3 00 2 01 O 3 00 Λ 4.00 Managed care simulated payments 3.00 37, 318, 953 0 37, 318, 953 37, 318, 953 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.025605 0.025605 0.025605 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 851, 667 221, 673 629 994 851, 667 6 00 IME payment adjustment for managed care (see 518, 510 518, 510 518, 510 6.01 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.002028 7.00 0.002028 7.00 IME payment adjustment factor (see 27.00 0.002028 instructions) 8.00 IME adjustment (see instructions) 28.00 124, 311 32, 356 91.955 124, 311 8.00 IME payment adjustment add on for managed 8.01 28.01 75, 683 75, 683 75, 683 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 975. 978 975. 978 9.00 254, 029 721.949 9.01 Total IME payment for managed care (sum of 29.01 594, 193 594, 193 594, 193 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0932 0.0932 10.00 0.0932(see instructions) 11.00 Disproportionate share adjustment (see 34.00 1, 428, 232 371.743 1.056.489 1, 428, 232 11.00 instructions) 768, 392 11.01 Uncompensated care payments 36.00 3, 161, 764 2, 393, 372 3, 161, 764 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see O 0 12 00 46 00 instructions) 13.00 Subtotal (see instructions) 47.00 71, 253, 145 18, 241, 440 53, 011, 705 71, 253, 145 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 15.00 49.00 71, 847, 338 18, 241, 440 53, 605, 898 71, 847, 338 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 5, 877, 210 1, 522, 525 4, 354, 685 5, 877, 210 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 1,044 3,099 4, 143 17.00 4.143 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 (replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 amount (see instructions) 19.00 SUBTOTAL 19, 765, 009 57, 963, 682 77, 728, 691 19. 00

Health Financial Systems	LUTHERAN HOSPIT	AL OF INDIANA		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der CO	CN: 15-0017 I	Peri od:	Worksheet E	
				From 07/01/2017		
			-	To 06/30/2018	Date/Time Pre	pared:
					11/30/2018 3:	38 pm_
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1.00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	4, 923, 800	1, 279, 71	3, 644, 084	4, 923, 800	20.00

						11/30/2018 3:	
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	4, 923, 800				20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	635, 332	160, 13	9 475, 193	635, 332	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0141	0. 014	0. 0141		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	69, 426	18, 04	4 51, 382	69, 426	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0505	0. 050	0. 0505		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	248, 652	64, 62	184, 026	248, 652	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	5, 877, 210	1, 522, 52	4, 354, 685	5, 877, 210	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
27. 00		70.0/					27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0	07.0	0 050 0/5	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-345, 433	-87, 06	-258, 365		
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0			0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	-90, 357	-22, 77	5 -67, 582	-90, 357	
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		196, 55	576, 377	772, 929	
100. 00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	LUTHERAN HOSPITAL OF INDIANA	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/30/2018 3:38 pm

