Health Financial Systems Kinc This report is required by law (42 USC 1395g; 42 CFI	Ired Hospital Nort			u of Form CMS-2552-10
payments made since the beginning of the cost report				OMB NO. 0938-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT		Provider CCN: 1	52018 Period:	Worksheet S
AND SETTLEMENT SUMMARY			From 09/01/2015	
			To 08/31/2016	Date/Time Prepared: 1/19/2017 7:11 am
PART I – COST REPORT STATUS				17172017 7.11 dill
Provider 1. [X] Electronically filed cost rep	ort		Date: 1/19/20	017 Time: 7:11 am
use only 2. [] Manually submitted cost repor	t			
3. [0] If this is an amended report			ider resubmitted this c	ost report
4. [F] Medicare Utilization. Enter "		for low.		
	Recei ved:		10. NPR Date:	(
use only (1) As Submitted 7. Contra (2) Settled without Audit 8. [N]	actor No. Enitial Report for	this Provider C	11. Contractor's Vendo	Jr Code: 4 Jumn 1 is 4: Enter
(2) Settled without Addit 0. [N]	Final Report for t	his Provider CCN	number of tin	nes reopened = 0-9.
(4) Reopened				
(5) Amended				
PART II - CERTIFICATION		LC AACT DEDADT M		
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATIO				
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF				
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA		KICKDACK OK WERE	official se release, citri	INAL, CIVIL AND
	HEODE II			
CERTIFICATION BY OFFICER OR ADMINIS	TRATOR OF PROVIDE	R(S)		
I HEREBY CERTIFY that I have read the above	certification sta	tement and that	I have examined the acc	ompanyi ng
electronically filed or manually submitted				
Expenses prepared by Kindred Hospital North				
09/01/2015 and ending 08/31/2016 and to the				
correct, complete and prepared from the boo				
instructions, except as noted. I further c				
provision of health care services, and that compliance with such laws and regulations.	the services iden	tiried in this co	ost report were provide	ain
compriance with such raws and regulations.				
	(Signed)			
	(Si grieu)_	Officer or	Administrator of Provic	lor(s)
		United of		
	Ī	ītle		
	_			
	C	Date		
		Title XVIII		
Cost Center Description	Title V		HIT	Title XIX
PART III - SETTLEMENT SUMMARY	1.00	2.00 3	4.00	5.00
1.00 Hospital	0	-562	0 0	0 1.00
2.00 Subprovi der – IPF	0	- 562	0	0 1.00
3.00 Subprovider - IRF	0	0	0	0 3.00
5.00 Swing bed - SNF	0	o	o	0 5.00
6.00 Swing bed - NF	0	Ĭ	-	0 6.00
7.00 SKILLED NURSING FACILITY	0	o	0	0 7.00
200_00 Total	o	-562	0 0	0 200 00

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

SPII	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	ЦA	Provi	der CCN:	152018	Period: From 09/0				
							To 08/3	1/2016	Date/T 1/18/2		
	1.00		. 00		3.00			4.00	17 107 2	2.0	
~ ~	Hospital and Hospital Health Care Co										
00 00	Street: 215 W 4th St, Ste 200 City: Mishawaka	PO Box: State: I	IN 7i	ip Code	· 46544	Cour	ty: St. Jos	enh			1.
		Component Na		CCN	CBSA	Provi de			ent Syst	em (P,	
			Nu	umber	Number	Туре	Certifie		, 0, or		4
		1.00		2.00	3.00	4.00	5.00	V 6. 00	XVIII 7.00	XI X 8.00	-
	Hospital and Hospital-Based Componen			2.00	3.00	4.00	5.00	0.00	7.00	0.00	
00	Hospi tal	Kindred Hospital		52018	43780	2	08/04/200	00 N	Р	0	3.
00	Subprovider - IPF	Northern Indiana									4.
00	Subprovider - IRF										5.
00	Subprovider - (Other)										6.
00	Swing Beds - SNF										7.
00 00	Swing Beds - NF Hospital-Based SNF										8.
00	Hospi tal -Based NF										10.
. 00	Hospital-Based OLTC										11.
. 00	Hospital-Based HHA										12.
00	Separately Certified ASC Hospital-Based Hospice										13.
00	Hospital -Based Health Clinic - RHC										15.
00	Hospital-Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) Renal Dialysis										17.
00	Other										10.
							Fro		Тс		
. 00	Cost Reporting Period (mm/dd/yyyy)						1.0		2. 08/31		20.
. 00	Type of Control (see instructions)						4		00/31	/2010	20.
	Inpatient PPS Information										1
00	Does this facility qualify and is it	2	0.5						1	1	22.
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en					(2)(11010					
. 01	Did this hospital receive interim un	•				. 0	N		1	1	22.
	period? Enter in column 1, "Y" for yo reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)		-								
. 02	Is this a newly merged hospital that determined at cost report settlement						N		1	1	22.
	or "N" for no, for the portion of the										
	in column 2, "Y" for yes or "N" for	no, for the porti	on of the	cost re	eporting	period o	on				
02	or after October 1.	la radiacci fi cati	on from ur	han to	rural a	e e rocul	t N				22.
03	Did this hospital receive a geograph of the OMB standards for delineating								r	4	22.
	in column 1, "Y" for yes or "N" for	no for the portio	on of the c	ost rep	orting	peri od					
	prior to October 1. Enter in column						ne				
	cost reporting period occurring on o hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N	N″ for no.								
. 00	Which method is used to determine Mer 1, enter 1 if date of admission, 2 i						1	2	1	1	23.
	method of identifying the days in th						Ł				
	used in the prior cost reporting per	iod? In column 2									
			In-State Medicaid	In-St Medic		Out-of State	Out-of State	Medica HMO da		ther di cai d	
			pai d days			di cai d	Medi cai d	TIMO GE		days	
				unpa		id days	eligible				
			1.00	day		2 00	unpai d 4.00	E 00		6.00	-
00	If this provider is an IPPS hospital	enter the	1.00	2.0	0	3.00	4.00	5.00	0	5.00 C	24.
- 0	in-state Medicaid paid days in colum				Ĩ	Ĭ	5		Ĭ		
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	column 6.									
~~	If this provider is an IRF, enter the		0	2	0	0	0		0		25.
00	Medicaid paid days in column 1, the										
00	Medicaid eligible unnaid days in col-										1
. 00	Medicaid eligible unpaid days in col out-of-state Medicaid days in column										
00		3, out-of-state umn 4, Medicaid									

IOSPI 1	Financial Systems Kindred Hos AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider (CCN: 152018 P	eri od:		u of For Workshe		
					rom 09/01/ o 08/31/		Part I Date/Ti	me Pre	pared:
							1/18/20		2 pm
					Urban/Rur 1.00		2. (1
6. 00	Enter your standard geographic classification (not wa			inning of the		1			26.0
7 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa			of the cost		1			27.0
/.00	reporting period. Enter in column 1, "1" for urban or					'			27.0
- 00	enter the effective date of the geographic reclassifi								05.0
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	number	r of periods SC	H status in		0			35.0
					Begi nni r	ng:	Endi	ng:	
(00	Estan and include the include and include datase of COU at			2/ fan muchan	1.00		2.0	00	24.0
5.00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 TOP NUMBER					36.0
7.00	If this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		0			37.0
7.01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	MDH t	ransitional na	vment in	N				37.0
/.01	accordance with FY 2016 OPPS final rule? Enter "Y" fo								57.0
0.00	instructions)	- 6 10		07 !-					20.0
8.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.0
	enter subsequent dates.								
					Y/N 1.00		Y/ 2. (-
9.00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	or low volume			2. (39.0
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii								
	or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes								
0. 00	Is this hospital subject to the HAC program reduction	adj ust	tment? Enter "Y	" for yes or	N		N		40. C
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			es or "N" for					
		(300 1	histi deti onsy			V	XVIII	XIX	
	Description Description (DDC) Constant					1.00	2.00	3.00	
5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for c	li sproporti onat	e share in ac	cordance	N	N	N	45. C
0.00	with 42 CFR Section §412.320? (see instructions)								
6. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					Ν	N	N	46. C
	Pt. III.	. L, PI	L. III anu wkst	. L-I, PL. I	thi ough				
	Is this a new hospital under 42 CFR §412.300 PPS capi					Ν	Ν	N	47.0
8.00	Is the facility electing full federal capital payment Teaching Hospitals	? Ente	er "Y" for yes	or "N" for no		N	N	N	48.0
6. 00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56.0
7 00	or "N" for no.								F7 0
7.00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for								57. C
	is "Y" did residents start training in the first mont	h of th	nis cost report	ing period?	Enter "Y"				
	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			E-4. If colu	mn2is				
8. 00	If line 56 is yes, did this facility elect cost reimb	ursemer	nt for physicia	ns' services a	as				58.0
0 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			D+ I		N			59. C
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					N			60. C
	provider-operated criteria under §413.85? Enter "Y"								
		Y/N	IME	Direct GME	IME		Di rect	t GME	
		1.00	2.00	3.00	4.00		5.(
1.00	Did your hospital receive FTE slots under ACA	N				0.00		0.00	61.0
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)								
1. 01	Enter the average number of unweighted primary care		0. 00	0.0	d				61. C
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								
	instructions)								
1. 02	Enter the current year total unweighted primary care		0.00	0.0	0				61. C
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								
	ACA). (see instructions)								
1.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0.0	U I				61. C
	determining compliance with the 75% test. (see								
1 04	instructions)		0.00	0.0					111
1. U4	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	4				61. C
	current cost reporting period. (see instructions).								
	Enter the difference between the baseline primary		0.00	0.0	q				61.0
1. 05									1
1. 05	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line								

SPITAL AND HOSPITAL HEALTH CARE COMPL			Provider (CCN: 152018 Pe	eri od:	u of Form CMS-2 Worksheet S-2	
				Fr Tc	rom 09/01/2015 08/31/2016	Part I Date/Time Pre	pareo
		Y/N	I ME	Direct GME	IME	1/18/2017 2:3 Direct GME	2 pm
		1.00	2.00	3.00	4.00	5.00	
06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs care or general surgery. (see ins	that are nonprimary		0.00	0.00			61.
		Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
10 Of the FTEs in line 61.05, special special ty, if any, and the number for each new program. (see instruction of the program code, enter in column 3, unweighted count and enter in column FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0. 00	0. 00	61.
20 Of the FTEs in line 61.05, special program specialty, if any, and the residents for each expanded program structions) Enter in column 1, enter in column 2, the program column 3, the IME FTE unweighted count a 4, direct GME FTE unweighted count	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0.00	61.
						1.00	
ACA Provisions Affecting the Hea 00 Enter the number of FTE residents					od for which	0.00	62
your hospital received HRSA PCRE	funding (see instruc	ctions)		1 31			
01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Re	riod of HRSA THC prop	gram. (s	ee instruction		your hospital	0.00	62.
00 Has your facility trained resider "Y" for yes or "N" for no in colu	nts in nonprovider se	ettings (during this co		eriod? Enter	N	63.
				Unwei ghted FTEs	FTEsin	Ratio (col. 1/ (col. 1 + col.	
				Nonprovider Site	Hospi tal	2))	
Section 5504 of the ACA Base Yea	n FTF Dagidanta in N		an Cattinga I	1.00	2.00	3.00	
 period that begins on or after Jr 00 Enter in column 1, if line 63 is in the base year period, the numl resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 	uly 1, 2009 and befor yes, or your facilit per of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	r <u>e June</u> ty traine -primar all non d non-pr n column	30, 2010. ed residents y care provider mary care 3 the ratio	0.00			64.
	Program Name	Pro	gram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
00 Enter in column 1, if line 63	1.00		2.00	3. 00 0. 00	4.00	5.00 0.000000	45
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in							

Heal th	Financial Systems	Kindred Hos	pital Northe	ern Indiar	าล	In	Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	ΤA	Provi der	F	eriod: rom 09/01/: o 08/31/:		Worksheet S-2 Part I Date/Time Pre 1/18/2017 2:3	epared:
					Unweighted FTEs Nonprovider Site	Unweight FTEs i Hospita	n	Ratio (col. 1. (col. 1 + col 2))	/
	Section 5504 of the ACA Current	Year FTF Residents in	n Nonprovide	r Settina	1.00	2.00 or cost rem	orti	<u> </u>	-
	beginning on or after July 1, 20	10	•	0					
66.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	ings. dent	0.00)	0.00	0. 00000	5 66.00
		Program Name	Program	Code	Unweighted FTEs Nonprovider Site	Unweight FTEs i Hospita	n	Ratio (col. 3. (col. 3 + col 4))	
		1.00	2.0	0	3.00	4.00		5.00	-
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			<u> </u>	0.00		0.00		0 67.00
			1		1	-			
	Inpatient Psychiatric Facility P	PS					1.00	0 2.00 3.00	-
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or doe	s it cont	ain an IPF subp	provi der?	Ν		70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	D04? Enter lity train)(D)? Enter	"Y" for y residents "Y" for y	es or "N" for r in a new teach es or "N" for r	וס. (see ni ng סו.		0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or	does it c	ontain an IRF		Ν		75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 20 new teachin for no. Col	04? Enter g program umn 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42		0	76.00
								1.00	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? En	iter	Y N	80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded un				no.	N	85. 00 86. 00
87.00	Is this hospital a "subclause (I			n 1886(d)	(1)(B)(iv)(II)	? Enter "Y"		N	87.00
	for yes or "N" for no.					V		XI X	
	Title V and VIX Services					1.00		2.00	
90.00	Title V and XIX Services Does this facility have title V		hospital se	rvi ces? E	nter "Y" for	N		Y	90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for		nrough the c	ost repor	t either in	N		N	91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy	es or "N" for no in t	the applicab	le column					92.00
	instructions) Enter "Y" for yes	or"N" for no in the	appl i cabl e	column.				N	
93.00	Does this facility operate an IC "Y" for yes or "N" for no in the		urposes of t	itle V an	d XIX? Enter	N		N	93.00
94.00	Does title V or XIX reduce capit applicable column.		or yes, and	"N" for n	o in the	N		Ν	94.00

Health Financial Systems Kindred Hospital HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 152018 F	In Li Period: From 09/01/201 To 08/31/201		2 epared:
	·	·	V	XI X	
95.00 If line 94 is "Y", enter the reduction percentage in the ap		2	1.00 0.00	2.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			N N	N N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	oplicable column	n.	0.00	0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (C 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	N		105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	nn 1. (see insti	ructions) lf			107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109.00
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for	1.00 N	110.00
			1.	00 2.00 3.00	1
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Dub 15 departs 23	2. If column 2 i ent for long te	is "E", enter rm care (inclu	in column des	I O	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu no.	2		"N" for Y		116. 00 117. 00
118. 00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1 i	if the policy	is 1		118.00
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:		33, 67	5	0 79,83	9 118. 01
			1.00	2.00	_
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 D0 NOT USE THIS LINE			N	2.00	118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y qualifies for th	" for yes or he Outpatient	Ν	N	119.00 120.00
121.00 Did this facility incur and report costs for high cost impl	antable devices	s charged to	N		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t			Ν		122.00
where these taxes are included. Transplant Center Information					105.00
where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f		for no. If	N		125. 00
 where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 	For yes and "N" enter the certin 2.	fication date	N		126.00
 where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 	For yes and "N" enter the certing 2. Iter the certifi 2.	fication date ication date	N		126. 00 127. 00
<pre>where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en</pre>	For yes and "N" 2. ther the certifi 2. ter the certifi 2. ter the certifi 2.	fication date ication date ication date			126.00
 where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 16 this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 127.00 17 this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 17 this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 18 this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 129.00 19 this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2. 130.00 19 this is a Medicare certified pancreas transplant center, 	For yes and "N" enter the certif 2. hter the certifi 2. hter the certifi 2. cer the certific enter the cert	fication date ication date ication date cation date in			126. 00 127. 00 128. 00
 where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 	For yes and "N" enter the certifi 2. hter the certifi 2. ter the certifi cert the certifi enter the certifi of umn 2. er, enter the certific	fication date ication date ication date cation date in tification			126.00 127.00 128.00 129.00

Ith Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE:	Kindred Hospi X IDENTIFICATION DATA	Provider CC	CN: 152018	Peri od:		Worksheet S	-2
					9/01/2015 3/31/2016	Part I Date/Time P 1/18/2017 2	
					1.00	2.00	_
3.00 If this is a Medicare certified ot in column 1 and termination date,	if applicable, in col	umn 2.		2			133.
4.00 If this is an organ procurement or and termination date, if applicabl All Providers		er the OPO number in	column 1				134.
D. 00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1	. If yes, and home o mber. (see instruction	ffice cost	s	Y	189003	140.
<u> </u>	n organization, enter	2.00 on lines 141 throug	h 143 the	name and	3.00 address	of the	
home office and enter the home off 1.00 Name: KINDRED HEALTHCARE OPERATIN		ne: WISCONSIN PHYSICIA		tor's Nu	mber: 0590	1	141.
INC. 2.00 Street: 680 SOUTH FOURTH AVENUE	PO Box:	SERVI CES					142.
3. 00 Ci ty: LOUI SVI LLE	State:	KY	Zip Coc	e:	4020	2	143.
						1.00	
. 00 Are provider based physicians' cos	ts included in Worksh	neet A?				Y	144.
					1.00	2.00	
.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for r lude Medicare utiliza	no in column 1. If co	lumn 1 is		Y		145.
.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	column 1. (See CMS F			f	N		146
						1.00	
7.00Was there a change in the statisti						N	147
7.00Was there a change in the statisti 3.00Was there a change in the order of 9.00Was there a change to the simplifi	allocation? Enter "Y	" for yes or "N" for od? Enter "Y" for yes	no.	or no.		N N N	148 149
3.00 Was there a change in the order of	allocation? Enter "Y	" for yes or "N" for od? Enter "Y" for yes Part A	no. or "N" fo Part B	Ti	itle V	N N Title XIX	148 149
Does this facility contain a provi	allocation? Enter "Y ed cost finding metho der that qualifies fo	" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from	no. or "N" fo Part B 2.00 the applic	cati on of	3.00 the lowe	N N Title XIX 4.00 r of costs	148 149
00 Was there a change in the order of 00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " 00 Hospital	allocation? Enter "Y ed cost finding metho der that qualifies fo	/" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption from pmponent for Part A a N	no. or "N" fc Part B 2.00 the applic nd Part B. N	cati on of	3.00 the lowe CFR §413 N	N N Title XIX 4.00 r of costs .13) N	148 149
.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF	allocation? Enter "Y ed cost finding metho der that qualifies fo	/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a	no. or "N" fo Part B 2.00 the applic ind Part B	cati on of	3.00 the lowe CFR §413	N N Title XIX 4.00 r of costs .13)	148 149
.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER	allocation? Enter "Y ed cost finding metho der that qualifies fo	/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a N N N	no. or "N" fc Part B 2.00 the applic ind Part B N N N	cati on of	3.00 the Iowe CFR §413 N N N	N N Title XIX 4.00 r of costs .13) N N N	148 149 155 156 157 158
.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SNF	allocation? Enter "Y ed cost finding metho der that qualifies fo	/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a N N N N	no. or "N" fc Part B 2.00 the applid nd Part B. N N N	cati on of	3.00 the Iowe CFR §413 N N N N	N N Title XIX 4.00 r of costs .13) N N N	148 149 155 156 157 158 159
.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SUBPROVIDER .00 SUBPROVIDER .00 HOME HEALTH AGENCY	allocation? Enter "Y ed cost finding metho der that qualifies fo	/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a N N N	no. or "N" fc Part B 2.00 the applic ind Part B N N N	cati on of	3.00 the Iowe CFR §413 N N N	N N Title XIX 4.00 r of costs .13) N N N	148 149 155 155 156 157 158 159 160
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.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SNF .00 HOME HEALTH AGENCY .00 CMHC Multicampus .00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	allocation? Enter "Y ed cost finding metho der that qualifies fo N" for no for each co mpus hospital that ha	<pre>/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a N N N N N N N N N N N N N N N N N N N</pre>	no. or "N" fc Part B 2.00 the applithe N N N N N N N N N S N N N S S State Z	cation of (See 42	3.00 The Lowe CFR §413 N N N N N SAs? CBSA	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N TI.00	148 149 155 156 157 158 159 160 161
.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SUBPROVIDER .00 HOME HEALTH AGENCY .00 HOME HEALTH AGENCY .00 CMHC .00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. .00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) .01	allocation? Enter "Y ed cost finding metho der that qualifies fo N" for no for each co mpus hospital that ha	<pre>/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a N N N N N N N N N N N N N N N N N N N</pre>	no. or "N" fc Part B 2.00 the applithe N N N N N N N N N S N N N S S State Z	cation of (See 42	3.00 The Lowe CFR §413 N N N N N SAs? CBSA	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	148 149 155 156 157 158 159 160 161 165 00 166
.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SUBPROVIDER .00 HOME HEALTH AGENCY .00 CMHC Multicampus .00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. .00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) .01 .02	allocation? Enter "Y ed cost finding metho der that qualifies fo N" for no for each co mpus hospital that ha	<pre>/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a N N N N N N N N N N N N N N N N N N N</pre>	no. or "N" fc Part B 2.00 the applithe N N N N N N N N N S N N N S S State Z	cation of (See 42	3.00 The Lowe CFR §413 N N N N N SAs? CBSA	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	148 149 155 156 157 158 159 160 161 165 00 166 00 166
.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SUBPROVIDER .00 HOME HEALTH AGENCY .00 CMHC Multicampus .00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. .00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) .01 .02	allocation? Enter "Y ed cost finding metho der that qualifies fo N" for no for each co mpus hospital that ha	<pre>/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a N N N N N N N N N N N N N N N N N N N</pre>	no. or "N" fc Part B 2.00 the applithe N N N N N N N N N S N N N S S State Z	cation of (See 42	3.00 The Lowe CFR §413 N N N N N SAs? CBSA	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	148 149 155 156 157 158 159 160 161 165 00 166 00 166
.00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SNF .00 HOME HEALTH AGENCY .00 CMHC .00 CMHC .00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) .01 .02 .03 .03	allocation? Enter "Yed cost finding method der that qualifies for N" for no for each co mpus hospital that ha <u>Name</u> 0 0	r" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption from mponent for Part A a N N N N N N N N N N N N N	no. or "N" fc Part B 2.00 the appli d N N N N N N N N N N N N N N N N N Res in diff	Ti Cati on of (See 42 Cerent CB	3.00 The Lowe CFR §413 N N N N N SAs? CBSA	N N N Title XIX 4.00 r of costs 5.13) N N N N N N N N N N N N N N N N N N N	148 149 155 156 157 158 159 160 161 165 00 166 00 166 00 166 00 166
00 Was there a change in the order of 00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " 00 Hospital 00 Subprovider - IPF 00 Subprovider - IRF 00 SUBPROVIDER 00 SUBPROVIDER 00 SNF 00 OOK HEALTH AGENCY 00 CMHC Multicampus 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 01	allocation? Enter "Y ed cost finding metho der that qualifies for N" for no for each co mpus hospital that ha <u>Name</u> 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	<pre>/" for yes or "N" for od? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A a N N N N N N N N N N N N N N N N N N N</pre>	no. or "N" fc Part B 2.00 the appli a N N N N N N N N N N N N N N N N N N N	Ti cati on of (See 42 Cerent CB Cerent CB Cip Code 3.00	3.00 the I owe CFR \$413 N N N SAS? CBSA 4.00	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	148 149 155 156 157 158 159 160 161 165 00 166