			00/30/2016	11/30/2018 3:	
		Title XVIII	Hospi tal	PPS	оо р
	·				
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1. 00	Medical and other services (see instructions)			29, 452	1
2.00	Medical and other services reimbursed under OPPS (see instruc-	tions)		26, 118, 091	2. 00
3. 00	OPPS payments			25, 801, 880	1
4.00	Outlier payment (see instructions)			149, 629	1
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)	V col 12 line 200		21 244	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	v, cor. 13, Trile 200		21, 266 0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			29, 452	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES		l	27, 432	11.00
	Reasonable charges				
12. 00	Ancillary service charges			270, 424	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
	Total reasonable charges (sum of lines 12 and 13)			270, 424	•
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	payment for services on a c	harge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(6	e)	Ţ.		
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)			270, 424	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds line	11) (see	240, 972	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds line	18) (see	0	20. 00
21 00	instructions)			29, 452	21 00
21. 00	Lesser of cost or charges (see instructions)			29, 452	ı
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see insti	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		25, 972, 775	•
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			25, 772, 775	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			91, 758	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		4, 466, 582	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26);		d 231 (see	21, 443, 887	1
	instructions)		- ,		
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		105, 776	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, 549, 663	
31. 00	Primary payer payments			10, 198	1
32. 00	Subtotal (line 30 minus line 31)	N50)		21, 539, 465	32. 00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			00.00
	Composite rate ESRD (from Wkst. I-5, line 11)			010 217	33. 00 34. 00
	Allowable bad debts (see instructions)			818, 317	
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		531, 906 656, 264	•
	Subtotal (see instructions)	uctions)		22, 071, 371	
38. 00	MSP-LCC reconciliation amount from PS&R			-207	38. 00
39. 00	OTHER ADJUSTMENTS			0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		_	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instructio	ns)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	`	,	0	39. 99
40.00	Subtotal (see instructions)			22, 071, 578	40.00
40. 01	Sequestration adjustment (see instructions)			441, 432	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00	Interim payments			21, 553, 845	41. 00
42. 00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			76, 301	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, cha	pter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			0	00 00
90.00	Original outlier amount (see instructions)			0	1
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00
93. 00	Time Value of Money (see instructions)			0.00	93.00
	Total (sum of lines 91 and 93)			0	•
, 1. 00	1.0 ca. (Sam of Fridos / Fand 70)		I	O	, , , , , , ,

Health Financial Systems LUTHER ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0017

					11/30/2018 3:3	38 pm
			XVIII	Hospi tal	PPS	
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		68, 728, 436		21, 003, 559	1. 00
2.00	Interim payments payable on individual bills, either		3, 276, 976	5	550, 286	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					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	<u> </u>				
3. 01	ADJUSTMENTS TO PROVIDER	06/05/2018	49, 500		0	3. 01
3. 02	THE TO THE TELL	00,00,20.0	(0	3. 02
3. 03						3. 03
3. 04					l ol	3. 04
3. 05			(0	3. 05
	Provider to Program			-1	_	
3.50	ADJUSTMENTS TO PROGRAM		(0	3.50
3.51			(o	3. 51
3.52			(0	3. 52
3.53			(0	3. 53
3.54			(0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		49, 500		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		72, 054, 912	2	21, 553, 845	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	I		1		5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02	TENTITIVE TO TROVIDEN					5. 02
5. 03					0	5. 03
	Provi der to Program			-1	_	
5.50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5.52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 490, 252		76, 301	6. 01
6.02	SETTLEMENT TO PROGRAM		(0	6. 02
7. 00	Total Medicare program liability (see instructions)		73, 545, 164		21, 630, 146	7. 00
				Contractor	NPR Date	
		,)	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(J	1. 00	2. 00	8. 00
0.00	INAME OF CONTRACTOR	l		1	1	0.00

Heal th	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0017 Period: From 07/01/2017 To 06/30/2018		Worksheet E- Part II Date/Time Pro 11/30/2018 3	epared:		
		Title XVIII	Hospi tal	PPS	. 50 piii
				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.		e 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2. 00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32. 00

Health Financial Systems	LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Pre 11/30/2018 3:	pared:
		Title XIX	Hospi tal	PPS	50 piii
			I nnoti ont	Outpoti ont	