Health Financial Systems	Kindred Hospital Nort	thern Indiana	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ENTIFICATION DATA	Provider CCN: 152018	Period:	Worksheet S-2 Part I	2
					epared:
				1/18/2017 2:3	32 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begin period respectively (mm/dd/yyyy)	ning date and ending dat	e for the reporting			170.00
				1.00	
171.00 If line 167 is "Y", does this provider				N	171.00
Medicare cost plans reported on Wkst. (see instructions)	S-3, Pt. I, line 2, col.	6? Enter "Y" for yes ar	nd "N" for no.		

OSPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 152018	Period: From 09/01/2015 To 08/31/2016	1/18/2017 2:	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N fo	r all NO ro	snonses Ente	1.00	2.00	-
	mm/dd/yyyy format.		sponses. Litte		ine	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the be			N		1.00
	reporting period? If yes, enter the date of the change in colu	mn 2. (see				
			Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare Prog	ram2 lf	1.00	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in column $\tilde{3}$ voluntary or "l" for involuntary.	, "V" for				2.00
. 00	Is the provider involved in business transactions, including m contracts, with individuals or entities (e.g., chain home offi or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of t	ces, drug or its he board	Y			3. 0
	of directors through ownership, control, or family and other s	imilar				
	relationships? (see instructions)		Y/N	Туре	Date	-
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Certifi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date availa column 3. (see instructions) If no, see instructions.	Compiled, ble in	Y	A	03/31/2017	4.00
. 00	Are the cost report total expenses and total revenues differen those on the filed financial statements? If yes, submit reconc		N			5.0
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2: If the legal operator of the program?	5	e provider is			6.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see instr Were nursing school and/or allied health programs approved and cost reporting period? If yes, see instructions.		during the	N N		7.00
. 00	Are costs claimed for Interns and Residents in an approved gra	duate medic	al education	N		9.0
0. 00	program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or r	enewed in t	he current	N		10.00
1.00	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		11.0
					Y/N 1.00	
	Bad Debts				1.00	-
2.00	Is the provider seeking reimbursement for bad debts? If yes, s	ee instruct	i ons.		Y	12.0
	If line 12 is yes, did the provider's bad debt collection poli period? If yes, submit copy.			ost reporting	Ν	13.0
4.00	If line 12 is yes, were patient deductibles and/or co-payments	waived? If	yes, see ins	structions.	N	14.0
5.00	Bed Complement Did total beds available change from the prior cost reporting		yes, see inst t A	tructions. Par	N 1	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
6. 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	10/31/2016	Y	10/31/2016	16.0
7. 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	Ν		Ν		17.0
8. 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	Ν		Ν		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.0

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (CCN: 152018	Period: From 09/01/2015 To 08/31/2016	Worksheet S- Part II Date/Time Pr 1/18/2017 2:	epared
		Descri		Y/N	Y/N	_
		0		1.00	3.00	
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.0
		Y/N	Date	Y/N	Date	
00	Was the cost report propagad only using the provider's	1.00 N	2.00	3.00 N	4.00	21. (
. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		IN .		21.0
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS HC	SPI TALS)			_
. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22. (
. 00	Have changes occurred in the Medicare depreciation expense		als made dur	ng the cost		23.
00	reporting period? If yes, see instructions.			0		24
. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	a into during t	nis cost re	borting period?		24.
. 00	Have there been new capitalized leases entered into during instructions.	the cost report	ing period?	lf yes, see		25.
. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reportir	ng period? I	f yes, see		26. (
. 00	Has the provider's capitalization policy changed during the	cost reporting	period?lf	yes, submit		27.
	copy. Interest Expense					
. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	tered into duri	ng the cost	reporting		28.
. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ot Service R	eserve Fund)		29.
. 00	Has existing debt been replaced prior to its scheduled matu	rity with new c	lebt? If yes	see		30.
. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	suance of new c	lebt? If yes	see		31.
. 00	Purchased Services Have changes or new agreements occurred in patient care ser	vi ces furni shec	l through co	ntractual		32.
. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		to competi	tive bidding? If		33.
	Provi der-Based Physi ci ans					
. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physi ci ans?		34.
. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		s with the	provi der-based		35.
				Y/N	Date	
	Home Office Costs			1.00	2.00	_
. 00	Were home office costs claimed on the cost report?			Y		36.
. 00	If line 36 is yes, has a home office cost statement been pr	epared by the h	nome office?	Ŷ		37.
. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			Y	12/31/2016	38.
. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			N		39.
. 00	see instructions. If line 36 is yes, did the provider render services to the	home office? I	f yes, see	N		40.
	instructions.					
	Cast Depart Draparar Captact Information	1.0	00	2.	00	_
00	held by the cost report preparer in columns 1, 2, and 3,	JOY		DAVI S		41.
00	1 5 1 5 1	KINDRED HEALTHC	ARE OPERATI	IG		42.

Heal th	Financial Systems	Kindred Hospital	North	ern Indiar	าล			In Lieu	u of Form CMS	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN:	152018	Peri	od: 09/01/2015	Worksheet S- Part II	2
			_						Date/Time Pr 1/18/2017 2:	
				3.	00					
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the	ti tl e/posi ti on	REIME	BURSEMENT	MANAC	GER				41.00
	held by the cost report preparer in colu	nns 1, 2, and 3,								
	respecti vel y.									
42.00	Enter the employer/company name of the co	ost report								42.00
	preparer.									
43.00	Enter the telephone number and email add	ress of the cost								43.00
	report preparer in columns 1 and 2, resp	ecti vel y.								

HOSPI T	Financial Systems Kind AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 152018	Pe	eri od:	Worksheet S-3	3
							om 09/01/2015	Part I	epared:
								I/P Days / O/P Visits / Trips	·
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available		CAH Hours	Title V	
		1.00		2.00	3.00		4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00		32	11, 7	12	0.00	C	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider								2.00 3.00
4.00	HMO I RF Subprovider							_	4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							C	
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			32	11, 7	12	0.00	C	
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00		0		0	0.00	C	
8.00 9.00	CORONARY CARE UNIT	31.00		0		U	0.00	Ĺ	9.00
10.00	BURN I NTENSI VE CARE UNI T								10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T								11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY								13.00
14.00	Total (see instructions)			32	11, 7	12	0.00	C	14.00
15.00	CAH visits							C	15.00
16.00	SUBPROVIDER - IPF								16.00
17.00	SUBPROVIDER - IRF								17.00
18.00	SUBPROVI DER								18.00
19.00	SKILLED NURSING FACILITY	44.00		0		0		C	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									24.00
24.10	HOSPICE (non-distinct part)	30.00							24.10
25.00	CMHC – CMHC RURAL HEALTH CLINIC								25.00
26.00 26.25	FEDERALLY QUALIFIED HEALTH CENTER								26.0
20.25	Total (sum of lines 14-26)			32					27.0
27.00	Observation Bed Days			32				C	
29.00	Ambul ance Trips							C	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			U		-			32.0
	outpatient days (see instructions)								
33 00	LTCH non-covered days					1			33.00

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.				Period: From 09/01/2015 Fo 08/31/2016		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 275	0			10100	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)	732	265				2.00
3.00	HMO I PF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	(D		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	(D		6.00
7.00	Total Adults and Peds. (exclude observation	5, 275	0	8, 18	7		7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0	(C		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	5, 275	0	8, 18	7 0.00	87.80	14.00
15.00	CAH visits	0	0	(C		15.00
16.00	SUBPROVIDER – I PF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	0	0	(0.00	0.00	
20. 00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	(D		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		-		0.00	87.80	
28.00	Observation Bed Days		0	(D		28.00
9.00	Ambul ance Tri ps	0					29.00
0.00	Employee discount days (see instruction)				D		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			(0		32.01
~ ~ ~	outpatient days (see instructions)	_					00.00
is. UU	LTCH non-covered days	0					33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 152018	Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 Part I Date/Time Prep 1/18/2017 2:32	
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1	95 0	320	1. 00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider				34 10 0		2.00 3.00 4.00
4.00 5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation				0		4.00 5.00 6.00 7.00
8.00 9.00 10.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						8. 00 9. 00 10. 00
11.00 12.00 13.00	SURGI CAL INTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						11.00 12.00 13.00
14. 00 15. 00 16. 00 17. 00 18. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0. 00	0	1'	95 0	320	14. 00 15. 00 16. 00 17. 00 18. 00
19.00 20.00 21.00 22.00 23.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	0. 00					19.00 20.00 21.00 22.00 23.00
24.00 24.10 25.00 26.00 26.25	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER						24.00 24.10 25.00 26.00 26.25
20. 23 27. 00 28. 00 29. 00 30. 00 31. 00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0.00					20. 23 27. 00 28. 00 29. 00 30. 00 31. 00
32. 00 32. 01 33. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days						32.00 32.01 33.00

PI T <i>i</i>	Financial Systems AL WAGE INDEX INFORMATION			Northern Indiar Provider	CCN: 152018 F	Period: From 09/01/2015	eu of Form CMS-2 Worksheet S-3 Part II	
						To 08/31/2016		
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	(col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	Worksheet A-6) 3.00	3)	<u>col. 4</u> 5.00	6.00	
	PART II - WAGE DATA							
	SALARIES Total salaries (see	200.00	5, 881, 403	0	5, 881, 403	3 182, 565. 65	32.22	1.00
	instructions) Non-physician anesthetist Part		C C					
	A		C			0.00	0.00	2.00
0	Non-physician anesthetist Part B		C	0	C	0.00	0.00	3.00
D	Physician-Part A -		C	0	C	0.00	0.00	4.00
1	Administrative Physicians - Part A - Teaching		C	0	(0.00	0.00	4.0
	Physician-Part B		C	0	(0.00		
	Non-physician-Part B	21.00	C	0	(0.00		
	Interns & residents (in an approved program)	21.00	C	0		0.00	0.00	7.0
1	Contracted interns and residents (in an approved programs)		C	0	C	0.00	0.00	7.0
	Home office personnel		C	0	C	0.00		
	SNF	44.00	C	-	122 451	0.00		•
	Excluded area salaries (see instructions)		Ĺ	132, 651	132, 651	1 3, 789. 00	35. 01	10.00
- E	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		(74.400		(74.40)	0 221 02	72.00	
	Care		674, 490	0	674, 490	9, 331. 00	12.28	11.00
	Contract labor: Top level management and other management and administrative		C	0	C	0.00	0.00	12.00
	services Contract Labor: Physician-Part		302, 884	0	202.99	2 091 00	74 09	12 00
	A - Administrative		302, 884		302, 884		70.08	13.00
00	Home office salaries & wage-related costs		655, 429	0	655, 429	9 10, 744. 75	61.00	14.00
00	Home office: Physician Part A		C	0	(0.00	0.00	15.0
00	- Administrative Home office and Contract		C	0		0.00	0.00	16.0
	Physicians Part A - Teaching					0.00	0.00	10.0
	WAGE-RELATED COSTS		744 452		74/ 45/			1 17 0
00	Wage-related costs (core) (see instructions)		746, 453	0	746, 453	3		17.0
	Wage-related costs (other) (see instructions)		C	0	(D		18.0
	Excluded areas Non-physician anesthetist Part		17, 224 C		17, 224			19.0 20.0
	A							
	Non-physician anesthetist Part B		C	0	(21.00
	Physician Part A - Administrative		C	0	(22.0
	Physician Part A - Teaching		C	0	(D		22.0
	Physician Part B		C	0	(D		23.00
	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	0				24.00
	approved program)							
	OVERHEAD COSTS - DIRECT SALARIE		40.015		40.010	- 050 (7	40.51	
	Employee Benefits Department Administrative & General	4.00 5.00	42, 215 1, 082, 066		42, 215 1, 082, 066			•
	Administrative & General under	0.00	7, 405		7, 405			
	contract (see inst.)		_	_				
	Maintenance & Repairs Operation of Plant	6.00 7.00		0		0.00		•
	Laundry & Linen Service	8.00	C	0	(0.00		31.00
00	Housekeeping Housekeeping under contract	9.00	172, 744 C	0	172, 744 (4 13, 669. 00 0 0. 00		32.00 33.00
00	(see instructions) Dietary	10. 00	69, 518	0	69, 518	3 2, 100. 00	33. 10	34.00
00	Dietary under contract (see	10.00	07, 518 C	0	07, 510	0.00		
	i nstructi ons) Cafeteri a	11.00	c	0	· · · · · · · · · · · · · · · · · · ·	0.00	0.00	36.00
	Maintenance of Personnel	12.00	C	0		0.00		36.00
00					E 40.00			
00	Nursing Administration Central Services and Supply	13.00 14.00	543, 025 58, 695		543, 025 58, 695			38.00 39.00

Health Financial Systems	Ki na	dred Hospital	Northern Indiar	na	In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		eriod:	Worksheet S-3	
					rom 09/01/2015		
					o 08/31/2016	Date/Time Pre 1/18/2017 2:3	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical Records Library	16.00	242, 920	0	242, 920	7, 547. 00	32. 19	41.00
42.00 Social Service	17.00	268, 367	-132, 651	135, 716	3, 877. 00	35.01	42.00
43.00 Other General Service	18.00	C	0	C	0.00	0.00	43.00

Heal th	Financial Systems	Ki na	dred Hospital	Northern Indiar	a	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 09/01/2015 Fo 08/31/2016		pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		5, 888, 808	0	5, 888, 80	3 182, 729. 65	32.23	1.00
	instructions)							
2.00	Excluded area salaries (see		0	132, 651	132, 65	1 3, 789. 00	35. 01	2.00
	instructions)							
3.00	Subtotal salaries (line 1		5, 888, 808	-132, 651	5, 756, 15	7 178, 940. 65	32.17	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 632, 803	0	1, 632, 80	3 24, 056. 75	67.87	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		746, 453	0	746, 45	3 0.00	12.97	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		8, 268, 064	-132, 651	8, 135, 41	3 202, 997. 40	40. 08	6.00
7.00	Total overhead cost (see		2, 906, 500	-132, 651	2, 773, 84	76, 093. 46	36.45	7.00
	instructions)							
				•				•

	Financial Systems Kindred Hospital Nort AL WAGE RELATED COSTS	hern Indiana Provider CCN:	152018	Peri od:	u of Form CMS-2 Worksheet S-3	
00111			102010	From 09/01/2015	Part IV	
				To 08/31/2016		pare
					1/18/2017 2:3	2 pr
					Amount	
					Reported	
					1.00	
	PART I V - WAGE RELATED COSTS					-
	Part A - Core List					-
	RETIREMENT COST					
00	401K Employer Contributions				0	1
00	Tax Sheltered Annuity (TSA) Employer Contribution				0	2
00	Nonqualified Defined Benefit Plan Cost (see instructions)				0	3
00	Qualified Defined Benefit Plan Cost (see instructions)				0	4
~ ~	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)					
00	401K/TSA Plan Administration fees				0	5
00	Legal /Accounting/Management Fees-Pension Plan				0	6
00	Employee Managed Care Program Administration Fees				0	7
	HEALTH AND INSURANCE COST					
00	Health Insurance (Purchased or Self Funded)				282, 132	
00	Prescription Drug Plan				0	
. 00	Dental, Hearing and Vision Plan				-2, 727	
	Life Insurance (If employee is owner or beneficiary)				3, 819	
	Accident Insurance (If employee is owner or beneficiary)				0	
. 00	Disability Insurance (If employee is owner or beneficiary)				17, 580	
	Long-Term Care Insurance (If employee is owner or beneficiary)				0	
. 00	'Workers' Compensation Insurance				28, 384	
. 00	Retirement Health Care Cost (Only current year, not the extrao	rdi nary accrual	requi re	d by FASB 106.	0	16
	Non cumulative portion)					
	TAXES					
	FICA-Employers Portion Only				399, 993	
	Medicare Taxes - Employers Portion Only				0	
	Unemployment Insurance				0	
	State or Federal Unemployment Taxes				9, 825	20
	OTHER					
. 00	Executive Deferred Compensation (Other Than Retirement Cost Re	ported on lines	1 throu	gh 4 above. (see	0	21
	instructions))					
	Day Care Cost and Allowances				0	
	Tuition Reimbursement				7, 446	
. 00	Total Wage Related cost (Sum of lines 1 -23)				746, 452	24
	Part B - Other than Core Related Cost					