				11/30/2018 3:	38 pm
		Title XIX	Hospi tal	PPS	•
	· · · · · · · · · · · · · · · · · · ·		Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX			
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient hospital/SNF/NF services		O		1.00
	Medical and other services		٩	2 015 112	2.00
2.00				2, 015, 113	
3.00	Organ acquisition (certified transplant centers only)		0	0.045.440	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	2, 015, 113	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	2, 015, 113	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		26, 890, 063	15, 055, 869	9.00
10.00	Organ acquisition charges, net of revenue		0	., ,	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		26, 890, 063	15, 055, 869	12. 00
12.00	CUSTOMARY CHARGES		20, 070, 003	13, 033, 007	12.00
13. 00		a comul acc an a abando	l ol	0	13. 00
13.00	Amount actually collected from patients liable for payment for	services on a charge	U	Ü	13.00
14 00	basis			0	14 00
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		26, 890, 063	15, 055, 869	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	26, 890, 063	13, 040, 756	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see insti	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line	16)	0	2, 015, 113	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	rs.		
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		o	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		22, 248	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		22, 248	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		22, 240	0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		22, 248	2, 015, 113	29.00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		22, 240	2,010,113	29.00
20.00					20.00
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))	22, 248	2, 015, 113	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	d 33)	22, 248	2, 015, 113	36.00
37.00	PPS PAYMENT METHODOLOGY ADJUSTMENT		-22, 060	-1, 995, 570	37.00
38.00	Subtotal (line 36 ± line 37)		188	19, 543	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	,	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		188	19, 543	40.00
41. 00	Interim payments		100	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		188	19, 543	42.00
43. 00		aco with CMS Dub 1E 2	100	19, 543	42.00
43.00	Protested amounts (nonallowable cost report items) in accordar chapter 1, §115.2	ICE WITH CMS PUD 15-2,	١	0	43.00
	Chapter 1, 3113.2		ı I		I

	Financial Systems LUTHERAN HOSPITAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT		CN: 15-0017	Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS	1. Ovi dei O	10 0017	From 07/01/2017 To 06/30/2018	Date/Time Prep	pared:
		Ti +Lo	e XVIII	Hospi tal	11/30/2018 3: 3 PPS	38 pm
		11 11 6	z AVIII	поѕрі таі	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng peri ods	8. 95	1.0
. 00	Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see instr	uctions)	0.00	2.0
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		R §413.79 (m).	(see	0. 00 0. 00	3. (3. (
. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and	osteopathi c	programs due	to a Medicare	8. 15	4. (
. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	0. 00	4. (
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0.00	4. (
5. 00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	•			17. 10	5.0
	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic		•		23. 58	
. 00	records (see instructions)	programs roi	the current	year ITOIII your		
7. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	17. 10 Total	7. C
			1. 00	2.00	3. 00	
. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	23. 5		23. 58	8. (
00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		17. 1	0.00	17. 10	9.
0. 00	weighted dental and podiatric resident FTE count for the curr	ent year		0.00		10.
0. 01	Unweighted dental and podiatric resident FTE count for the cu	ırrent year		0.00		10.
1. 00 2. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportin	ng year (see	17. 1		•	11. 12.
3. 00	instructions) Total weighted resident FTE count for the penultimate cost re	eporting	0.0	0.00		13.
4. 00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	l by 2)	5. 7	0.00		14.
5. 00	Adjustment for residents in initial years of new programs	i by 3).	0.0			15.
5. 01	Unweighted adjustment for residents in initial years of new p	rograms	0.0			15.
6. 00	Adjustment for residents displaced by program or hospital clo		0.0			16.
6. 01	Unweighted adjustment for residents displaced by program or h	nospi tal	0.0	0.00		16.
7. 00	Adjusted rolling average FTE count		5. 7	0.00		17.
8. 00	Per resident amount		102, 601. 4	98, 514. 57		18.
9. 00	Approved amount for resident costs		584, 82	.8 0	584, 828	19.
					1. 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	eived under 42	3. 70	20.
1. 00	Direct GME FTE unweighted resident count over cap (see instru	ıcti ons)			6. 48	21.
2. 00	Allowable additional direct GME FTE Resident Count (see instr	uctions)			3. 70	22.
3. 00	Enter the locality adjustment national average per resident a	mount (see i	nstructions)		100, 008. 33	
i. 00	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				370, 031 954, 859	24. 25.
<u>. 00</u>	Total direct GML amount (Sum of Times 19 and 24)		Inpatient Par	t Managed care	754, 657	23.
			· A	ŭ		
	COMPUTATION OF PROGRAM PATIENT LOAD		1. 00	2. 00	3. 00	
6. 00	Inpatient Days (see instructions)		31, 15	20, 326		26.
7. 00	Total Inpatient Days (see instructions)		94, 22			27.
8. 00	Ratio of inpatient days to total inpatient days		0. 33063	0. 215722		28.
9. 00	Program direct GME amount		315, 70			29.
0.00	Reduction for direct GME payments for Medicare Advantage			29, 106	400 504	30.
ı. UU	Net Program direct GME amount		I	1	492, 584	J 31.

Heal th	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10		
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0017	Peri od:	Worksheet E-4			
MEDI CA	MEDICAL EDUCATION COSTS		From 07/01/2017 To 06/30/2018	Date/Time Prep 11/30/2018 3:3			
	Title XVIII Hospital						
				1. 00			
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	· ·		CAL			
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00		
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	13, 151, 829	33. 00		
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)		0.000000	34. 00		
35.00	Medicare outpatient ESRD charges (see instructions)			0	35. 00		
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00		
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY					
	Part A Reasonable Cost						
37. 00	Reasonable cost (see instructions)			93, 048, 803	1		
38. 00				2, 730, 993			
	0 Cost of physicians' services in a teaching hospital (see instructions)			0			
	0 Primary payer payments (see instructions)			121, 354	1		
41. 00							
40.00	Part B Reasonable Cost			0/ 4/0 000	40.00		
	Reasonable cost (see instructions)			26, 168, 809	1		
43. 00	Primary payer payments (see instructions)			10, 198			
44. 00				26, 158, 611			
	Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (lin-	o 41 . Lino 45)		121, 817, 053	1		
	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 785263 0. 214737	1		
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 214/3/	47.00		
48 00	Total program GME payment (line 31)	KI D		492, 584	48 00		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		386, 808	•		
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			105, 776	1		
50.00	prair b mearcare ome payment (Title 47 x 40) (title xviii only)	(See Thisti de ti ons)		103, 770	1 30.00		

Health Financial Systems

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

Provider CCN: 15-0017

——————————————————————————————————————					11/30/2018 3:	38 pm_
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-355, 067		_	1	
2. 00 3. 00	Temporary investments Notes receivable	0	0		l	2. 00 3. 00
4. 00	Accounts receivable	136, 780, 987	1	_	0	
5. 00	Other recei vabl e	0	Ö	_	o o	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-43, 329, 365	0	0	0	
7.00	Inventory	16, 004, 913	0	0	0	
8.00	Prepai d expenses	5, 878, 972		0	0	
9.00	Other current assets	899, 451		_	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	115, 879, 891	0	_	0	10.00
11.00	FIXED ASSETS	113, 679, 691		0	0	11.00
12. 00	Land	13, 479, 606	0	0	0	12. 00
13.00	Land improvements	5, 152, 219	1	0	l	13. 00
14.00	Accumulated depreciation	-1, 902, 671	0	0	0	14. 00
15. 00	Bui I di ngs	236, 512, 374	1	0		15. 00
16. 00	Accumulated depreciation	-50, 806, 315	1	0	0	
17. 00	Leasehold improvements	46, 580, 593	1	_	1	17. 00
18. 00 19. 00	Accumulated depreciation	-12, 073, 086	1	_	0	18. 00 19. 00
20. 00	Fixed equipment Accumulated depreciation	13, 939, 049 -5, 159, 954	1	_		20.00
21. 00	Automobiles and trucks	1, 704, 177		_	0	21.00
22. 00	Accumulated depreciation	-1, 298, 129		_	Ö	22. 00
23. 00	Major movable equipment	85, 253, 351		0	Ō	23. 00
24.00	Accumulated depreciation	-53, 075, 591	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	26, 458, 837	0	0	0	25. 00
26. 00	Accumul ated depreciation	-18, 073, 053	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	_	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	286, 691, 407	0			29. 00 30. 00
30.00	OTHER ASSETS	200, 091, 407		0	0	30.00
31. 00	Investments	0	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	17, 949, 492				34. 00
35. 00	Total other assets (sum of lines 31-34)	17, 949, 492	1			35. 00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	420, 520, 790	0	0	0	36. 00
37. 00	Accounts payable	25, 234, 402	el o	0	0	37. 00
38. 00	Salaries, wages, and fees payable	11, 004, 748		_	1	38.00
39. 00	Payroll taxes payable	1, 280, 082	•	0	0	39.00
40.00	Notes and Loans payable (short term)	111, 666	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	-1, 086, 463, 268	1	0	0	
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	6, 723, 086 -1, 042, 109, 284			0 0	1
45.00	LONG TERM LIABILITIES	<u> -1,042,109,264</u>	·] 0	0	0	45.00
46. 00	Mortgage payable	T 0	0	0	0	46. 00
47.00	Notes payable	88, 352	2	0	l e	
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	-270, 357		0	1	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-182, 005				
51. 00	Total liabilities (sum of lines 45 and 50)	-1, 042, 291, 289	0	0	0	51.00
E2 00	CAPITAL ACCOUNTS General fund balance	1, 462, 812, 079	1			52.00
52. 00 53. 00	Specific purpose fund	1, 402, 812, 079	ĺ o			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 05	repl acement, and expansi on	4 4/0 010 5==		_	_	F0 05
59.00	Total fund balances (sum of lines 52 thru 58)	1, 462, 812, 079		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	420, 520, 790	0		0	60.00
	l∝,\	1	1	I	I	I