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 152018	Peri od:	Worksheet A	
					From 09/01/2015 To 08/31/2016		
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
. 00	00100 CAP REL COSTS-BLDG & FIXT		1, 025, 202	1, 025, 20	02 8, 401	1, 033, 603	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		355, 116	355, 1			2.00
8.00	00300 OTHER CAP REL COSTS		25, 666				
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT	42, 215	811, 763			853, 978	
. 00	00500 ADMI NI STRATI VE & GENERAL	1, 082, 066	1, 233, 061			2, 315, 127	
. 00	00700 OPERATION OF PLANT	0	227, 432			227, 432	
8.00	00800 LAUNDRY & LINEN SERVICE	0	113, 331			113, 331	
9.00	00900 HOUSEKEEPI NG	172, 744	44, 078			216, 822	
0.00	01000 DI ETARY	69, 518	264, 994			334, 512	
1.00	01100 CAFETERIA	0 E 42 02E	0		0 0	0 540-241	
3.00 4.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	543, 025 58, 695	6, 236 10, 356			549, 261	
4.00 5.00	01500 PHARMACY	419, 545	37, 026			69, 051 456, 571	
6.00	01600 MEDICAL RECORDS & LIBRARY	242, 920	7, 774			250, 694	
	01700 SOCIAL SERVICE	268, 367	21, 891			146, 786	
7.00	INPATIENT ROUTINE SERVICE COST CENTERS	200, 307	21,071	270,2	143,472	140,700	17.0
0.00	03000 ADULTS & PEDI ATRI CS	2, 367, 241	972, 733	3, 339, 9	74 184	3, 340, 158	30.0
1.00	03100 I NTENSI VE CARE UNI T	0	184		-184	0	
4.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.0
	ANCILLARY SERVICE COST CENTERS			•			1
50.00	05000 OPERATI NG ROOM	83, 666	441, 513	525, 1	79 - 102, 923	422, 256	50.0
64.00	05400 RADI OLOGY-DI AGNOSTI C	156, 313	42, 475	198, 7	88 0	198, 788	54.0
0.00	06000 LABORATORY	0	381, 821	381, 83	21 0	381, 821	60.0
5.00	06500 RESPI RATORY THERAPY	375, 088	8, 554			383, 642	
6.00	06600 PHYSI CAL THERAPY	0	646, 372			646, 372	
57.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
8.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
1.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	368, 501				
3.00	07300 DRUGS CHARGED TO PATIENTS	0	664, 814			664, 814	
4.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	U	289, 768	289, 70	0	289, 768	74.0
90.00	09000 CLINIC	0	0		0 0	0	90.0
	09100 EMERGENCY	0	0		0 0		
	OTHER REIMBURSABLE COST CENTERS				<u> </u>		1
5.00	09500 AMBULANCE SERVICES	0	0		0 0	0	95. C
8.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98. C
	SPECIAL PURPOSE COST CENTERS						
18.00		5, 881, 403	8, 000, 661	13, 882, 0	64 -143, 472	13, 738, 592	118.0
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 0
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192. C
	07950 NONALLOWABLE CLINICAL LIAISON	0	0		0 143, 472	143, 472	
94.01	07951 I DLE SPACE	0	0		0 0	0	194. C
	07952 REGIONAL OFFICE	0	0		0 0	0	194. C
	07953 DI STRI CT OFFI CE	0	0		0 0		194.0
	07954 NON MCR CERTIFIED UNIT	0	0		0 0		194.0
	07955 REG NURSG OFFICE	0	0		0 0		194.0
	07956 CONTACT CENTER 07957 CENTRALIZED ADMISSIONS DEPT	0	0		0 0		194. 0 194. 0
	07959 OTHER NONREIMBURSABLE - OPEN		0		0 0		194. C
74. UÖ	07959 UTHER NUNRETMBURSABLE - OPEN 07958 VISITOR MEALS		0		0 0		194.0
0/ 00	UT 750 VISITOR WEALS		0				
	07962 OTHER NONRELMBURSARIE COST CENTERS		∩		() ()	n	119/1
94.10	07962 OTHER NONREIMBURSABLE COST CENTERS 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		0 0		194. 1 194. 1

RECLASS	Financial Systems Kin IFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES		CCN: 152018	Peri od: From 09/01/2015 To 08/31/2016	Worksheet A Date/Time P 1/18/2017 2	repared:
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00	-			
G	ENERAL SERVICE COST CENTERS	0.00	1.00	1			
	00100 CAP REL COSTS-BLDG & FIXT	51, 456	1, 085, 059				1.00
	0200 CAP REL COSTS-MVBLE EQUIP	-157,011					2.00
	0300 OTHER CAP REL COSTS	0		1			3.00
. 00 0	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 931	852, 047				4.00
	00500 ADMI NI STRATI VE & GENERAL	251, 199					5.00
.00 0	00700 OPERATION OF PLANT	-1, 247	226, 185				7.00
3.00 C	00800 LAUNDRY & LINEN SERVICE	0	113, 331				8.00
. 00 0	00900 HOUSEKEEPI NG	0	216, 822				9.00
0.00 0	1000 DI ETARY	3, 960	338, 472				10.00
1.00 0	01100 CAFETERI A	0	0				11.00
3.00 0	1300 NURSI NG ADMI NI STRATI ON	0	549, 261				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	69, 051				14.00
	1500 PHARMACY	-66, 143	390, 428				15.00
6.00 0	1600 MEDICAL RECORDS & LIBRARY	-311	250, 383				16.00
	1700 SOCIAL SERVICE	0	146, 786	1			17.00
	NPATIENT ROUTINE SERVICE COST CENTERS		1	1			
	03000 ADULTS & PEDIATRICS	-576, 323		1			30.00
	03100 INTENSIVE CARE UNIT	0		•			31.00
	04400 SKILLED NURSING FACILITY	0	0				44.00
	NCI LLARY SERVICE COST CENTERS	-		1			_
	5000 OPERATING ROOM	0	422, 256	1			50.00
	05400 RADI OLOGY-DI AGNOSTI C	0					54.00
	6000 LABORATORY	0	381, 821				60.00
	06500 RESPI RATORY THERAPY	2,060		1			65.00
	06600 PHYSI CAL THERAPY	-49, 682		1			66.00
	06700 OCCUPATI ONAL THERAPY		0				67.00
	06800 SPEECH PATHOLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	471, 424				68.00 71.00
	7300 DRUGS CHARGED TO PATIENTS	0	664, 814	1			73.00
	7400 RENAL DIALYSIS	165		1			74.00
	UTPATIENT SERVICE COST CENTERS	105	207, 733				/4.00
	99000 CLINIC	0	0				90.00
	09100 EMERGENCY			1			91.00
	THER REIMBURSABLE COST CENTERS			1			
	09500 AMBULANCE SERVICES	0	0				95.00
	9850 OTHER REIMBURSABLE COST CENTERS	0					98.00
	PECIAL PURPOSE COST CENTERS						
18.00	SUBTOTALS (SUM OF LINES 1-117)	-543, 808	13, 194, 784				118.00
	IONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
92.001	9200 PHYSICIANS' PRIVATE OFFICES	0	0				192.00
	7950 NONALLOWABLE CLINICAL LIAISON	0	143, 472				194.00
94.010	07951 I DLE SPACE	0		1			194. 0 ⁴
	7952 REGIONAL OFFICE	0	0				194. 02
94.030	07953 DI STRI CT OFFI CE	0	0				194. 0
	07954 NON MCR CERTIFIED UNIT	0	0				194.04
94. 05 C	7955 REG NURSG OFFICE	0	0				194. 0
94.060	7956 CONTACT CENTER	0	0				194.0
94. 07 C	7957 CENTRALIZED ADMISSIONS DEPT	0	0				194. 0
94.080	7959 OTHER NONREIMBURSABLE - OPEN	0	0				194. 08
94.090	7958 VISITOR MEALS	0	0				194. 09
94.100	7962 OTHER NONREIMBURSABLE COST CENTERS	0	0				194.10
	7961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0				194.1
00.00	TOTAL (SUM OF LINES 118-199)	-543, 808	13, 338, 256	1			200. 0

Heal th	Financial Systems	Ki n	dred Hospital	Northern India	ina	In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provi der	CCN: 152018	Period: From 09/01/2015	Worksheet A-	6
						To 08/31/2016	Date/Time Pr 1/18/2017 2:	epared: 32 pm
		Increases		_				
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A - RECLASS NON ALLOWABLE CAS	E MANAGER						
1.00	NONALLOWABLE CLINICAL	194.00	132, 651	10, 821				1.00
	LI AI SON							
	TOTALS		132, 651	10, 821				
	C - RECLASS I CU EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	0	184				1.00
	TOTALS		0	184				
	F - RECLASS MED SUPPLIES BOOK	CED TO OR						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	102, 923				1.00
	PATI ENTS							
	TOTALS		0	102, 923				
500.00	Grand Total: Increases		132, 651	113, 928				500.00

Heal th	Financial Systems	Kir	ndred Hospital	Northern India	na	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 152018	Period:	Worksheet A-	6
						From 09/01/2015 To 08/31/2016	Date/Time Pr 1/18/2017 2:	epared: 32 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - RECLASS NON ALLOWABLE CAS	SE MANAGER						
1.00	SOCI AL SERVI CE	17.00	132, 651	10, 821		0		1.00
	TOTALS	+	132, 651	10, 821				
	C - RECLASS I CU EXPENSE							
1.00	INTENSIVE CARE UNIT	31.00	0	184		0		1.00
	TOTALS		0	184				
	F - RECLASS MED SUPPLIES BOOI	KED TO OR						1
1.00	OPERATING ROOM	50.00	C	102, 923		0		1.00
	TOTALS			102, 923		7		
500.00	Grand Total: Decreases		132, 651	113, 928				500.00

Heal th	Financial Systems Kin	dred Hospital N	lorthern Indiar	na	In Lie	eu of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 152018	Period: From 09/01/2015 To 08/31/2016		pared:
				Acqui si ti ons	5		
		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	BALANCES					
1.00	Land	0	0		0 0	0 0	1.00
2.00	Land Improvements	126, 200	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	685, 539	121, 810		0 121, 810	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	1, 892, 601	25, 924		0 25, 924	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2, 704, 340	147, 734		0 147, 734	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	2, 704, 340	147, 734		0 147, 734	0	10.00
		Ending Balance	Fully				
		Ũ	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	126, 200	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	807, 349	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	1, 918, 525	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	2, 852, 074	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	2, 852, 074	0				10.00

Heal th	Financial Systems Kir	ndred Hospital I	Northern Indiar	าล	In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 152018	Period: From 09/01/2015 To 08/31/2016		pared:
			SL	JMMARY OF CAP	PITAL	1/10/2017 2.3.	2 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 WOR						
1.00	CAP REL COSTS-BLDG & FIXT	134, 205	890, 997		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	217, 155	137, 961		0 0	0	2.00
3.00	Total (sum of lines 1-2)	351, 360	1, 028, 958		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 025, 202				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	355, 116				2.00
3.00	Total (sum of lines 1-2)	0	1, 380, 318				3.00

2.00 CAP REL COSTS-MVBLE EQUIP 1,918,525 0 1,918,525 0.672677 1,858 2.00 3.00 Total (sum of lines 1-2) 2,852,074 0 2,852,074 1.000000 2,762 3.00 Cost Center Description Taxes Other Capital -Relate Costs through 7) 10.00 10.00 6.00 7.00 8.00 9.00 10.00 0 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00	Heal th	Financial Systems Kin	dred Hospital I	Northern Indiar	าล	In Lie	u of Form CMS-2	2552-10		
Cost Center Description Gross Assets Capitalized Leases Gross Assets for Ratio (col. 1 - col. 2) Ratio (see instructions) Insurance 1.00 2.00 3.00 4.00 5.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 933,549 0 933,549 0.327323 904 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 1,918,525 0 1,918,525 0.672677 1.868 2.00 3.00 Total (sum of lines 1-2) 2,852,074 0 2,852,074 0.200,2,762 3.00 Cost Center Description Taxes Other Capital - Rel ate d Costs Total (sum of col s. 5 Depreciation Lease 1.00 CAP REL COSTS-MUBLE EQUIP 15,407 0 8.00 9.00 10.00 0 Cap REL COSTS-MUBLE EQUIP 15,407 0 8.00 9.00 10.00 0 CAP REL COSTS-MUBLE EQUIP 15,407 0 1.00 2.01 2.00 0 CAP REL COSTS-BLOG & FIXT 7,497 0 8.401 186,628 890,977 1.00 1.00 CAP REL COSTS-MUBLE EQUIP 15,407 0	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	rom 09/01/2015	Part III Date/Time Prep			
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 CAP REL COSTS-BLDG & FIXT 933, 549 0 933, 549 0.327323 904 1.00 2.00 CAP REL COSTS-BLDG & FIXT 933, 549 0 933, 549 0.327323 904 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 1, 918, 525 0 1, 918, 525 0.672677 1, 858 2.00 3.00 Total (sum of lines 1-2) 2, 852, 074 0 2, 852, 074 1.000000 2, 762 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL 50 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.05 1.00 1.00 2.05 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00			COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 CAP REL COSTS-BLDG & FIXT 933,549 0 933,549 0.327323 904 1.00 2.00 CAP REL COSTS-BUGE & FIXT 933,549 0 933,549 0.327323 904 1.00 3.00 CAP REL COSTS-BUGE & FIXT 933,549 0 2,852,074 0 2,852,074 1.918,525 0.672677 1.858 2.00 3.00 Total (sum of lines 1-2) 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 2,852,074 0 0 0 0 0 0 0 0 0 0 0		Cost Center Description	Gross Assets		for Ratio (col. 1 - col.		Insurance			
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 933, 549 0 933, 549 0.327323 904 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 1, 918, 525 0 1, 918, 525 0.672677 1, 858 2.00 3.00 Total (sum of lines 1-2) 2, 852, 074 0 2, 852, 074 1.000000 2, 762 3.00 ALLOCATION OF OTHER CAPITAL Cost Center Description Taxes Other Total (sum of cols, 5 through 7) 0 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 15,407 0 22,904 0 25,666 246,772 1,028,958 3.00 SUMMARY OF CAPITAL Summary of colspan="4">Cost Center Description Interest Insurance (see Taxes (see Other Total (2)			1.00	2 00		4.00	5.00			
2.00 CAP REL COSTS-MVBLE EQUIP 1,918,525 0 1,918,525 0.672677 1,858 2.00 3.00 Total (sum of lines 1-2) 2,852,074 0 2,852,074 0 2,852,074 0.672677 1,858 2.00 ALLOCATION OF OTHER CAPI TAL Cost Center Description Taxes 0 ther Capi tal -Rel ate d Costs Total (sum of cols. 5 Depreciation Lease PART 111 - RECONCILIATION OF CAPI TAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 15,407 0 17,265 60,144 137,961 2.00 SUMMARY OF CAPI TAL Cost Center Description Interest Insurance (see instructions) Taxes (see capi tal -Rel ate d Costs (see Other of cols. 9 Total (2) (sum of cols. 9 SUMMARY OF CAPI TAL		PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	5.00	4.00	5.00			
3.00 Total (sum of lines 1-2) 2,852,074 0 2,852,074 1.000000 2,762 3.00 ALLOCATION OF OTHER CAPITAL Cost Center Description Taxes 0 ther Capital -Relate d Costs Total (sum of Lines 1-2) Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 15,407 0 17,265 60,144 137,961 2.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see Other Total (2) (sum of cols. 9 Cost Center Description	1.00	CAP REL COSTS-BLDG & FIXT	933, 549	0	933, 549	0. 327323	904	1.00		
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Lease Cost Center Description Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS I.00 CAP REL COSTS-BLDG & FIXT 7,497 O 8,401 186,628 890,997 1.00 CAP REL COSTS-BLDG & FIXT 7,497 O 8,401 186,628 890,997 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 15,407 O 1,028,958 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Taxes (see Other Total (2) (sum Cost Center Description Interest Instructions) Capital -Relate Other Total (2) (sum Other Total (2) (sum <th <="" colspan="2" td=""><td>2.00</td><td></td><td>1, 918, 525</td><td>0</td><td>1, 918, 525</td><td>0. 672677</td><td>1, 858</td><td>2.00</td></th>	<td>2.00</td> <td></td> <td>1, 918, 525</td> <td>0</td> <td>1, 918, 525</td> <td>0. 672677</td> <td>1, 858</td> <td>2.00</td>		2.00		1, 918, 525	0	1, 918, 525	0. 672677	1, 858	2.00
Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 PART PARL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 2.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 CAP REL COSTS-MVBLE EQUIP 15,407 0 17,265 60,144 137,961 2.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital -Relate d Costs (see Total (2) (sum of col s. 9 through 14)	3.00	Total (sum of lines 1-2)						3.00		
Capital-Relate d Costs cols. 5 through 7) cols. 5 through 7) PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 15,407 0 17,265 60,144 137,961 2.00 3.00 Total (sum of lines 1-2) 22,904 0 25,666 246,772 1,028,958 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital-Relate d Costs (see Total (2) (sum of cols. 9 through 14)			ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL			
Image: Part III - RECONCILIATION OF CAPITAL COSTS CENTERS Image: Cost Center Description Image: Cost Center Descripti		Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease			
6.00 7.00 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 15,407 0 17,265 60,144 137,961 2.00 3.00 Total (sum of lines 1-2) 22,904 0 25,666 246,772 1,028,958 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other of cols. 9 instructions) instructions) Capital -Relate of cols. 9 of cols. 9 through 14)										
1.00 CAP REL COSTS-BLDG & FIXT 7,497 0 8,401 186,628 890,997 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 15,407 0 17,265 60,144 137,961 2.00 3.00 Total (sum of lines 1-2) 22,904 0 25,666 246,772 1,028,958 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other of cols.9 Total (2) (sum of cols.9) Interest Instructions) Instructions) Capital -Relate of cols.9 0 <			6.00	7.00		9.00	10.00			
2.00 CAP REL COSTS-MVBLE EQUIP 15,407 0 17,265 60,144 137,961 2.00 3.00 Total (sum of lines 1-2) 22,904 0 25,666 246,772 1,028,958 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see other of cols. 9 Instructions) Instructions)					1					
3.00 Total (sum of lines 1-2) 22,904 0 25,666 246,772 1,028,958 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum of col s. 9 d Costs (see through 14)								1.00		
SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see of the instructions) Total (2) (sum of cols. 9) Interest Instructions Instructions Instructions Capital -Relate of cols. 9) Interest Instructions Instructions Instructions Instructions								2.00		
Cost Center DescriptionInterestInsurance (see instructions)Taxes (see instructions)OtherTotal (2) (sum of cols. 9 d Costs (seed Costs (seethrough 14)	3.00	Total (sum of lines 1-2)	22, 904				1, 028, 958	3.00		
instructions) instructions) Capital-Relate of cols. 9 d Costs (see through 14)				SL	JMMARY OF CAPII	AL				
d Costs (see through 14)		Cost Center Description	Interest							
				instructions)	instructions)					
							through 14)			
11.00 12.00 13.00 14.00 15.00			11.00	12.00	13.00	(15.00			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS		PART III - RECONCILIATION OF CAPITAL COSTS CE								
1.00 CAP REL COSTS-BLDG & FIXT 0 -63 7, 497 0 1, 085, 059 1.00	1.00	CAP REL COSTS-BLDG & FIXT	0	-63	7, 497	0	1, 085, 059	1.00		
	2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 858	15, 407	0		2.00		
3.00 Total (sum of lines 1-2) 0 1,795 22,904 0 1,300,429 3.00	3.00	Total (sum of lines 1-2)	0	1, 795	22, 904	0	1, 300, 429	3.00		

th Financial Systems	Kindred Hospital Northern Indiana

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1 1 1		eu	UI.		0

	Financial Systems	Ki na	dred Hospital I	Northern Indiana		eu of Form CMS-2	2552-10
ADJUST	IENTS TO EXPENSES			Provider CCN: 152018	Period: From 09/01/2015 To 08/31/2016		
				Expense Classification o To/From Which the Amount is			2 pm
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00		3.00
	(chapter 2) Trade, quantity, and time	В		ADMI NI STRATI VE & GENERAL	5.00		4.00
	discounts (chapter 8)	D					
	Refunds and rebates of expenses (chapter 8)		0		0.00		5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
	Telephone services (pay stations excluded) (chapter 21)	A	-3, 287	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
	Television and radio service (chapter 21)	А	-1, 247	OPERATION OF PLANT	7.00	0	8.00
10.00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -636, 282		0.00	0 0	9. 00 10. 00
	Sale of scrap, waste, etc.		0		0.00	0	11.00
	(chapter 23) Related organization transactions (chapter 10)	A-8-1	499, 018			0	12.00
13.00	Laundry and linen service		0		0.00		13.00
	Cafeteria-employees and guests Rental of quarters to employee		0 0		0.00		14.00 15.00
16. 00	and others Sale of medical and surgical		0		0.00	0	16.00
17.00	supplies to other than patients Sale of drugs to other than		0		0.00	0	17.00
	patients Sale of medical records and	В	-311	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
	abstracts Nursing school (tuition, fees,	b	0		0.00		19.00
	books, etc.)						
21.00	Vending machines Income from imposition of interest, finance or penalty		0 0		0. 00 0. 00		20. 00 21. 00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments	A-8-3	0		45.00		23.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-0-3	0	RESPI RATORY THERAPY	65.00		23.00
	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 00 30. 00
	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest		0		0.00	0	33.00
	MI SCELLANEOUS I NCOME	В	-	ADMI NI STRATI VE & GENERAL	5.00		