Period: Worksheet G-1 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0017

					From 07/01/201 To 06/30/201		
		Genera	l Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		1, 362, 316, 442	l .		0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		90, 917, 746	l .			2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	1, 453, 234, 188		0	0	3. 00 4. 00
5.00	Additions (credit adjustments) (specify)	0			0		5. 00
6. 00		O			Ö	l ol	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0	_		0	0	9. 00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		1, 453, 234, 188		0		11. 00 12. 00
12.00	beductions (debit adjustments) (specify)	0			0	0	12.00
14. 00		0			o		14. 00
15. 00		0			Ö	Ö	15. 00
16.00		0			0	0	16.00
17. 00		0			0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1, 453, 234, 188			0	19. 00
	Sheet (Title II millus IIIle 10)	Endowment Fund	PI ant	Fund			
	I -	6. 00	7. 00	8. 00			
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)	0			0		3. 00
4. 00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5.00
6.00			0				6. 00
7.00			0				7. 00
8. 00 9. 00			0				8. 00 9. 00
10.00	Total additions (sum of line 4-9)	0	U		0		9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12. 00	Deductions (debit adjustments) (specify)		0				12. 00
13.00			0				13.00
14. 00			0				14.00
15. 00			0				15.00
16. 00 17. 00			0				16. 00 17. 00
17.00	Total deductions (sum of lines 12-17)		Ü		0		17.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

Health Financial Systems LU STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0017

			10	06/30/2018	Date/lime Prep 11/30/2018 3:3	
	Cost Center Description	Inpati	ent	Outpati ent	Total	30 p
	<u> </u>	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	98, 00			98, 005, 071	1. 00
2.00	SUBPROVIDER - I PF		0		0	2. 00
3.00	SUBPROVI DER - I RF					3. 00
4.00	SUBPROVI DER					4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8. 00 9. 00	NURSING FACILITY OTHER LONG TERM CARE					8. 00 9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	08.00	5, 071		98, 005, 071	
10.00	Intensive Care Type Inpatient Hospital Services	90,00	3, 071		96, 003, 071	10.00
11. 00	INTENSIVE CARE UNIT		0		0	11. 00
11. 01	PEDIATRIC INTENSIVE CARE UNIT	2 54	6, 349		2, 546, 349	
11. 02	NEONATAL INTENSIVE CARE UNIT		1, 039		15, 601, 039	
11. 03	CARDIO INTENSIVE CARE UNIT		5, 946		79, 155, 946	
12. 00	CORONARY CARE UNIT		8, 747		27, 938, 747	12. 00
13. 00	BURN INTENSIVE CARE UNIT	27,73	0, 717		27, 700, 717	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 125, 24	2. 081		125, 242, 081	16. 00
	11-15)		,		., .,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	223, 24	7, 152		223, 247, 152	17.00
18.00	Ancillary services	1, 489, 06	3, 301	1, 014, 732, 882	2, 503, 796, 183	18.00
19.00	Outpati ent servi ces	53, 77	6, 279	133, 613, 560	187, 389, 839	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY					22.00
23. 00	AMBULANCE SERVICES		0	9, 386, 855	9, 386, 855	23.00
24.00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26. 00	HOSPI CE					26.00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 1,766,08	6, 732	1, 157, 733, 297	2, 923, 820, 029	28. 00
	G-3, line 1)					
00.00	PART II - OPERATING EXPENSES			140 740 005		00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		0	449, 742, 985		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31. 00 32. 00
32. 00 33. 00			0			32.00
34.00			0			34. 00
35.00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		U	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	O		37. 00
38. 00	DEBOOT (OF EOTT)		0			38. 00
39. 00			0			39. 00
40.00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		J	0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		449, 742, 985		43. 00
.5. 55	to Wkst. G-3, line 4)	, ()		, , , , , , , , , , , , , , , , , ,		
		1			'	