Health Financial Systems	Kindred Hospital Northern Indiana	In Lieu of Form CMS-2552

ADJUSTMENTS	Τ0	EXPENSES

	Financial Systems TMENTS TO EXPENSES	Kind	ired Hospital Nor	Provi der CCN: 152018	Period:	u of Form CMS-2 Worksheet A-8	
ADJUST	MENTS TO EXPENSES			Provider CCN: 152018	From 09/01/2015 To 08/31/2016		pared:
				Expense Classification c /From Which the Amount is			
			–				
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33.02		1.00	2.00	3.00	4.00		33.02
33.03			0		0.00		
33.04			0		0.00		
33.05	OCCUPATIONAL INCENTIVE INCOME	A	-26, 106 ADN	MINISTRATIVE & GENERAL	5.00		
33.06 33.07			0		0.00		
33.08	MEDICARE BAD DEBT - PART A	А	-120.030 ADA	MINISTRATIVE & GENERAL	5.00		
33.09			0		0.00		
33. 10	OTHER MEDICARE NON ALLOWABLE	A		MINISTRATIVE & GENERAL	5.00		
33. 11	OTHER OPERATING - PATIENT	A	-4, 594 ADN	MINISTRATIVE & GENERAL	5.00	0	33. 11
33. 12	RELATIONS OTHER OPERATING - PUBLIC	А	-30 10	MINISTRATIVE & GENERAL	5.00	0	33. 12
JJ. 12	RELATI ONS	~	-37/00	IN STRATIVE & GENERAL	5.00	0	55.12
33. 13	OTHER OPERATING - MARKETING	A	-51, 510 ADN	MINISTRATIVE & GENERAL	5.00	0	33. 13
33.14			0		0.00		
33.15			0		0.00		
33.16 33.17			0		0.00		
33.18			0		0.00		
33.19			0		0.00		
33. 20	OTHER OPERATING - TRADE SHOW	A	-38 ADN	MINISTRATIVE & GENERAL	5.00	0	33.20
33. 21	BOOTH		o		0.00	0	33. 21
33. 22			0		0.00		
33. 23			0		0.00		
33. 24			0		0.00		
33.25			0		0.00		
33.26 33.27			0		0.00		
33. 28	AGGREGATE CAPITAL EROSION	A	-9, 538 ADN	MINISTRATIVE & GENERAL	5.00		
33. 29			0		0.00		
33.30			0		0.00		
33.31 33.32			0		0.00	0 0	
33.32	EMP BEN - ADMISSION BONUS	А	-2. 247 ADI	MENISTRATI VE & GENERAL	5.00		
33.34	MALPRACTICE TAIL LIABILITY	A		MINISTRATIVE & GENERAL	5.00		
33.35			0		0.00		
33.36	PHYSICIAN BILLING COLLECTION				0.00		
33.31	FEES	A	-45, 48 TADN	MINISTRATIVE & GENERAL	5.00	0	33.37
33. 38			0		0.00	0	33. 38
33. 39			0		0.00		
33.40			0		0.00		
33. 41 33. 42					0.00		
33.42	DISTRICT OFFICE SALES AND	А	-22, 541 ADM	MENISTRATI VE & GENERAL	5.00		
	MARKETING						
33. 44	DISTRICT OFC SALES AND MKT BENEFITS	A	-1, 931 EMF	PLOYEE BENEFITS DEPARTMEN	IT 4.00	0	33. 44
33. 45	BUSINESS INTERRUPTIONS INS	А	-967 CAF	P REL COSTS-BLDG & FIXT	1.00	12	33. 45
34.00	PREMIUM MEDICARE VS BOOK BLDG	А	-60 287040	P REL COSTS-BLDG & FIXT	1.00	9	34.00
34.00	MEDICARE VS BOOK BLDG MEDICARE VS BOOK MOV EQUIP	A		P REL COSTS-BLDG & FIXT P REL COSTS-MVBLE EQUIP	2.00		
34. 02			0		0.00		
	ASSET ADD-ON BLDG	A		P REL COSTS-BLDG & FIXT	1.00	9	
34.04	ASSET ADD-ON MOV EQUIP	A	14, 601 CAF	P REL COSTS-MVBLE EQUIP	2.00	9	34.04

-1, 111 ADMI NI STRATI VE & GENERAL

0

0

0

14, 601 CAP REL COSTS-MVBLE EQUIP

2.00 0.00

0.00 0.00 0.00

5.00

0.00 0.00

0.00

0.00

0.00 0.00

0.00

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9 0

0

0 34.07

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0 34.10

0 34.12

34.05

34.06

34.11

34. 13 34. 14

34.15

34.16

34.17

NON ALLOWABLE LOBBYING FEES

А

34.05

34.06

34.07

34.08

34.09

34.10 34.11

34.12

34. 13 34. 14

34.15 34.16

34.17

ADJUST	IENTS TO EXPENSES			Provider CCN: 152018	Peri od:	Worksheet A-8	}
					From 09/01/2015 To 08/31/2016	Date/Time Pre 1/18/2017 2:3	epared: 2 pm
				Expense Classification	on Worksheet A		
				To/From Which the Amount	is to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34. 18			C		0.00		
34.19			C		0.00		
34.20			C		0.00		
34. 21			C)	0.00	0	
34.22			C		0.00		
34.23			C		0.00	0	1 0 11 20
34.24			C)	0.00	0	
34.25			C		0.00	0	
34.26			C		0.00	0	
34.27			C		0.00	0	
34.28			C		0.00	0	
35.00					0.00	0	
35. 01 35. 02					0.00 0.00		
35.02					0.00		
35.03					0.00	-	
	PHYSICIAN FEE ADJUSTMENT	А	3 960	DI ETARY	10.00		
35.06	THISTOTAN TEL ADSOSTMENT	~	3, 700		0.00	-	
35.07			0		0.00		
	PHYSICIAN FEE ADJUSTMENT	А	-66 143	PHARMACY	15.00		
35.09			00,110		0.00		
35.10			C		0.00		
	PHYSICIAN FEE ADJUSTMENT	A	56, 884	ADULTS & PEDIATRICS	30.00	0	
35.12			Ċ		0.00	0	35.12
35.13			C		0.00	0	35.13
35.14			C		0.00	0	35.14
35.15			C	D	0.00	0	35.15
35.16			C		0.00	0	35.16
35. 17	PHYSICIAN FEE ADJUSTMENT	A	4,950	RESPI RATORY THERAPY	65.00	0	35.17
35. 18			C		0.00	0	
35.19			C		0.00	0	
35.20			C		0.00	0	
	PHYSICIAN FEE ADJUSTMENT	A	350	RENAL DIALYSIS	74.00	0	
35. 22			C		0.00	0	
35.23			C		0.00		
35.24			C	D	0.00		
35.25			C		0.00	0	35.25

50.00

35.24 35.25 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, -543, 808 50.00 column 6, line 200.)

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

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems Kindred Hospital Northern Indiana In Lieu of Form CMS							
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 152018	Period: From 09/01/2015	Worksheet A-8	-1	
OFFICE	COSTS			To 08/31/2016		pared: 2 pm	
	Line No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost			
					Wks. A, column		
					5		
	1.00	2.00	3.00	4.00	5.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED						
	HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	1, 024, 109	475, 409	1.00	
2.00	0.00			0	0	2.00	
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	26, 379	26, 379	3.00	
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	89, 470	89, 470	4.00	
4.01	66.00	PHYSI CAL THERAPY	Therapy Servi ces	596, 428	646, 110	4.01	
5.00	0		0	1, 736, 386	1, 237, 368	5.00	

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

	Related Organization(s) and/or Home Office									
	Symbol (1)	Namo	Democratere of	Nama	Dependenters of					
	Symbol (1)	Name	Percentage of	Name	Percentage of					
			Ownership		Ownership					
	1.00	2.00	3.00	4.00	5.00					
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:										

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

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

6.00	В	КНОІ	100. 00 Admi r	n & Gen	100. 00	6.00
7.00	В	КНОІ	100. 00 Corne	erstone	100.00	7.00
8.00	В	КНОІ	100. 00 Corne	erstone	100.00	8.00
9.00	В	КНОІ	100. 00 Rehat	bCare	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Health Financial Systems	Kindred Hospital North	hern Indiana	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RE OFFICE COSTS	ELATED ORGANIZATIONS AND HOME	Provider CCN: 152018	Period: From 09/01/2015 To 08/31/2016	Worksheet A-8-1 Date/Time Prepared:
			10 06/31/2010	1 (10 (2017 2 22 are

					1/18/2017 2:	32 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	548, 700	0				1.00
2.00	0	0				2.00
3.00	0	0				3.00
4.00	0	0				4.00
4.01	-49, 682	0				4.01
5.00	499, 018					5.00

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

nus not	been posted to norkaneet A,	cordinas r and/or 2, the amount arrowable should be marcated in cordinary or 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	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

rerinbu									
6.00	HomeOffice Cost	6.00							
7.00	Worker Comp Ins	7.00							
8.00	Liability Insur	8.00							
9.00	Therapy Svcs	9.00							
10.00		10.00							
100.00		100.00							

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Heal th	Financial Sy	stems		Ki	ndred Hospital	Northern	l ndi a	na	In Li	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYS	ICIA	I ADJU	STMENT		Pr	ovi der	CCN: 152018	Period: From 09/01/2015 To 08/31/2016		
	Wkst. A Line	#	Cost	Center/Physician Identifier	Total Remuneration	Professi Compon		Provider Component		1/18/2017 2:3 Physician/Prov ider Component	32 pm
										Hours	
	1.00			2.00	3.00	4.00		5.00	6.00	7.00	
1.00		00 DR			234, 710		0	234, 71			1.00
2.00		00 DR			51, 400		51, 400		0 171, 400		
3.00		00 DR	. C		350		0	35			
4.00	0.		_		0		0		0 0	-	4.00
5.00		00 DR			3, 245		0	3, 24			5.00
6.00		00 DR			12, 021		12, 021		0 171, 400		6.00
7.00		00 DR			131, 863		31, 863		0 171, 400		7.00
8.00		00 DR			413, 556		13, 556		0 171, 400		8.00
9.00		00 DR	. I		4, 950	1	0	4, 95			9.00
10.00	0.				0		0		0 0	-	10.00
12.00	30.	00 DR	. L		22, 028		22, 028		0 171, 400		
200.00					874, 123		30, 868			3, 649	
	Wkst. A Line	#	Cost	Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	
				ldenti fier	Limit			Memberships 8		of Malpractice	
						Limi	t	Conti nui ng	Share of col.	Insurance	
	1.00			2.00	8,00	9.00	0	Education	12	14.00	
1 00	1.00	00 DR	٨	2.00	297, 560	-	0 14, 878	12.00	13.00 0 0	14.00 0	1.00
1.00 2.00		00 DR			297, 560	1					
2.00		00 DR			165		0 8			-	
3.00 4.00	0.				0		0 0			°	4.00
4.00 5.00		00 DR	F		906		45			-	
6.00		00 DR			908	1	40 0			-	6.00
7.00		00 DR			0		0			°,	7.00
8.00		OODR			0		0			-	
9.00		00 DR			2,060		103			0	9,00
9.00 10.00		0000			2,080		0			°	9.00 10.00
12.00		00 DR			0		0			°	
200.00	30.	UUUR	. L		300, 691		0 15, 034			-	
200.00	Wkst. A Line	. #	Cost	Center/Physician	Provi der	Adjuste		RCE	Adjustment	0	200.00
	WKSL. A LINE	π	0031	Identifier	Component	Limi		Di sal I owance	Aujustilient		
				ruenti i ei	Share of col.		L	DI Sal I Owalice			
					14						
	1.00			2.00	15.00	16.0	0	17.00	18.00		
1.00		00 DR	. A		0		97, 560		0 0		1.00
2.00		00 DR			0		0		51,400		2.00
3.00		00 DR			0		165	18			3.00
4.00	0.				0		0		0 0		4.00
5.00	30.	00 DR	. E		0		906	2, 33	2, 339		5.00
6.00		00 DR			0		0		0 12,021		6.00
7.00		00 DR			0		0		0 131, 863		7.00
8.00		00 DR			0		0		0 413, 556		8.00
9.00	65.	00 DR	. 1		0		2,060	2, 89			9.00
10.00	0.	00			0		0		o o		10.00
12.00	30.	00 DR	. L		0		0		22, 028		12.00
200.00					0	30	00, 691	5, 41			200.00
											-

COST AL	Financial Systems Kir LOCATION - GENERAL SERVICE COSTS	ndred Hospital N		CCN: 152018 P F	eriod: rom 09/01/2015 o 08/31/2016	u of Form CMS-2 Worksheet B Part I Date/Time Pre 1/18/2017 2:3	pared:
			CAPI TAL REL	ATED COSTS			T
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS				1		
	00100 CAP REL COSTS-BLDG & FIXT	1, 085, 059	1, 085, 059				1.00
	00200 CAP REL COSTS-MVBLE EQUIP	215, 370	0.040	215, 370			2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	852,047	9, 848				4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	2, 566, 326	189, 740			2, 953, 808	
	00800 LAUNDRY & LINEN SERVICE	226, 185	276, 403 9, 697	54, 862 1, 925		557,450	
	00900 HOUSEKEEPING	113, 331 216, 822	9, 697 4, 697	932		124, 953 248, 007	
	01000 DI ETARY	338, 472	7, 727	1, 534		358, 017	
	01100 CAFETERIA	550,472	1, 121	1, 534		358,017	1
	01300 NURSI NG ADMI NI STRATI ON	549, 261	0	0	80, 335	629, 596	
	01400 CENTRAL SERVICES & SUPPLY	69,051	10, 454	2,075		90, 263	
	01500 PHARMACY	390, 428	72, 724			539, 654	
	01600 MEDICAL RECORDS & LIBRARY	250, 383	24, 292	4, 822		315, 435	
	01700 SOCIAL SERVICE	146, 786	7, 424	1, 474		175, 762	
-	INPATIENT ROUTINE SERVICE COST CENTERS		., .=.	.,			
30.00	03000 ADULTS & PEDIATRICS	2, 763, 835	408, 065	80, 995	350, 210	3, 603, 105	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	422, 256	0	0		434, 634	
	05400 RADI OLOGY-DI AGNOSTI C	198, 788	0	0	23, 125	221, 913	
	06000 LABORATORY	381, 821	0	0	0	381, 821	1
	06500 RESPI RATORY THERAPY	385, 702	0	0	55, 491	441, 193	
	06600 PHYSI CAL THERAPY	596, 690	25, 454	5, 052		627, 196	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	471, 424	0	0	0		1
	07300 DRUGS CHARGED TO PATIENTS	664, 814	0		0	471, 424 664, 814	
	07400 RENAL DIALYSIS	289, 933	38, 534	0	-	336, 115	
	OUTPATIENT SERVICE COST CENTERS	207, 733	50, 554	7,040	<u> </u>	330, 113	/4.00
	09000 CLINIC	0	0	0	0	0	90.00
	09100 EMERGENCY	0	0			0	
	OTHER REIMBURSABLE COST CENTERS				-1		
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
1	SPECIAL PURPOSE COST CENTERS	1					
118.00	SUBTOTALS (SUM OF LINES 1-117)	13, 194, 784	1, 085, 059	215, 370	844, 226	13, 175, 160	118.00
	NONREI MBURSABLE COST CENTERS		_	-	-1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	142 472	0	0	-		192.00
	07950 NONALLOWABLE CLINICAL LIAISON	143, 472	0	0	19, 624	163, 096	
	07951 I DLE SPACE	0	0	0	0		194.01
	07952 REGIONAL OFFICE 07953 DISTRICT OFFICE	0	0		0		194. 02 194. 03
	07953 DISTRICT OFFICE 07954 NON MCR CERTIFIED UNIT	0	0		0		194.03
	07955 REG NURSG OFFICE		0				194.04
	07956 CONTACT CENTER		0	0 0	0		194.05
	07957 CENTRALIZED ADMISSIONS DEPT		0	n 0	0		194.00
	07959 OTHER NONREI MBURSABLE - OPEN	0	0	0 0	0		194.07
	07958 VI SI TOR MEALS	0	0	0	0		194.00
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194.11
194.11		J J	Ű	j j	Ŭ		
200.00	Cross Foot Adjustments					0	200.00
	Cross Foot Adjustments Negative Cost Centers		0	0	0		

Health Financial Systems Kir	ndred Hospital M	Northern Indian	าล	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 09/01/2015	Worksheet B Part I	
			Ť			
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2. 00 00200 CAP REL COSTS-BEDG & TTXT						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	2, 953, 808					5.00
7.00 00700 OPERATION OF PLANT	158, 564					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	35, 542	11, 399	171, 894			8.00
9. 00 00900 HOUSEKEEPI NG	70, 544	5, 522	0	324, 073		9.00
10. 00 01000 DI ETARY	101, 836			4, 211	473, 148	1
11. 00 01100 CAFETERIA	0	0	0	0	0	
13.00 01300 NURSING ADMINISTRATION	179, 085		0	0	0	
14. 00 01400 CENTRAL SERVICES & SUPPLY	25, 675			5, 697	0	
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	153, 502			39, 632	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	89, 724 49, 995				0	
INPATIENT ROUTINE SERVICE COST CENTERS	47, 773	0,720	<u> </u>	4, 040	0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 024, 890	479, 717	171, 894	222, 379	400, 634	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0			0	1
44.00 04400 SKILLED NURSING FACILITY	0				0	1
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	123, 629	C	0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	63, 122	C	0	0	0	1
60. 00 06000 LABORATORY	108, 607	C	0	0	0	
65. 00 06500 RESPI RATORY THERAPY	125, 495		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	178, 403	29, 923	0	13, 871	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68. 00 06800 SPEECH PATHOLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	134, 094		0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	189, 103		0	0	0	1
74. 00 07400 RENAL DIALYSIS	95, 606			-	0	
OUTPATIENT SERVICE COST CENTERS	70,000	10,000	<u> </u>	20,777		/ 1. 00
90. 00 09000 CLINIC	0	C	0	0	0	90.00
91.00 09100 EMERGENCY	0				0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0				0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 907, 416	716, 014	171, 894	324, 073	400, 634	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190.00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0		0	0		190.00
194. 00 07950 NONALLOWABLE CLINICAL LIAISON	46, 392		0	0		194.00
194. 01 07951 I DLE SPACE	40, 372		0	0		194.00
194. 02 07952 REGI ONAL OFFI CE	0	C C	0	0		194. 02
194. 03 07953 DI STRI CT OFFI CE	0	C	0	0		194.03
194.04 07954 NON MCR CERTIFIED UNIT	0	C	0	0	0	194.04
194.0507955 REG NURSG OFFICE	0	C	0	0	0	194.05
194.0607956CONTACT CENTER	0	0	0	0		194.06
194. 07 07957 CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194.07
194. 08 07959 OTHER NONREI MBURSABLE - OPEN	0	0	0	0		194.08
194. 09 07958 VI SI TOR MEALS	0	0	0	0		194.09
194. 10 07962 OTHER NONREI MBURSABLE COST CENTERS	0		0	0		194.10
194. 1107961NONREIMB NEW BUSINESS IMPLEMENTATION200. 00Cross Foot Adjustments	0	0	0	0	0	194.11
200.00Cross Foot Adjustments201.00Negative Cost Centers		_	0	_	0	200. 00 201. 00
201.00 TOTAL (sum lines 118-201)	2, 953, 808	716, 014	171, 894	324, 073	473, 148	
	2,700,000	1 , 10, 014	1 171,074	527,075	775, 140	1-02.00

. 00 (. 00 (. 00 (Cost Center Description						
. 00 (. 00 (. 00 (Cost Center Description				To 08/31/2016	Date/Time Pre 1/18/2017 2:3	epare
. 00 (. 00 (. 00 (CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
. 00 (. 00 (. 00 (11.00	13.00	14.00	15.00	16.00	
. 00	GENERAL SERVICE COST CENTERS	1	-				
. 00 0	DO100 CAP REL COSTS-BLDG & FIXT						1.
	20200 CAP REL COSTS-MVBLE EQUIP						2.
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.
	DOBOO LAUNDRY & LINEN SERVICE						8.
	DO900 HOUSEKEEPING						9.
	D1000 DI ETARY						10.
	D1100 CAFETERIA	(o				11.
	01300 NURSI NG ADMI NI STRATI ON	(808, 681				13.
1	01400 CENTRAL SERVICES & SUPPLY	(0 0	133, 92	25		14.
5.00	D1500 PHARMACY	(o o	6	72 818, 954		15.
6.00	D1600 MEDICAL RECORDS & LIBRARY	(0 0		0 0	446, 954	4 16.
	D1700 SOCIAL SERVICE	(0 0		0 0	C) 17.
-	NPATIENT ROUTINE SERVICE COST CENTERS	1	I	1	T		
	D3000 ADULTS & PEDIATRICS		0 788, 957	1, 72		216, 851	
	03100 I NTENSI VE CARE UNI T		0 0		0 0	C	
-	04400 SKILLED NURSING FACILITY	(00		0 0	C) 44.
-	ANCI LLARY SERVICE COST CENTERS	1	40.704			0.404	1 50
	D5000 OPERATING ROOM		0 19, 724		19 0	3, 494	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY				0 0	14, 567	
	26500 RESPIRATORY THERAPY			1-	70 0	42, 315 59, 913	
	D6600 PHYSI CAL THERAPY				16 0	23, 947	
	06700 OCCUPATI ONAL THERAPY				0 0	23, 747	
	D6800 SPEECH PATHOLOGY				0 0	C	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0 0	130, 9 [.]	19 0	17, 299	
	07300 DRUGS CHARGED TO PATIENTS	(o o		0 818, 954	57, 688	
4.00	07400 RENAL DIALYSIS	(o o		9 0	10, 880	74.
C	DUTPATIENT SERVICE COST CENTERS						
	29000 CLI NI C		0 0		0 0	C	90.
	09100 EMERGENCY	(0 0		0 0	C	91.
	OTHER REIMBURSABLE COST CENTERS	T	1	1	T		4
1	09500 AMBULANCE SERVICES		0 0		0 0	C	
	09850 OTHER REIMBURSABLE COST CENTERS	(0 0		0 0	C	98.
	SPECIAL PURPOSE COST CENTERS		0 808, 681	133, 92	010 054	114 OF A	1110
18.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS		0 808, 681	133, 9.	25 818, 954	446, 954	1118.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(0 0		0 0	C	0 190.
	19200 PHYSI CLANS' PRI VATE OFFICES				0 0) 192.
	07950 NONALLOWABLE CLINICAL LIAISON				0 0		194.
	07951 I DLE SPACE		0 0		0 0		194.
	07952 REGIONAL OFFICE		o o		0 0		194.
74. O3 (D7953 DI STRI CT OFFI CE	(o o		0 0	C	194.
94.04	07954 NON MCR CERTIFIED UNIT	(0 0		0 0	C	194.
	D7955 REG NURSG OFFICE	(0 0		0 0		194.
	D7956 CONTACT CENTER	(0 0		0 0		194.
	07957 CENTRALIZED ADMISSIONS DEPT	(0 ס		0 0) 194.
	07959 OTHER NONREI MBURSABLE - OPEN	(0 0		0 0		194.
	07958 VISITOR MEALS	(0		0 0) 194.
	07962 OTHER NONREI MBURSABLE COST CENTERS	(0		0 0) 194.
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	(0 0		U 0	C	194.
00.00	Cross Foot Adjustments					-	200.
01.00 02.00	Negative Cost Centers TOTAL (sum lines 118-201)		0 0 0 808, 681	133, 92	0 0 25 818, 954	C 446, 954	201.

ST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 152018	Peri od:	Worksheet B
				From 09/01/2015 To 08/31/2016	Part I Date/Time Prepar 1/18/2017 2:32 p
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		1710/2017 2.32
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS			-		
00 00100 CAP REL COSTS-BLDG & FIXT					
00 00200 CAP REL COSTS-MVBLE EQUIP					
00400 EMPLOYEE BENEFITS DEPARTMENT					
00500 ADMINISTRATIVE & GENERAL					
00700 OPERATION OF PLANT					
00800 LAUNDRY & LINEN SERVICE					
00 00900 HOUSEKEEPI NG					
. 00 01000 DI ETARY					1
. 00 01100 CAFETERI A					1
. 00 01300 NURSING ADMINISTRATION					1
. 00 01400 CENTRAL SERVICES & SUPPLY					1
. 00 01500 PHARMACY					1
. 00 01600 MEDI CAL RECORDS & LI BRARY					1
. 00 01700 SOCIAL SERVICE	238, 531				1
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS	238, 531	7, 148, 678	3	0 7, 148, 678	3
. 00 03100 INTENSIVE CARE UNIT	0	C	D	0 0	3
. 00 04400 SKILLED NURSING FACILITY	0	C	D	0 0	4
ANCI LLARY SERVICE COST CENTERS					
. OO 05000 OPERATING ROOM	0	581, 600		0 581, 600	5
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	299, 602	2	0 299, 602	5
. 00 06000 LABORATORY	0	532, 743	3	0 532, 743	6
. 00 06500 RESPI RATORY THERAPY	0	627, 071		0 627, 071	6
. 00 06600 PHYSI CAL THERAPY	0	873, 356	b l	0 873, 356	6
. 00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	6
00 06800 SPEECH PATHOLOGY	0	C	D	0 0	6
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	753, 736	b l	0 753, 736	7
. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 730, 559		0 1, 730, 559	7
. 00 07400 RENAL DIALYSIS	0	508, 909	9	0 508, 909	7
OUTPATIENT SERVICE COST CENTERS			1		
. 00 09000 CLINIC	0	C		0 0	9
00 09100 EMERGENCY	0	0	ו	0 0	9
OTHER REIMBURSABLE COST CENTERS	0		1		
00 09500 AMBULANCE SERVICES 00 09850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0 0 0	9
SPECIAL PURPOSE COST CENTERS	U	(<u>/</u>	0 0	7
B. 00 SUBTOTALS (SUM OF LINES 1-117)	238, 531	13, 056, 254	1	0 13, 056, 254	11
NONREI MBURSABLE COST CENTERS	200,001	10,000,20	·1	10,000,201	
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0	19
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0	19.
4.00 07950 NONALLOWABLE CLINICAL LIAISON	0	209, 488	3	0 209, 488	19
4. 01 07951 I DLE SPACE	0	C		0 0	19
4. 02 07952 REGIONAL OFFICE	0	(b	0 0	19
4. 03 07953 DI STRI CT OFFI CE	0	(b	0 0	19
4. 04 07954 NON MCR CERTIFIED UNIT	0	(b	0 0	19
4. 05 07955 REG NURSG OFFICE	0	(b	0 0	19
4. 06 07956 CONTACT CENTER	0	(b	0 0	19
4. 07 07957 CENTRALIZED ADMISSIONS DEPT	0	(b	0 0	19
4. 08 07959 OTHER NONREI MBURSABLE - OPEN	0	ſ		0 0	19
4. 09 07958 VI SI TOR MEALS	0	72, 514	1	0 72, 514	19
4. 10 07962 OTHER NONREL MBURSABLE COST CENTERS	0	, 2, 314		0 ,2, 0, 14	19
4. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	ſ		0 0	19
0.00 Cross Foot Adjustments	0	C C	5		20
1.00 Negative Cost Centers	0	C C			20
	238, 531	13, 338, 256	[0 13, 338, 256	20
2.00 TOTAL (sum lines 118-201)					1.711

Heal th	Financial Systems Kir	ndred Hospital M	Northern Indiar	na	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS			F	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part II Date/Time Pre 1/18/2017 2:3	
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00200 CAP REL COSTS-BLDG & FIXT						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	9, 848	1, 955	11, 803	11, 803	
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	93, 113	189, 740	37, 661		2, 187	5.00
7.00	00700 OPERATION OF PLANT	0	276, 403	54, 862		2, 107	
8.00	00800 LAUNDRY & LINEN SERVICE	0	9, 697	1, 925		0	
9.00	00900 HOUSEKEEPING	0	4, 697	932		349	9.00
10.00	01000 DI ETARY	0	7, 727	1, 534		140	
11.00	01100 CAFETERIA	0	0	(0	0	11.00
	01300 NURSING ADMINISTRATION	0	0		0	1,097	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	10, 454	2, 075	12, 529	119	1
	01500 PHARMACY	0	72, 724	14, 435		848	
	01600 MEDICAL RECORDS & LIBRARY	0	24, 292	4, 822		491	
	01700 SOCIAL SERVICE	0	7, 424	1, 474		274	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	408, 065	80, 995	489, 060	4, 787	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	C	0 0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0	0	(0 0	0	44.00
	ANCILLARY SERVICE COST CENTERS	1	1		-		
50.00	05000 OPERATI NG ROOM	0	0	C	0 0	169	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0 0	316	
	06000 LABORATORY	0	0	(0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0	758	
66.00	06600 PHYSI CAL THERAPY	0	25, 454	5, 052	30, 506	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	67.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
	07400 RENAL DIALYSIS	0	38, 534	7, 648	46, 182	0	
74.00	OUTPATIENT SERVICE COST CENTERS	0	30, 334	7,040	40,102	0	74.00
90.00	09000 CLINIC	0	0	(0	0	90.00
	09100 EMERGENCY	0	0			0	
	OTHER REIMBURSABLE COST CENTERS	-			-	-	
95.00	09500 AMBULANCE SERVICES	0	0	(0 0	0	95.00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0 0	0	98.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	93, 113	1, 085, 059	215, 370	1, 393, 542	11, 535	118.00
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0 0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0 0		192.00
	07950 NONALLOWABLE CLINICAL LIAISON	0	0	C	0 0		194.00
	07951 I DLE SPACE	0	0	C	0 0		194.01
	07952 REGIONAL OFFICE	0	0	C	0		194.02
	07953 DI STRI CT OFFI CE	0	0	C	0		194.03
	07954 NON MCR CERTIFIED UNIT	0	0	0	0		194.04
	07955 REG NURSG OFFICE	0	0		0		194.05
	07956 CONTACT CENTER	0	0		0		194.06
	07957 CENTRALIZED ADMISSIONS DEPT	0	0		0		194.07
	07959 OTHER NONREI MBURSABLE - OPEN	0	0		0		194.08
	07958 VISITOR MEALS	0	0				194.09
	07962 OTHER NONREIMBURSABLE COST CENTERS 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0				194. 10 194. 11
200.00		0	0			0	200.00
200.00			_	, , , , , , , , , , , , , , , , , , ,		0	200.00
201.00		93, 113	1, 085, 059	215, 370	1, 393, 542		201.00
202.00		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	., 000, 007	210,070	., 0, 0, 0, 2	11,000	

ALLOCA	Financial Systems Ki TION OF CAPITAL RELATED COSTS Ki	ndred Hospital I		CCN: 152018 P	eri od:	u of Form CMS-2 Worksheet B	
				F	rom 09/01/2015 o 08/31/2016	Part II Date/Time Prep 1/18/2017 2:32	pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		1	1	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.00	00500 ADMINI STRATI VE & GENERAL	322, 701					5.0
7.00	00700 OPERATION OF PLANT	17, 323					7.0
3.00	00800 LAUNDRY & LINEN SERVICE	3, 883					8.0
9.00	00900 HOUSEKEEPI NG	7,707					9.0
10.00	01000 DI ETARY	11, 125			213	25, 161	10.0
1.00	01100 CAFETERI A	0	-	0	0	0	11.0
13.00	01300 NURSING ADMINISTRATION	19, 565		0	0	0	13.0
4.00	01400 CENTRAL SERVICES & SUPPLY	2, 805		0	288	0	14.0
5.00	01500 PHARMACY	16, 770			2,002	0	15.0
6.00	01600 MEDICAL RECORDS & LIBRARY	9, 802				0	16.0
7.00	01700 SOCI AL SERVI CE	5, 462	4, 249	0	204	0	17.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-			I		
30.00	03000 ADULTS & PEDIATRICS	111, 970				21, 305	30.0
31.00	03100 INTENSIVE CARE UNIT	0				0	31.0
14.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.0
	ANCI LLARY SERVI CE COST CENTERS	- i		1			
50.00	05000 OPERATING ROOM	13, 506				0	50.0
64.00	05400 RADI OLOGY-DI AGNOSTI C	6, 896		0	0	0	54.0
0.00	06000 LABORATORY	11, 865		0	0	0	60.0
5.00	06500 RESPI RATORY THERAPY	13, 710		0	0	0	65.0
56.00	06600 PHYSI CAL THERAPY	19, 490	14, 568	0	701	0	66.0
57.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.0
58.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 650		0	0	0	71.0
73.00	07300 DRUGS CHARGED TO PATIENTS	20, 659		0		0	73.0
74.00	07400 RENAL DI ALYSI S	10, 445	22, 054	0	1, 061	0	74.0
	OUTPATIENT SERVICE COST CENTERS				I		
90.00	09000 CLINIC	0				0	90.0
91.00	09100 EMERGENCY	0	0	0	0	0	91.0
	OTHER REIMBURSABLE COST CENTERS	-	-	-	-		
95.00	09500 AMBULANCE SERVICES	0				0	95.0
8.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.0
	SPECIAL PURPOSE COST CENTERS	017 (00	0.10.500	01.055	4 (070	01.005	
18.00		317, 633	348, 588	21, 055	16, 373	21, 305	118.0
~~ ~	NONREI MBURSABLE COST CENTERS						100 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-	0			190.0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	-	0	0		192.0
	07950 NONALLOWABLE CLINICAL LIAISON	5, 068	-	0	0		194.0
	07951 I DLE SPACE	0	0	0	0		194. C
	07952 REGIONAL OFFICE	0	0	0	0		194. C
	07953 DI STRI CT OFFI CE	0	-	0	0		194. C
94.04	07954 NON MCR CERTIFIED UNIT	0		0	0		194. C
	07955 REG NURSG OFFICE	0		0	0		194.0
	07956 CONTACT CENTER	0		0	0		194.0
	07957 CENTRALIZED ADMISSIONS DEPT	0		0	0		194. C
	07959 OTHER NONREI MBURSABLE - OPEN	0		0	0		194.0
94.09	07958 VISITOR MEALS	0		0	0	3, 856	
01 11	07962 OTHER NONREIMBURSABLE COST CENTERS	0		0	0		194.1
							194.1
94. 1 <i>°</i>	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0		0	9		
194.11 200.00	Cross Foot Adjustments	0		0	0		200. 0
	Cross Foot Adjustments Negative Cost Centers	0 322, 701	-	0 21, 055	0 0 16, 373		200. C 201. C

LLOC	ATION OF CAPITAL RELATED COSTS		Provi der	CCN: 152018	Peri od:	Worksheet B	
					From 09/01/2015 To 08/31/2016	Part II Date/Time Pre	epare
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON		PHARMACY	1/18/2017 2:3 MEDI CAL RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	+
	GENERAL SERVICE COST CENTERS		1				
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
. 00	00500 ADMINI STRATI VE & GENERAL						5.
. 00	00700 OPERATION OF PLANT						7.
. 00	00800 LAUNDRY & LINEN SERVICE						8.
. 00	00900 HOUSEKEEPI NG						9.
0.00	01000 DI ETARY						10.
1.00							11.
3.00	01300 NURSI NG ADMI NI STRATI ON		20, 662	1			13.
4.00	01400 CENTRAL SERVICES & SUPPLY						14.
5.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY				09 148, 510	53, 979	15
6.00 7.00	01700 SOCIAL SERVICE				0 0	53, 979	
7.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				<u> </u>	0	1 17
0. 00	03000 ADULTS & PEDIATRICS		20, 158	2	79 0	26, 188	3 30
1.00	03100 I NTENSI VE CARE UNI T	1			0 0	20, 100	
4.00	04400 SKI LLED NURSI NG FACI LI TY				0 0	C	
Ŧ. 00	ANCI LLARY SERVICE COST CENTERS		0 0	1	<u> </u>	0	
0. 00	05000 OPERATING ROOM		0 504		19 0	422	2 50
4.00	05400 RADI OLOGY-DI AGNOSTI C				0 0	1, 759	
0. 00	06000 LABORATORY				0 0	5, 111	
5. 00	06500 RESPI RATORY THERAPY		ol c	-	76 0	7, 236	
6.00	06600 PHYSI CAL THERAPY		ol c)	3 0	2, 892	
7.00	06700 OCCUPATI ONAL THERAPY		o c)	0 0	0	67
8.00	06800 SPEECH PATHOLOGY		ol c)	0 0	C	68
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		ol c	21, 23	37 0	2, 089	71
3. 00	07300 DRUGS CHARGED TO PATIENTS		o c		0 148, 510	6, 968	3 73
4.00	07400 RENAL DIALYSIS	(o c		1 0	1, 314	1 74
	OUTPATIENT SERVICE COST CENTERS						
0. 00	09000 CLI NI C		0 C		0 0	0	90
1.00			0 C		0 0	0	91
	OTHER REIMBURSABLE COST CENTERS		+				
5.00	09500 AMBULANCE SERVI CES		D C		0 0	C	
3. 00			0 C		0 0	0	98
	SPECIAL PURPOSE COST CENTERS	1					
8.00			0 20, 662	21, 72	148, 510	53, 979	1118
	NONREI MBURSABLE COST CENTERS	1			0 0		100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0 0) 190) 192
	07950 NONALLOWABLE CLINICAL LIAISON				0 0) 192
	107951 I DLE SPACE				0 0		194
	207952 REGI ONAL OFFI CE				0 0		194
	307953 DI STRI CT OFFI CE						194
	407954 NON MCR CERTIFIED UNIT				0 0		194
	507955 REG NURSG OFFICE				0 0		194
	507956 CONTACT CENTER				0 0		194
	7 07957 CENTRALIZED ADMISSIONS DEPT				0 0		194
	307959 OTHER NONRELMBURSABLE - OPEN				0 0		194
	07958 VISITOR MEALS				0 0		194
	07962 OTHER NONRELMBURSABLE COST CENTERS				0 0		194
	1 07961 NONREI MB NEW BUSI NESS I MPLEMENTATI ON				0 0		194
00.00						0	200
00.00 01.00			ol c		0 0	C.	201
	TOTAL (sum lines 118-201)	1	- I	21, 72	148, 510	53, 979	