	Financial Systems LUTHERAN HOSPITAL	-		u of Form CMS-2	
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0017	Peri od:	Worksheet G-3	
			From 07/01/2017 To 06/30/2018	Date/Time Pre	nared:
			10 00/30/2010	11/30/2018 3:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		2, 923, 820, 029	1. 00
2.00	Less contractual allowances and discounts on patients' accour	nts		2, 385, 563, 284	2. 00
3.00	Net patient revenues (line 1 minus line 2)			538, 256, 745	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		449, 742, 985	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			88, 513, 760	5. 00
	OTHER INCOME			<u> </u>	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00				0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and quests			0	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients	•		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER REVENUE			2, 403, 986	
	Total other income (sum of lines 6-24)			2, 403, 986	
	Total (line 5 plus line 25)			90, 917, 746	
	OTHER EVRENCES (SPECIEV)				

90, 917, 746 29. 00

28. 00

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

27. 00 OTHER EXPENSES (SPECIFY)

Heal th	Financial Systems LUTHERAN HOSPITAL	OF INDIANA	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0017	Peri od: From 07/01/2017 To 06/30/2018		
		Title XVIII	Hospi tal	PPS	30 piii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT			4 000 000	1 00
1. 00 1. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			4, 923, 800 0	1
2. 00	Capital DRG outlier payments			635, 332	
2. 01	Model 4 BPCI Capital DRG outlier payments			033, 332	1
3.00	Total inpatient days divided by number of days in the cost re	eportina period (see inst	ructions)	263. 13	
4.00	Number of interns & residents (see instructions)	3 1 1 1 1	,	13. 10	
5.00	Indirect medical education percentage (see instructions)			1. 41	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	69, 426	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. 76	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instru	ictions)		19. 61	8. 00
9. 00	Sum of Lines 7 and 8	ictions)		24. 37	1
10.00	Allowable disproportionate share percentage (see instructions	:)		5. 05	1
11. 00					
12.00	Total prospective capital payments (see instructions)			248, 652 5, 877, 210	
				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	3. 00
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 circumstance	ces (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0 0.00	
4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see in	netructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary		(line 6)	0.00	1
8.00	Capital minimum payment level (line 5 plus line 7)	, 664666 (6.2.)		Ö	1
9.00	Current year capital payments (from Part I, line 12, as appli	cabl e)		0	9.00
10.00	Current year comparison of capital minimum payment level to c		less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over of Worksheet L. Part III, line 14)	capital payment (from pri	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital pa	ayments (line 10 plus lir	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter			Ö	
14. 00	Carryover of accumulated capital minimum payment level over c		,	0	
15 00	(if line 12 is negative, enter the amount on this line)	structions)		0	15 00
15. 00 16. 00	Current year allowable operating and capital payment (see ins Current year operating and capital costs (see instructions)	structions)		0	
	Current year exception offset amount (see instructions)			0	
	journal jour anaption of fact amount (300 first detrons)			۰	1 17. 55