Health Financial Systems Kir	ndred Hospital No	orthern Indiar	าล	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 09/01/2015 To 08/31/2016	Worksheet B Part II Date/Time Prepared: 1/18/2017 2:32 pm
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS	1 1			1 1	
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P					2.00
4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5. 00 00500 ADMINI STRATI VE & GENERAL					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT					5.00
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 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	10.007				16.00
17. 00 01700 SOCIAL SERVICE	19, 087				17.00
30. 00 03000 ADULTS & PEDI ATRI CS	10.007	050 (72	1		
31. 00 03100 INTENSIVE CARE UNIT	19, 087 0	958, 673 0		0 958, 673 0 0	30.00 31.00
44. 00 04400 SKI LLED NURSING FACILITY	0	0		0 0	44.00
ANCI LLARY SERVICE COST CENTERS		0	1		
50. 00 05000 OPERATING ROOM	0	14, 620		0 14, 620	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	8, 971		0 8, 971	54.00
60. 00 06000 LABORATORY	0	16, 976		0 16, 976	60.00
65. 00 06500 RESPI RATORY THERAPY	0	21, 780		0 21, 780	65.00
66. 00 06600 PHYSI CAL THERAPY	0	68, 160		0 68, 160	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0 0 37.976	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	37, 976 176, 137		0 37, 976 0 176, 137	71.00 73.00
74. 00 07400 RENAL DIALYSIS	0	81, 057		0 81,057	73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	01,007	<u> </u>	01,007	, 1. 00
90. 00 09000 CLINIC	0	0		0 0	90.00
91.00 09100 EMERGENCY	0	0		0 0	91.00
OTHER REIMBURSABLE COST CENTERS			1		
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	95.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0	98.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	19, 087	1, 384, 350	1	0 1 204 250	118.00
NONREI MBURSABLE COST CENTERS	19,007	1, 364, 350		0 1, 384, 350	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES	0	0		0 0	192.00
194.00 07950 NONALLOWABLE CLINICAL LIAISON	0	5, 336		0 5, 336	194.00
194. 01 07951 I DLE SPACE	0	0		0 0	194.01
194. 02 07952 REGI ONAL OFFI CE	0	0		0 0	194. 02
194. 03 07953 DI STRI CT OFFI CE	0	0		0 0	194.03
194.04 07954 NON MCR CERTIFIED UNIT	0	0		0 0	194.04
194. 05 07955 REG NURSG OFFICE	0	0		0	194.05
194. 06 07956 CONTACT_CENTER 194. 07 07957 CENTRALIZED_ADMISSIONS_DEPT	0	0			194.06 194.07
194. 08 07959 OTHER NONREI MBURSABLE - OPEN	0	0			194.07
194. 09 07958 VI SI TOR MEALS	0	3, 856		0 3,856	194.09
194. 10 07962 OTHER NONREL MBURSABLE COST CENTERS	0	0		0 0	194.10
194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		0 0	194. 11
200.00 Cross Foot Adjustments		0		o o	200.00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118-201)	19, 087	1, 393, 542	I	0 1, 393, 542	202.00

	Financial Systems Kin LLOCATION - STATISTICAL BASIS	dred Hospital I		CCN: 152018 P	eri od:	worksheet B-1	
				F	rom 09/01/2015 o 08/31/2016	Date/Time Pre	pare
			ATED COSTS			1/18/2017 2:3	2 pm
		CAFTIAL KEL	LATED COSTS				
	Cost Center Description	BLDG & FI XT	MVBLE EQUI P		Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET #1)	(SQUARE FEET #2)	BENEFI TS DEPARTMENT		& GENERAL (ACCUM. COST)	
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	"2)	(GROSS			
		1.00	2.00	SALARI ES) 4. 00	5A	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	JA	5.00	
00	00100 CAP REL COSTS-BLDG & FIXT	21, 485					1 1
1	00200 CAP REL COSTS-MVBLE EQUIP	105	21, 485	5 000 400			2
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	195 3, 757	195 3, 757	5, 839, 188 1, 082, 066		10, 384, 448	4
	00700 OPERATION OF PLANT	5, 473	5, 473	1, 002, 000	-2, 755, 600		
	00800 LAUNDRY & LINEN SERVICE	192	192	0	0		
	00900 HOUSEKEEPI NG	93	93	172, 744			
	01000 DI ETARY 01100 CAFETERI A	153	153 0	69, 518 0	0	358, 017 0	
	01300 NURSI NG ADMI NI STRATI ON	0	0	543, 025	0	-	
	01400 CENTRAL SERVICES & SUPPLY	207	207	58, 695	0	90, 263	
	01500 PHARMACY	1, 440	1, 440	419, 545			
	01600 MEDI CAL RECORDS & LI BRARY	481	481	242, 920			
7.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	147	147	135, 716	0	175, 762	17
0. 00	03000 ADULTS & PEDI ATRI CS	8, 080	8, 080	2, 367, 241	0	3, 603, 105	30
	03100 I NTENSI VE CARE UNI T	0	0	0	0		
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44
	ANCI LLARY SERVI CE COST CENTERS	0	0	83, 666	0	434, 634	50
	05400 RADI OLOGY-DI AGNOSTI C	0	0	156, 313			
	06000 LABORATORY	0	0	0	0		
	06500 RESPI RATORY THERAPY	0	0	375, 088	0	441, 193	65
	06600 PHYSI CAL THERAPY	504	504	0	0	627, 196	
		0	0	0	0	0	
	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0		
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	-		
	07400 RENAL DI ALYSI S	763	763	0	0	336, 115	74
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09100 EMERGENCY	0	0	0			
	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	7
	09500 AMBULANCE SERVICES	0	0	0	0	0	95
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98
t t	SPECIAL PURPOSE COST CENTERS	04.405	04 405	F 70/ F07	0.050.000	40.004.050	1
18.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	21, 485	21, 485	5, 706, 537	-2, 953, 808	10, 221, 352	1118
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192
	07950 NONALLOWABLE CLINICAL LIAISON	0	0	132, 651	0	163, 096	
	07951 I DLE SPACE 07952 REGIONAL OFFICE	0	0	0	0		194 194
	07953 DI STRI CT OFFI CE		0	0	0		194
	07954 NON MCR CERTIFIED UNIT	0	0	0	0		194
	07955 REG NURSG OFFICE	0	0	0	0		194
	07956 CONTACT CENTER	0	0	0	0		194
	07957 CENTRALIZED ADMISSIONS DEPT 07959 OTHER NONREIMBURSABLE – OPEN	0	0	0	0		194 194
	07959 VISITOR MEALS		0	0	0		194
	07962 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194
4.11	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194
0.00	Cross Foot Adjustments						200
01.00	Negative Cost Centers	1 005 050	04E 070				201
02.00	Cost to be allocated (per Wkst. B, Part I)	1, 085, 059	215, 370	863, 850		2, 953, 808	202
03. 00	Unit cost multiplier (Wkst. B, Part I)	50. 503095	10. 024203	0. 147940		0. 284445	203
04.00	Cost to be allocated (per Wkst. B,			11, 803		322, 701	
	Part II)			0.0000		0 0000	0.0-
05.00	Unit cost multiplier (Wkst. B, Part	1	1	0. 002021	1	0.031075	1205

OST AL	Financial Systems Kin LOCATION - STATISTICAL BASIS	·	Provi der	F	eriod: rom 09/01/2015 o 08/31/2016	Worksheet B-1 Date/Time Pre	
						1/18/2017 2:3	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPI NG (SQUARE FEET #4)	DI ETARY (MEALS SERVED)	CAFETERI A (CAFETERI A FTES)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	1	1		1 1		
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1
	00200 CAP REL COSTS-MUBLE EQUIP						4
-	00500 ADMINI STRATI VE & GENERAL						5
	00700 OPERATION OF PLANT	12,060					7
0	00800 LAUNDRY & LINEN SERVICE	192	8, 187				8
	00900 HOUSEKEEPI NG	93		11, 775			9
	01000 DI ETARY	153		153			10
	01100 CAFETERI A	0	-	0	0	70	
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	7	
	01400 CENTRAL SERVICES & SUPPLY	207	0	207		2	
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 440		1, 440 481		5	
	01700 SOCIAL SERVICE	147		147		4	
- H	INPATIENT ROUTINE SERVICE COST CENTERS						1
- H	03000 ADULTS & PEDIATRICS	8, 080	8, 187	8, 080	18, 199	40	30
	03100 INTENSIVE CARE UNIT	0		0		C	31
00	04400 SKILLED NURSING FACILITY	0	0	0	0	C	44
	ANCI LLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	-	0		1	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	-	1	-
	06000 LABORATORY	0	0	0		0	
	06500 RESPI RATORY THERAPY	0	0	0		6	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	504	0	504	0	0	
	06800 SPEECH PATHOLOGY				0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	C	
	07400 RENAL DI ALYSI S	763	0	763	0	C	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0		0		C	90
	09100 EMERGENCY	0	0	0	0	C	91
	OTHER REIMBURSABLE COST CENTERS	1					1
	09500 AMBULANCE SERVICES	0		0		0	
	09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	0	0	0	0	C	98
3. 00	SUBTOTALS (SUM OF LINES 1-117)	12,060	8, 187	11, 775	18, 199	70	118
	NONREIMBURSABLE COST CENTERS	12,000	0,107	11,775	10, 199	70	1110
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		0			192
	07950 NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0	194
. 01	07951 I DLE SPACE	0	0	0	0	C	194
	07952 REGIONAL OFFICE	0	0	0	0		194
	07953 DI STRI CT OFFI CE	0	0	0	0		194
	07954 NON MCR CERTIFIED UNIT	0	0	0	0		194
	07955 REG NURSG OFFICE	0	0	0	0		194
	07956 CONTACT CENTER	0	0	0	0		194
	07957 CENTRALIZED ADMISSIONS DEPT 07959 OTHER NONREIMBURSABLE - OPEN				0) 194) 194
	07959 UTHER NUNRETMBURSABLE - OPEN 07958 VISITOR MEALS				3, 294		194
	07962 OTHER NONREI MBURSABLE COST CENTERS			0	5, 274		194
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION		0	0	0		194
. 00	Cross Foot Adjustments			-		-	200
. 00	Negative Cost Centers						201
2. 00	Cost to be allocated (per Wkst. B,	716, 014	171, 894	324, 073	473, 148	0	202
	Part I)						
8.00	Unit cost multiplier (Wkst. B, Part I)	59. 370978		27.522123		0.00000	
. 00	Cost to be allocated (per Wkst. B,	348, 588	21, 055	16, 373	25, 161	C	204
5. 00	Part II) Unit cost multiplier (Wkst. B, Part	28. 904478	2. 571760	1. 390488	1. 170660	0.00000	205
. 00	UNIT COST MULTIPITER (WKSL. D, Part	20. 9044/8	2.3/1/00	1. 370488	1. 170000	0.000000	'Izuo

		ndred Hospital N				Workshoot R 1	
JUSIA	ALLOCATION - STATISTICAL BASIS		Provider (Period: From 09/01/2015	Worksheet B-1	
				٦	To 08/31/2016		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	1/18/2017 2:3 SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)		(PATIENT DAYS)	
		(NURSING FTES)	(COSTED REQUI S.)		(GROSS REVENUE)		
		13.00	14.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS		1		1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.0
3.00	00800 LAUNDRY & LINEN SERVICE						8.0
9.00	00900 HOUSEKEEPI NG						9.0
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	41					13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	0	482, 245				14.00
15.00	01500 PHARMACY	0	2, 419	664, 814	4		15.0
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		51, 858, 100		16.00
17.00	01700 SOCIAL SERVICE	0	0	(0 0	8, 187	17.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	40	6, 192		25, 161, 007	8, 187	30.00
31.00	03100 I NTENSI VE CARE UNI T	40	0, 172			0,107	
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0	0	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	1	429		405, 419	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	0	(1, 690, 051	0	1
50.00 55.00	06500 RESPIRATORY THERAPY	0	1, 693	(0 4, 909, 459 0 6, 951, 274	0	60.00 65.00
55.00 56.00	06600 PHYSI CAL THERAPY	0	56	(2, 778, 392	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	О	(0 0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	471, 424		2, 007, 033	0	
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 32	664, 814		0	
74.00	OUTPATIENT SERVICE COST CENTERS	0	32		1, 262, 338	0	74.00
90.00	09000 CLINIC	0	0	(0 0	0	90.00
91.00	09100 EMERGENCY	0	0	(0 0	0	91.00
	OTHER REIMBURSABLE COST CENTERS	1			1		
95.00	09500 AMBULANCE SERVICES	0	0		0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	98.00
118.00		41	482, 245	664, 814	4 51, 858, 100	8, 187	118.00
	NONREI MBURSABLE COST CENTERS	н					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	(0		192.00
	07950 NONALLOWABLE CLINICAL LIAISON	0	0	(194.00 194.0
	207952 REGIONAL OFFICE	0	0	(194. 02
	3 07953 DI STRI CT OFFI CE	0	0	(0 0		194.03
	07954 NON MCR CERTIFIED UNIT	0	0	(0 0	0	194. 04
	07955 REG NURSG OFFICE	0	0	(0 0		194. 0
	07956 CONTACT CENTER	0	0	(194. 00 194. 0
	7 07957 CENTRALIZED ADMISSIONS DEPT 3 07959 OTHER NONREIMBURSABLE – OPEN	0	0	(194.0
	07958 VISITOR MEALS	0	0	(o o		194.00
94.10	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0 0		194.1
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	(0 0	0	194. 1
200.00							200.0
201.00		000 401	122 025	010 05		220 524	201.0
202.00	Part I)	808, 681	133, 925	818, 954	4 446, 954	238, 531	202.0
203.00		19, 723. 926829	0. 277712	1. 231854	4 0. 008619	29. 135337	203.00
204.00	Cost to be allocated (per Wkst. B,	20, 662	21, 724	148, 510		19, 087	
204.00							
204.00	Part II) Unit cost multiplier (Wkst. B, Part	503. 951220	0. 045048	0. 223386	0. 001041	2. 331379	

Health Financial Systems K	indred Hospital 1	Northern India	าล	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Pre 1/18/2017 2:3	pared: 2 pm
		Titl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	7 4 40 4 70				7 454 047	
30. 00 03000 ADULTS & PEDI ATRI CS	7, 148, 678		7, 148, 67	8 2, 339		
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	31.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0 0	0	44.00
ANCI LLARY SERVI CE COST CENTERS	F01 (00		E01 (0		E01 (00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	581,600		581,60		581,600	
60. 00 06000 LABORATORY	299, 602 532, 743		299, 60		299, 602 532, 743	
65. 00 06500 RESPI RATORY THERAPY	627,071		532, 74 627, 07			
66. 00 06600 PHYSI CAL THERAPY	873, 356				873, 356	
67. 00 06700 OCCUPATI ONAL THERAPY	8/3, 300		873, 35		873, 356	67.00
68. 00 06800 SPEECH PATHOLOGY	0			0 0	0	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	753, 736		753, 73	6 0	753, 736	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 730, 559		1, 730, 55		1, 730, 559	
74. 00 07400 RENAL DI ALYSI S	508, 909		508, 90			74.00
OUTPATIENT SERVICE COST CENTERS	500, 707		500,70	105	307, 074	74.00
90. 00 09000 CLINIC	0			0 0	0	90.00
91. 00 09100 EMERGENCY	0			0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98.00
200.00 Subtotal (see instructions)	13, 056, 254	l a	13, 056, 25	4 5, 414	13, 061, 668	
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	13, 056, 254	c	13, 056, 25	4 5, 414	13, 061, 668	202.00

Health Financial Systems	Kindred Hospital M	lorthern India	าล	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				rom 09/01/2015	Part I	
				To 08/31/2016	Date/Time Pre 1/18/2017 2:3	
		Ti †I	e XVIII	Hospi tal	PPS	z pili
		Charges	<u>c</u> Milli		115	
Cost Center Description	I npati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	inpatront	outputtont	+ col. 7	Ratio	Inpatient	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	· · ·					
30. 00 03000 ADULTS & PEDIATRICS	25, 161, 007		25, 161, 00	7		30.00
31.00 03100 INTENSIVE CARE UNIT	0			C		31.00
44.00 04400 SKILLED NURSING FACILITY	0			C		44.00
ANCILLARY SERVICE COST CENTERS				_		
50.00 05000 OPERATING ROOM	405, 419	C	405, 41	9 1. 434565	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 690, 051	C	1, 690, 05		0.00000	54.00
60. 00 06000 LABORATORY	4, 909, 459	C	4, 909, 45		0.00000	
65. 00 06500 RESPI RATORY THERAPY	6, 951, 274	C	6, 951, 27		0.00000	
66. 00 06600 PHYSI CAL THERAPY	2, 778, 392	0	2, 778, 39			
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0		0. 000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,007,033	0	2, 007, 03			
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 693, 127	0	6, 693, 12			1
74.00 07400 RENAL DIALYSIS	1, 262, 338	C	1, 262, 33	0. 403148	0.00000	74.00
OUTPATIENT SERVICE COST CENTERS			1	1		
90. 00 09000 CLINIC	0	C		0. 000000		
91. 00 09100 EMERGENCY	0	0		0. 000000	0.00000	91.00
OTHER REIMBURSABLE COST CENTERS		-	1			
95. 00 09500 AMBULANCE SERVICES	0	0		0. 000000		
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0.00000	
200.00 Subtotal (see instructions)	51, 858, 100	C	51, 858, 10	נ		200.00
201.00 Less Observation Beds	F4 050 400	~	F4 050 10			201.00
202.00 Total (see instructions)	51, 858, 100	C	51, 858, 10			202.00

Health Financial Systems Ki	indred Hospital Nor	rthern Indiana	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152018	Period: From 09/01/2015 To 08/31/2016	1/18/2017 2:3	epared: 32 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	1. 434565				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 177274				54.00
60. 00 06000 LABORATORY	0. 108514				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 090625				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 314339				66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 375547				71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 258558				73.00
74. 00 07400 RENAL DI ALYSI S	0. 403295				74.00
90. 00 09000 CLINIC	0, 000000				90.00
90. 00 109000 CET NTC 91. 00 09100 EMERGENCY	0.000000				90.00
OTHER REIMBURSABLE COST CENTERS	0.00000				91.00
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000				98.00
200.00 Subtotal (see instructions)	0.00000				200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00

Health Financial Systems Ki	ndred Hospital	Northern India	าล	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 09/01/2015 To 08/31/2016	1/18/2017 2:3	pared: 2 pm
	-	Tit	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS					- 454 043	
30. 00 03000 ADULTS & PEDI ATRI CS	7, 148, 678		7, 148, 67	8 2, 339	7, 151, 017	
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	31.00
44. 00 O4400 SKI LLED NURSI NG FACI LI TY	0			0 0	0	44.00
ANCI LLARY SERVI CE COST CENTERS	E01 (00		E01 (0		E01 (00	
	581,600		581,60		581,600	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	299, 602		299, 60		299, 602	
65. 00 06500 RESPI RATORY THERAPY	532, 743		532, 74 627, 07		532, 743 629, 961	
66. 00 06600 PHYSI CAL THERAPY	873, 356				873, 356	
67. 00 06700 0CCUPATI ONAL THERAPY	8/3, 300		873, 35		873, 356	67.00
68. 00 06800 SPEECH PATHOLOGY	0			0 0	0	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	753, 736		753, 73	6 0	753, 736	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 730, 559		1, 730, 55		1, 730, 559	
74. 00 07400 RENAL DIALYSIS	508, 909		508, 90		509, 094	74.00
OUTPATIENT SERVICE COST CENTERS	500, 707		500, 70	105	307, 074	74.00
90. 00 09000 CLINIC	0			0 0	0	90.00
91. 00 09100 EMERGENCY	0			0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98.00
200.00 Subtotal (see instructions)	13, 056, 254	l a	13, 056, 25	4 5, 414	13, 061, 668	
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	13, 056, 254	c	13, 056, 25	4 5, 414	13, 061, 668	202.00

Health Financial Systems K	indred Hospital N	Northern India	าล	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				From 09/01/2015	Part I	
				To 08/31/2016	Date/Time Pre	pared:
		ті +	le XIX	Hospi tal	1/18/2017 2:3 Cost	z pili
		Charges		nospi tai	COST	
Cost Center Description	Inpati ent	Outpati ent	Total (col 4	Cost or Other	TEFRA	
cost center bescription	Inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
				Na tr o	Ratio	
	6,00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00 03000 ADULTS & PEDI ATRI CS	25, 161, 007		25, 161, 00	7		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0		31.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	405, 419	C	405, 41	9 1. 434565	0.00000	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 690, 051	C	1, 690, 05	0. 177274	0. 000000	54.00
60. 00 06000 LABORATORY	4, 909, 459	C	4, 909, 45	9 0. 108514	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	6, 951, 274	C	6, 951, 27	4 0. 090210	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 778, 392	C	2, 778, 39	2 0. 314339	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0.000000	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0.000000	0.00000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,007,033	C	2, 007, 03	3 0. 375547	0.00000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 693, 127	C	6, 693, 12		0. 000000	73.00
74.00 07400 RENAL DIALYSIS	1, 262, 338	C	1, 262, 33	8 0. 403148	0.00000	74.00
OUTPATIENT SERVICE COST CENTERS			1	T.		
90. 00 09000 CLI NI C	0	C		0 0. 000000	0. 000000	1
91. 00 09100 EMERGENCY	0	C		0 0.00000	0.00000	91.00
OTHER REIMBURSABLE COST CENTERS			-			
95. 00 09500 AMBULANCE SERVI CES	0	C		0 0. 000000	0.00000	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0. 000000	0.00000	
200.00 Subtotal (see instructions)	51, 858, 100	C	51, 858, 10	0		200.00
201.00 Less Observation Beds				_		201.00
202.00 Total (see instructions)	51, 858, 100	C	51, 858, 10	D		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 152018 Period: From 09/01/2015 To 08/31/2016 Worksheet C Pate/Time Prepared: 118/2017 2:32 pm Title XIX Worksheet C Prom 09/01/2015 To 08/31/2016 Worksheet C Prom 09/01/2015 INPATI ENT ROUTINE SERVICE COST CENTERS 11.00 Title XIX Hospital Cost 30.00 03000 ADULTS & PEDIATRICS 30.00 30.00 30.00 30.00 31.00 03000 (ADULTS & PEDIATRICS 30.00 30.00 31.00 31.00 44.00 04400 (Skil LLED NURSING FACILITY 44.00 44.00 44.00 65.00 05000 (DERATING ROM 0.000000 54.00 56.00 66.00 66.00 06500 RESPI RATORY 0.000000 66.00 66.00 66.00 66.00 67.00 06700 DCCUPATIONAL THERAPY 0.000000 67.00 67.00 67.00 67.00 71.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00	Health Financial Systems	Kindred Hospital Nor	thern Indiana	In Lie	u of Form CMS-255	52-10
Cost Center Description PPS Inpatient Ratio Net in the structure Net in	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 09/01/2015 To 08/31/2016	Part I Date/Time Prepa	red: pm
Ratio Ratio 11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 05000 OPERATING ROOM 0.000000 50.00 60.00 06000 LABORATORY 0.000000 50.00 61.00 06000 LABORATORY 0.000000 66.00 62.00 06500 RESPI RATORY THERAPY 0.000000 66.00 63.00 06600 PHYSI CAL THERAPY 0.000000 66.00 64.00 06600 PHYSI ES CHARGED TO PATI ENTS 0.000000 67.00 65.00 06800 SPEECH PATHOLOGY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 73.00 73.00 07300 RUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 07400 RENAL DI ALYSIS 0.000000 73.00 75.00 09000 CLINIC 0.0000000 000000 </td <td></td> <td></td> <td>Title XIX</td> <td>Hospi tal</td> <td>Cost</td> <td></td>			Title XIX	Hospi tal	Cost	
30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 OKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 54.00 05000 DRADIOLOGY-DIAGNOSTIC 0.000000 60.00 60.00 0.6000 LABORATORY 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 60.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 0C700 OCUPATI ONAL THERAPY 0.000000 66.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 73.00 07300 DRUSC CHARGED TO PATIENTS 0.000000 73.00 74.00 07400 REMAL DIALYSIS 0.000000 73.00 75.00 09100 CENTERS 0.000000 74.00 91.00 OPIOOE CENTERS 0.000000 90.00 <	Cost Center Description	Ratio				
31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 04400 SKI LLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 PERATING ROM 0.000000 50.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 54.00 60.00 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 66.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 73.00 07300 DRUSC CHARGED TO PATIENTS 0.000000 73.00 74.00 OT400 RENAL DIALYSIS 0.000000 73.00 00.000 OTHER REI MBURSABLE COST CENTERS 0.000000 90.00 91.00 09100 CLINIC 0.000000 90.00 91.00 09100 CLINER 0.000000 90.00 91.00 09100 CLINIC 0.000000 90.00						
44.00 O4400 Ski LLED NURSING FACILITY 44.00 ANCI LARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROM 50.00 54.00 O5000 OPERATING ROM 0.000000 54.00 66.00 O6000 LABORATORY 0.000000 60.00 65.00 O6500 RESPI RATORY THERAPY 0.000000 60.00 66.00 O6600 PHYSI CAL THERAPY 0.000000 65.00 66.00 O6600 PHYSI CAL THERAPY 0.000000 67.00 68.00 O6700 OCCUPATI ONAL THERAPY 0.000000 68.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 O7400 RENAL DI ALYSI S 0.000000 73.00 90.00 O9000 CLINIC 0.000000 74.00 91.00 O9100 EMERGENCY 0.000000 91.00 91.00 O9500 AMBULANCE SERVICES 0.000000 95.00 95.00 O9500 AMBULANCE SERVICES						
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 0PERATING ROOM 0.000000 50.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 54.00 60.00 06000 LABORATORY 0.000000 65.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 65.00 67.00 06700 0CCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 67.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74.00 09.000 CLITER 0.000000 91.00 90.00 09100 EMERGENCY 0.000000 91.00 91.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 98.00 90.00 Less Observati on Beds					4	14.00
54.00 05400 RADI 0L0GY-DI AGNOSTI C 0.000000 54.00 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 73.00 90.00 09000 CLI NI C 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 91.00 09100 EMERGENCY 0.000000 95.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 920.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 920.00 Subtotal (s						
60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 74.00 007400 RENAL DI ALYSI S 0.000000 74.00 90.00 09000 CLI NI C 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 74.00 91.00 09100 EMERGENCY 0.000000 90.00 91.00 09500 AMBULANCE SERVI CES 0.000000 95.00 98.00 09500 OTHER REI MBURSABLE COST CENTERS 0.000000 95.00 95.00 920.00 Subtotal (see instructions) 0.000000 200.00 200.00 201.00 201.00						
65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 73.00 07300 REMAL DI ALYSI S 0.000000 74.00 0017400 RENAL DI ALYSI S 0.000000 74.00 017400 OP000 CLI NI C 0.000000 90.00 90.00 09000 CLI NI C 0.000000 90.00 91.00 OP100 EMERGENCY 0.000000 91.00 91.00 09100 EMERGENCY 0.000000 91.00 95.00 09500 AMBULANCE SERVI CES 0.000000 95.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 95.00 200.00 Subtotal (see instructions) 0.000000 200.00 200.00 201.00 Less Observation Beds 0.00000						
66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 74.00 00000 CLI NI C 0.000000 90.00 90.00 91.00 09100 EMEGENCY 0.000000 91.00 01.00 OTHER REI MBURSABLE COST CENTERS 0.000000 91.00 95.00 09500 AMBULANCE SERVI CES 0.000000 95.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 90.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 90.00 UDISCHARGENCY 0.000000 95.00 98.00 9200.00 Subtotal (see instructions) 0.000000 95.00 98.00 200.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 07400 RENAL DI ALYSIS 0.000000 73.00 00 00000 CLINIC 0.000000 90.00 0100 09100 EMERGENCY 0.000000 91.00 01100 09100 EMERGENCY 0.000000 91.00 01100 09100 EMERGENCY 0.000000 91.00 01100 09500 AMBULANCE SERVICES 0.000000 91.00 01100 09500 MBURSABLE COST CENTERS 0.000000 95.00 0200.00 Subtotal (see instructions) 0.000000 95.00 98.00 200.00 Less Observation Beds 201.00 201.00 201.00						
68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74.00 00000 017401 ENSTRICE COST CENTERS 0.000000 74.00 90.00 09000 CLINIC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 90.00 91.00 09500 AMBULANCE SERVICES 0.000000 91.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 200.00 Subtotal (see instructions) 0.000000 98.00 200.00 201.00 Less Observation Beds 201.00 201.00 201.00						
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 07400 RENAL DI ALYSIS 0.000000 74.00 0UTPATIENT SERVICE COST CENTERS 0.000000 74.00 90.00 90.00 09100 EMERGENCY 0.000000 90.00 0THER REI MBURSABLE COST CENTERS 0.000000 91.00 95.00 950.00 950.00 988.00 988.00 988.00 980.00 200.00 201.00 Less Observation Beds 200.00 201.						
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74.00 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 0THER REI MBURSABLE COST CENTERS 0.000000 95.00 95.00 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 98.00 09850 0THER REI MBURSABLE COST CENTERS 0.000000 98.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
74.00 07400 RENAL DI ALYSI S 0.00000 74.00 0UTPATI ENT SERVICE COST CENTERS 0.00000 00000 90.00 91.00 0.000000 91.00 90.00 91.00 91.00 0.000000 91.00 91.00 91.00 91.00 91.00 95.00 9						
OUTPATI ENT SERVICE COST CENTERS 0 90.00 09000 CLINIC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 0THER REI MBURSABLE COST CENTERS 0.000000 91.00 95.00 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
90.00 09000 CLINIC 0.00000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 0THER REIMBURSABLE COST CENTERS 91.00 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00		0. 000000			/	4.00
91.00 09100 EMERGENCY 0.000000 91.00 0THER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00 95.00 95.00 9500 AMBULANCE SERVICES 0.000000 95.00 98.00 98.00 98.00 200.00 98.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 <td< td=""><td></td><td>0,000000</td><td></td><td></td><td></td><td>0 00</td></td<>		0,000000				0 00
OTHER REI MBURSABLE COST CENTERS95.0009500AMBULANCE SERVI CES0.00000095.0098.0009850OTHER REI MBURSABLE COST CENTERS0.00000098.00200.00Subtotal (see instructions)200.00200.00201.00Less Observation Beds201.00201.00						
95.00 09500 AMBULANCE SERVICES 0.000000 95.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00		0.000000			9	71.00
98.00 09850 OTHER RELIMBURSABLE COST CENTERS 0.000000 98.00 200.00 Subtotal (see instructions) 200.00		0,000000				
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00						
201.00 Less Observation Beds 201.00		0.000000				
202.00 $10131.(See instructions)$ (202.00)	202.00 Total (see instructions))2.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	F	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part I Date/Time Prep 1/18/2017 2:32	
		Titl	e XVIII	Hospi tal	PPS	- 1
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col.	Total Patient Days	Per Diem (col. 3 / col. 4)	
	26)	2.00	2)	1.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30-199) Cost Center Description	958, 673 0 0 958, 673 I npati ent Program days	Inpati ent Program	0 958, 673 (958, 673	0 0 0 0	0.00 0.00	31.00
		Capital Cost (col. 5 x col. 6) 7.00	_			
INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00 ADULTS & PEDIATRICS	5, 275	617, 703			I	30.0
31. 00 INTENSIVE CARE UNIT	U U				1	31.0
44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30-199)	5, 275	617, 703			ļ	44. 0 200. 0

		Northern Indiar			u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der	CCN: 152018	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part II Date/Time Pre 1/18/2017 2:3	
	-		e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50. 00 05000 OPERATI NG ROOM	14, 620				8, 032	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 971				5, 082	
50. 00 06000 LABORATORY	16, 976				10, 476	
55. 00 06500 RESPI RATORY THERAPY	21, 780				11, 728	
56. 00 06600 PHYSI CAL THERAPY	68, 160	2, 778, 392			39, 782	
57.00 06700 OCCUPATI ONAL THERAPY	0	0	0.0000		0	67.00
58.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 00	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 976	2,007,033	0. 01892	21 1, 371, 459	25, 949	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	176, 137	6, 693, 127	0. 02631	16 4, 591, 642	120, 834	73.00
74. 00 07400 RENAL DIALYSIS	81, 057	1, 262, 338	0.0642	12 842, 602	54, 105	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.0000		0	90.00
91. 00 09100 EMERGENCY	0	0	0.0000	0 00	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000	0 00	0	98.00
200.00 Total (lines 50-199)	425, 677	26, 697, 093		16, 380, 538	275, 988	200.00

Health Financial Systems Kindred Hospital Northern Indiana In Lieu of Form CMS-25								
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	PASS THROUGH COS			Period: From 09/01/2015 To 08/31/2016	Date/Time Pre 1/18/2017 2:3			
	-		e XVIII	Hospi tal	PPS			
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs			
		Cost	Medi cal	Adjustment	(sum of cols.			
			Education Cos	t Amount (see	1 through 3,			
				instructions)	minus col. 4)			
	1.00	2.00	3.00	4.00	5.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS								
30. 00 03000 ADULTS & PEDI ATRI CS	C	C)	0 0	0	30.00		
31.00 03100 I NTENSI VE CARE UNI T	C	C		0	0	31.00		
44.00 04400 SKILLED NURSING FACILITY	C) c			0	44.00		
200.00 Total (lines 30-199)	C) c		0	0	200.00		
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent				
	Days	5 ÷ col. 6)	Program Days					
		, i i i i i i i i i i i i i i i i i i i		Pass-Through				
				Cost (col. 7 x				
				col. 8)				
	6.00	7.00	8.00	9.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000 ADULTS & PEDI ATRI CS	8, 187	0.00	5, 27	5 0		30.00		
31.00 03100 INTENSIVE CARE UNIT	C	0.00		o o		31.00		
44.00 04400 SKILLED NURSING FACILITY	C C	0.00		o o		44.00		
200.00 Total (lines 30-199)	8, 187	,	5, 27	5 0		200. 00		

Health Financial Systems Kindred Hospital Northern Indiana In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der	CCN: 152018	Peri od:	Worksheet D		
THROUGH COSTS				From 09/01/2015 To 08/31/2016		norod.	
				To 08/31/2016	Date/Time Pre 1/18/2017 2:33		
			e XVIII	Hospi tal	PPS		
Cost Center Description		Nursing School	Allied Healt	h All Other	Total Cost		
	Anesthetist			Medi cal	(sum of col 1		
	Cost			Education Cost	through col.		
					4)		
	1.00	2.00	3.00	4.00	5.00		
ANCI LLARY SERVI CE COST CENTERS	1	1	1				
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00	
60. 00 06000 LABORATORY	0	0		0 0	0	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00	
OUTPATIENT SERVICE COST CENTERS	т		1				
90. 00 09000 CLINIC	0	0		0 0	0	90.00	
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00	
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES						95.00	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00	
200.00 Total (lines 50-199)	0	0		0 0	0	200.00	

Health Financial Systems Kir	Northern India	าล	In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 09/01/2015		
				To 08/31/2016	Date/Time Pre 1/18/2017 2:33	pared:
		Ti +I	e XVIII	Hospi tal	PPS	z pili
Cost Center Description	Total	Total Charges			I npati ent	
COST CENTER Description		(from Wkst. C,		Ratio of Cost		
	Cost (sum of				Charges	
	col. 2, 3 and	8)	7)	$(col. 6 \div col.$	charges	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	405, 419	0. 00000	0.000000	222, 720	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 690, 051	0.00000	0.000000	957, 468	54.00
60. 00 06000 LABORATORY	0	4, 909, 459	0. 00000	0.000000	3, 029, 563	60.00
65. 00 06500 RESPI RATORY THERAPY	0	6, 951, 274	0. 00000	0.000000	3, 743, 464	65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 778, 392	0. 00000	0.000000	1, 621, 620	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	0.000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000	0.000000	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,007,033	0.00000	0.000000	1, 371, 459	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 693, 127	0. 00000	0.000000	4, 591, 642	73.00
74.00 07400 RENAL DIALYSIS	0	1, 262, 338	0.00000	0.000000	842, 602	74.00
OUTPATIENT SERVICE COST CENTERS	<u>.</u>					
90. 00 09000 CLINIC	0	C	0.00000	0 0. 000000	0	90.00
91.00 09100 EMERGENCY	0	0	0. 00000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.00000	0.000000	0	98.00
200.00 Total (lines 50-199)	0	26, 697, 093			16, 380, 538	200. 00

Health Financial Systems Kin	ndred Hospital Northern Indiana			In Lieu of Form CMS-2552		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 152018	Peri od:	Worksheet D	
THROUGH COSTS				From 09/01/2015		
				To 08/31/2016	Date/Time Prep 1/18/2017 2:32	
		Ti †I	e XVIII	Hospi tal	PPS	<u>z piii</u>
Cost Center Description	Inpati ent	Outpati ent	Outpati ent		110	
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	5	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	C		0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
60. 00 06000 LABORATORY	0	C		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
74.00 07400 RENAL DIALYSIS	0	0)	0		74.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLI NI C	0	C		0		90.00
91.00 09100 EMERGENCY	0	C		0		91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C		0		98.00
200.00 Total (lines 50-199)	0	C		0		200. 00

IPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 152018	Period: From 09/01/2015	Worksheet D-1	
		71.11	To 08/31/2016	Date/Time Prep 1/18/2017 2:33	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	oveluding nowhern)	I	0 107	1 1
00	Inpatient days (including private room days, excluding swing-bed days)			8, 187 8, 187	
00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0,107	
	do not complete this line.		5		
00	Semi-private room days (excluding swing-bed and observation be		01 6 11	8, 187	4
00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			_	
00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	davs) after December 3	1 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			0	
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	5, 275	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including privato r	nom dave)	0	10
00	through December 31 of the cost reporting period (see instruct			0	
00	Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private r	oom days) after	0	11
~~	December 31 of the cost reporting period (if calendar year, en			0	1.
00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lir	e)		
	Medically necessary private room days applicable to the Progra	m (excluding swing-bed	days)	0	
00 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT				
00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	10
00	reporting period	Salter December 51 01		0.00	
00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
00	reporting period			0100	
00	Total general inpatient routine service cost (see instructions			7, 151, 017	
00	Swing-bed cost applicable to SNF type services through December 5×1 (ine 17)	er 31 of the cost report	ing period (line	0	22
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23
	x line 18)		511111		
00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	and the cost reporting	period (line 8	0	25
	x line 20)			0	_`
00	Total swing-bed cost (see instructions)			0	
00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7, 151, 017	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
00	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
00	Average per diem private room cost differential (line 34 x lin			0.00	
00	Private room cost differential adjustment (line 3 x line 35)	and anivota name and -"	fforontial (list	0	36
00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nu private room cost di	iierential (line	7, 151, 017	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				1
00	Adjusted general inpatient routine service cost per diem (see			873.46	
00	Program general inpatient routine service cost (line 9 x line			4, 607, 502	
00	Medically necessary private room cost applicable to the Progra	um (line 1/ v line 25)	1	0	40

		ndred Hospital I					u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Prov	ider		Period: From 09/01/2015	Worksheet D-1	
						Fo 08/31/2016		pared:
				Title	e XVIII	Hospi tal	1/18/2017 2: 3 PPS	2 pili
	Cost Center Description	Total	Total		Average Per	Program Days	Program Cost	
		Inpatient Cost	I npati ent	Days		+	(col. 3 x col.	
		1.00	2.00		col. 2) 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)	1.00	2.00		0.00	1.00	0.00	42.00
	Intensive Care Type Inpatient Hospital Units							
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0		0	0.00	0 0	0	43.00 44.00
	BURN INTENSIVE CARE UNIT							44.00 45.00
	SURGI CAL I NTENSI VE CARE UNI T							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200	0)			3, 709, 049	48.00
	Total Program inpatient costs (sum of lines				ns)		8, 316, 551	49.00
F0 00	PASS THROUGH COST ADJUSTMENTS	-+!++!		(6	What D arm	- C Davata I and	(17, 70)	F0 00
50.00	Pass through costs applicable to Program inp	atient routine	servi ces	(Trom	WKST. D, SUM	of Parts I and	617, 703	50.00
51.00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry service:	s (fr	om Wkst. D, su	um of Parts II	275, 988	51.00
52.00	Total Program excludable cost (sum of lines						893, 691	52.00
53.00	Total Program inpatient operating cost exclu		elated, noi	n-phy	sician anesthe	etist, and	7, 422, 860	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program di scharges						0	54.00
	Target amount per discharge						0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	ardet amoui	nt (I	ine 56 minus l	ine 53)	0	56.00 57.00
	Bonus payment (see instructions)	The cost and to	n get anou			The 55)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	npounded by the	0.00	59.00				
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport un	dated by	tho m	arkat backat		0.00	60.00
	If line 53/54 is less than the lower of line					the amount by	0.00	61.00
	which operating costs (line 53) are less tha		s (lines !	54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see	instructions)					0	62.00
								63.00
	PROGRAM I NPATI ENT ROUTI NE SWI NG BED COST							
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of	f the	cost reportin	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of	the c	ost reporting	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 li	ine 6	5)(title XVIII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December	31 o	f the cost rep	orting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 3	1 of	the cost repo	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 +	line	68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N							
	Skilled nursing facility/other nursing facil	5						70.00
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ i	i i ne	2)			71.00 72.00
	Medically necessary private room cost applic		n (line 14	x li	ne 35)			73.00
	Total Program general inpatient routine serv							74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (fi	rom W	orksheet B, Pa	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76.00
	Program capital-related costs (line 9 x line							77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		wavi dan m		c)			78.00
79.00 80.00	Total Program routine service costs for comp	· · ·			· ·	us line 79)		79.00 80.00
81.00	Inpatient routine service cost per diem limi				、 · · · · · · · · · · ·	/		81.00
82.00	Inpatient routine service cost limitation (I							82.00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)					83.00 84.00
	Utilization review - physician compensation		ons)					85.00
	Total Program inpatient operating costs (sum	of lines 83 th						86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions						0	87.00
	Adjusted general inpatient routine cost per		line 2)					88.00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)					0	89.00

Health Financial Systems Kir	ndred Hospital	Northern India	na	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 09/01/2015 To 08/31/2016	Date/Time Pre 1/18/2017 2:3	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	958, 673	7, 151, 01	0. 13406	1 0	0	90.00
91.00 Nursing School cost	(7, 151, 01	0. 00000	0 0	0	91.00
92.00 Allied health cost	(7, 151, 01	0. 00000	0 0	0	92.00
93.00 All other Medical Education		7, 151, 01	0. 00000	0 0	0	93.00

		Provider CCN: 152018	Period: From 09/01/2015	Worksheet D-1	
			To 08/31/2016	Date/Time Prep 1/18/2017 2:32	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-	0		8, 187 8, 187	1.00 2.00
3.00	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		8, 187	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	er 31 of the cost	0	5.00	
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	5		-	
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	r 31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	n swing-bed and	0	9.00
	newborn days)	0		-	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private i	room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12.00
	through December 31 of the cost reporting period	5 . 6 .	3 /		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00	Medically necessary private room days applicable to the Progr				14.00
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00 16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 (of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	the cost	0.00	18.00	
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	0.00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of [.]	the cost	0.00	20.00
21 00	reporting period			7 140 470	21 00
21.00 22.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	7, 148, 678 0	21.00
23.00	5 x line 17) Swing had cost applicable to SNE type convices after December	21 of the cost reportin	an portiod (Line 6)	0	23.00
23.00	Swing-bed cost applicable to SNF type services after December x line 18) $$	ST OF THE COST TEPOLIT	ig period (The o	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe 7×1 (ine 19)	r 31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
26. 00	x line 20) 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)		7, 148, 678	27.00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed c	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)				32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		ati ana)	0.00	
34.00	Average per diem private room charge differential (line 32 mi				34.0
35.00 36.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)			0.00	35. 0 36. 0
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 148, 678	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	·			
	PART IT - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJI	JSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see	instructions)		873.17	38.0
		-		873. 17 0	

		ndred Hospital I					u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Prov	'i der		Period: From 09/01/2015	Worksheet D-1	
						Fo 08/31/2016		
				Ti t	le XIX	Hospi tal	1/18/2017 2:32 Cost	2 piii
	Cost Center Description	Total	Total		Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpati ent	Days		÷	(col. 3 x col.	
		1.00	2.00		col. 2) 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)							42.00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT				0.00	0 0	0	42 00
	CORONARY CARE UNIT	0		0	0.00	0	0	43.00 44.00
	BURN INTENSIVE CARE UNIT							45.00
	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47.00
	cost center bescription						1.00	
	Program inpatient ancillary service cost (Wk						0	48.00
49.00	Total Program inpatient costs (sum of lines	41 through 48)(<u>see instr</u>	uctio	ns)		0	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	servi ces	(from	Wkst. D. sum	of Parts L and	0	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	ry service	s (fr	om Wkst. D, su	um of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)					0	52.00
	Total Program inpatient operating cost exclu		elated, no	n-phy	sician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line	52)						
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54.00
	Target amount per discharge						0.00	55.00
	Target amount (line 54 x line 55)						0	56.00
	Difference between adjusted inpatient operat	ing cost and ta	arget amou	nt (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	ondina 10	06 11	indated and cor	nounded by the	0 0. 00	58.00 59.00
57.00	market basket	ipounded by the	0.00	39.00				
60.00	Lesser of lines 53/54 or 55 from prior year						0.00	60.00
61.00	.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							61.00
	amount (line 56), otherwise enter zero (see		.s (TTTTES	34 X	00), 01 1% 01	the target		
								62.00
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instru	ictions)				0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 o	f the	cost reportir	ng period (See	0	64.00
	instructions)(title XVIII only)							
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of	the c	ost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus l	ine 6	5)(title XVIII	only). For	0	66.00
(7.00	CAH (see instructions)			0.1	C 11 1			(7.00
67.00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	le costs through	December	31 0	or the cost rep	orting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 3	1 of	the cost repor	ting period	0	68.00
69.00	(line 13 x line 20)	routino costs (line 47 .	Lino	40)		0	69.00
09.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						0	09.00
70.00	Skilled nursing facility/other nursing facil							70.00
71.00	Adjusted general inpatient routine service of		ine 70 ÷	line	2)			71.00
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 14	v Li	ne 35)			72.00 73.00
74.00	Total Program general inpatient routine serv	-						74.00
75.00	Capital-related cost allocated to inpatient	routine service	e costs (f	rom W	lorksheet B, Pa	art 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	Inpatient routine service cost (line 74 minu	,						78.00
79.00	Aggregate charges to beneficiaries for exces				•	- 1 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ωσι ΠΠΠΤ	auon	ι (IIIe /δ mINU	13 11110 /4)		80.00 81.00
82.00	Inpatient routine service cost per diem rim)					82.00
	Reasonable inpatient routine service costs (ıs)					83.00
84.00 85.00	Program inpatient ancillary services (see in		ne)					84.00 85.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum							85.00 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	57					
	Total observation bed days (see instructions		line 2				0 0.00	87.00
88.00 89.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se							88.00 89.00

Health Financial Systems Ki	ndred Hospital	Northern India	าล	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 09/01/2015 To 08/31/2016	Date/Time Pre 1/18/2017 2:3	
	_	Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	958, 673	3 7, 148, 678	0. 13410	5 0	0	90.00
91.00 Nursing School cost	(7, 148, 678	0. 00000	0 0	0	91.00
92.00 Allied health cost	(7, 148, 678	0. 00000	0 0	0	92.00
93.00 AII other Medical Education	(7, 148, 678	0.00000	0 0	0	93.00

th Financial Systems Kin RTIONMENT OF COST OF SERVICES RENDERED BY INTER	dred Hospital N NS AND RESIDENT		CCN: 152018 P	eriod: rom 09/01/2015	u of Form CMS-2 Worksheet D-2	
			T		Date/Time Pre 1/18/2017 2:3	pare
					Health Care	
					Program Inpatient Days	
Cost Center Description	Percent of	Expense	Total	Average Cost	Title V	<u> </u>
	Assigned Time	Allocation	Inpatient Day	Per Day		
	1.00	2.00	All Patients 3.00	4.00	5.00	-
PART I - NOT IN APPROVED TEACHING PROGRAM	1.00	2.00	3.00	4.00	5.00	
Total cost of services rendered	0.00	(] 1
Hospital Inpatient Routine Services:	0.00		0.407	0.00		
ADULTS & PEDIATRICS	0. 00 0. 00	(0. 00 0. 00		
CORONARY CARE UNI T	0.00			0.00	Ŭ	4
BURN INTENSIVE CARE UNIT						5
SURGI CAL I NTENSI VE CARE UNI T						6
OTHER SPECIAL CARE (SPECIFY) NURSERY						7
Subtotal (sum of lines 2 through 8)	0.00	(b			9
0 SUBPROVIDER - IPF						10
0 SUBPROVIDER - IRF						11
0 SUBPROVIDER 0 SKILLED NURSING FACILITY	0.00	ſ	0	0.00	0	12
0 NURSING FACILITY	0.00	C C		0.00	0	14
O OTHER LONG TERM CARE						15
0 HOME HEALTH AGENCY						16
0 CMHC 0 AMBULATORY SURGICAL CENTER (D. P.)						17
0 HOSPICE						19
0 Subtotal (sum of lines 9 through 19)	0.00	()			20
					Titles V and XIX Outpatient	
					and Title	
					XVIII Part B	
Cast Conton Decerintian			Tatal Charges	Datia of Coat	Charges Title V	-
Cost Center Description			(from	Ratio of Cost to Charges	ntie v	
				(col . 2 ÷ col .		
			Part I, column	3		
			8, lines 88 through 93)			
	1.00	2.00	3.00	4.00	5.00	
Hospital Outpatient Services:	T		1			
0 RURAL HEALTH CLINIC 0 FEDERALLY QUALIFIED HEALTH CENTER						21
O CLINIC	0.00	(o o	0.000000	0	
0 EMERGENCY	0.00	(0 0	0.000000	0	24
0 OBSERVATION BEDS (NON-DISTINCT PART)						25
0 OTHER OUTPATIENT SERVICE COST CENTER 0 Subtotal (sum of lines 21 through 26)	0.00	(26
0 Total (sum of lines 20 and 27)	0.00	(28
Cost Center Description	Expenses	Swing bed	Net cost	Total	Average Cost	
	Allocated To	Amount	(column 1 plus	Inpatient Days - All Patients		
	cost centers on Worksheet		column 2)		3 ÷ col. 4)	
	B, Part I					
	columns 21 and					
	22 1.00	2.00	3.00	4.00	5.00	+
PART II - IN AN APPROVED TEACHING PROGRAM (T						
				0 107	0.00	1
Hospital Inpatient Routine Services:	0	(8, 187 0		
Hospital Inpatient Routine Services: 0 ADULTS & PEDIATRICS	0	1	. 0	0	0.00	31
Hospital Inpatient Routine Services: 0 ADULTS & PEDIATRICS	0	(D			
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT	0		0	0	0.00	
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT CORONARY CARE UNIT			-	0	0.00	33
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF O INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT			-	0	0.00	33 34
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT			-	0	0.00	33 34 35
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF O INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT			-	0	0. 00	33 34 35 36
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT OSURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Subtotal (sum of lines 29, and 32 through 36)	0		0	0	0. 00	33 34 35 36 37
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT CORONARY CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT O OTHER SPECIAL CARE (SPECIFY) Subtotal (sum of lines 29, and 32 through 36) SUBPROVIDER - IPF	0		0	0	0. 00	33 34 35 36 37 38
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF O INTENSIVE CARE UNIT CORONARY CARE UNIT D BURN INTENSIVE CARE UNIT O SURGICAL INTENSIVE CARE UNIT O THER SPECIAL CARE (SPECIFY) O Subtotal (sum of lines 29, and 32 through 36) O SUBPROVIDER - IPF O SUBPROVIDER - IRF	0		0	0	0. 00	33 34 35 36 37 38 38
Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT CORONARY CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT O OTHER SPECIAL CARE (SPECIFY) Subtotal (sum of lines 29, and 32 through 36) SUBPROVIDER - IPF	0		0	0		33 34 35 36 37 38 39 40

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS Provider CCN: 152018 Period: From 09/01/2015 To 08/31/2016 Worksheet D-2 Date/Time Prepared: 1/18/2017 2: 32 pm Cost Center Description Not In Approved Teaching Program In Approved Teaching Program In Approved Teaching Program RART 111 - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) 0 3.00 Hospital col. 9, line 9.00 col. 9, line 27.00 0 0 43.00 Total Hospital (sum of lines 43 and 44) 46.00 col. 9, line 27.00 0 43.00 0 45.00 SUBPROVIDER - IPF 47.00 SUBPROVIDER - IRF IRF 43.00 44.00	Health Financial Systems Kind	dred Hospital Northern	Indi ana	In Lieu of Form CM	S-2552-10
Cost Center Description Not In Approved Teaching Program In Approved Teaching Program Cost Center Description (from Part I:) Amount (from Part II, col. 7, -) 1.00 2.00 3.00 PART 111 - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) Hospital 43.00 Inpatient 0 01 ine 37.00 44.00 00 (utpatient) 43.00 SUBPROVIDER - IPF	APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	NS AND RESIDENTS Pro	ovider CCN: 152018		-2
1/18/2017 2: 32 pm Not In Approved Teaching Program In Approved Teaching Program Cost Center Description (from Part I:) Amount (fro					
Not In Approved Teaching Program In Approved Teaching Program Cost Center Description (from Part I:) Amount (from Part II, col. 7, -) Cost Center Description (from Part I:) Amount (from Part II, col. 7, -) PART 111 - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) Hospital Hospital Oline 37.00 43.00 In patient Col. 9, line 9.00 Oline 37.00 43.00 43.00 Outpatient Col. 9, line 9.00 Oline 37.00 43.00 43.00 Outpatient Col. 9, line 9.00 Oline 37.00 44.00 43.00 Oline 37.00 44.00 43.00 Oline 37.00 43.00 Adv colspan="2">43.00 0 43.00 0 44.00 45.00 0 44.00 45.00 45.00 4					repared: · 32 nm
Cost Center Description (from Part I:) Amount (from Part II, col. 7, -) 1.00 2.00 3.00 PART 111 - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) 3.00 Hospital Col. 9, line 9.00 0 line 37.00 43.00 Inpatient col. 9, line 27.00 0 45.00 Total Hospital (sum of lines 43 and 44) 0 45.00 46.00 SUBPROVIDER - IPF 43 and 44) 44.00		Not In Approved T	Teaching Program		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) Hospital 43.00 Inpatient col. 9, line 9.00 0 line 37.00 43.00 44.00 Outpatient col. 9, line 27.00 0 44.00 45.00 45.00 SUBPROVIDER - IPF F 43.00 44.00 45.00 45.00			5 5	11 11 11 11 11 11 11 11	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) Hospital 43.00 Inpatient col. 9, line 9.00 0 line 37.00 43.00 44.00 Outpatient col. 9, line 27.00 0 44.00 45.00 SUBPROVIDER - IPF F 43.00 44.00					
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) Hospital 43.00 Inpatient col. 9, line 9.00 0 line 37.00 43.00 44.00 Outpatient col. 9, line 27.00 0 44.00 45.00 SUBPROVIDER - IPF F 43.00 44.00					
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)Hospital43.00Inpatient00044.000045.00500001000<	Cost Center Description	(from Part I:)	Amount	(from Part II, col. 7, -	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)Hospital43.00Inpatient00044.000045.0046.00SUBPROVIDER - IPF		1.00		0.00	_
Hospital Col. 9, line 9.00 Oline 37.00 43.00 44.00 Outpatient col. 9, line 27.00 0 44.00 44.00 45.00 Total Hospital (sum of lines 43 and 44) col. 9, line 27.00 0 45.00 45.00 46.00					
43.00 Inpatient col. 9, line 9.00 0 line 37.00 43.00 44.00 Outpatient col. 9, line 27.00 0 44.00 45.00 Total Hospital (sum of lines 43 and 44) 0 45.00 46.00		IPLETED ONLY IF BOTH PA	ARTS I AND II ARE US	SED)	
44.00 Outpatient col. 9, line 27.00 0 44.00 45.00 Total Hospital (sum of lines 43 and 44) 0 45.00 46.00 46.00 SUBPROVIDER - IPF 46.00 46.00	Hospi tal				
45.00 Total Hospital (sum of lines 43 and 44) 0 45.00 46.00 46.00	43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
46. 00 SUBPROVI DER - I PF 46. 00	44.00 Outpatient	col. 9, line 27.00		0	44.00
	45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
47.00 SUBPROVIDER - LRF 47.00	46.00 SUBPROVIDER - IPF				46.00
	47.00 SUBPROVIDER - IRF				47.00
48.00 SUBPROVI DER 48.00	48.00 SUBPROVI DER				48.00
49.00 SKILLED NURSING FACILITY col. 9, line 13.00 0 col. 9, line 41.00 49.00	49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0col. 9, line 41.00	49.00

Health Financial Systems Ki APPORTIONMENT OF COST OF SERVICES RENDERED BY INTE	ndred Hospital M			In Lie Period:	u of Form CMS-2 Worksheet D-2	
AFFORTIONWENT OF COST OF SERVICES RENDERED BITINTE	KNS AND RESIDEN	13 FI OVI del	F	From 09/01/2015 To 08/31/2016		pared:
	Heal th Car Inpatie	9			1710/2017 2.3	
Cost Center Description	Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	6.00	7.00	8.00	9.00	10.00	
PART I - NOT IN APPROVED TEACHING PROGRAM 1.00 Total cost of services rendered						1.00
Hospital Inpatient Routine Services:						1.00
2.00 ADULTS & PEDIATRICS	5, 275	0	-	0 0	0	
3. 00 I NTENSI VE CARE UNI T 4. 00 CORONARY CARE UNI T 5. 00 BURN I NTENSI VE CARE UNI T 6. 00 SURGI CAL I NTENSI VE CARE UNI T	0	0	(0 0	0	3.00 4.00 5.00 6.00
7.00 OTHER SPECIAL CARE (SPECIFY) 8.00 NURSERY 9.00 Subtotal (sum of lines 2 through 8) 10.00 SUBPROVIDER - IPF			(0 0	0	7.00 8.00 9.00 10.00
11.00 SUBPROVIDER - IRF 12.00 SUBPROVIDER 13.00 SKILLED NURSING FACILITY 14.00 NURSING FACILITY	0	0	(0 0	0	11.00 12.00 13.00 14.00
15.00 OTHER LONG TERM CARE 16.00 HOME HEALTH AGENCY 17.00 CMHC 18.00 AMBULATORY SURGICAL CENTER (D.P.)						15.00 16.00 17.00 18.00
19. 00 HOSPICE						19.00
20.00 Subtotal (sum of lines 9 through 19)						20.00
	and Title X Char			nd XIX Outpatier (VIII Part B Cos		
Cost Center Description	Title XVIII Part B 6.00	Title XIX 7.00	Title V 8.00	Title XVIII Part B 9.00	Title XIX 10.00	
Hospital Outpatient Services:	0.00	7.00	0.00	7.00	10.00	
 21.00 RURAL HEALTH CLINIC 22.00 FEDERALLY QUALIFIED HEALTH CENTER 23.00 CLINIC 24.00 EMERGENCY 25.00 OBSERVATION BEDS (NON-DISTINCT PART) 26.00 OTHER OUTPATIENT SERVICE COST CENTER 27.00 Subtotal (sum of lines 21 through 26) 	0	0 0	(0 0	24.00 25.00 26.00 27.00
28.00 Total (sum of lines 20 and 27) Cost Center Description	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents			28.00
	6.00	7.00	11.00	1		
PART II - IN AN APPROVED TEACHING PROGRAM (1	TITLE XVIII, PAR	T B INPATIENT	ROUTI NE COSTS	ONLY)		-
Hospital Inpatient Routine Services: 29.00 ADULTS & PEDIATRICS	0	0	(29.00
30.00 Swing Bed - SNF 31.00 Swing Bed - NF 32.00 INTENSIVE CARE UNIT 33.00 CORONARY CARE UNIT	0	0	C	D		30.00 31.00 32.00 33.00
34.00BURN INTENSIVE CARE UNIT35.00SURGICAL INTENSIVE CARE UNIT36.00OTHER SPECIAL CARE (SPECIFY)37.00Subtotal (sum of lines 29, and 32 through		0	(D		34. 00 35. 00 36. 00 37. 00
36) 38. 00 SUBPROVI DER – I PF 39. 00 SUBPROVI DER – I RF						38. 00 39. 00
40. 00 SUBPROVI DER						40.00

Health Financial Systems Kin	dred Hospital N	Northern Indiana	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	NS AND RESIDENT	TS Provider CCN: 152018	Period:	Worksheet D-2	
			From 09/01/2015 To 08/31/2016	Date/Time Pre 1/18/2017 2:33	
	In Approved	Total Title XVIII	Costs		
	Teachi ng				
	Program				
Cost Center Description	Amount	(to Wkst. E, Part B -)	(col. 2 + col.		
			4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COM	MPLETED ONLY IF	BOTH PARTS I AND II ARE U	SED)		
Hospi tal					
43.00 Inpatient	0		0		43.00
44.00 Outpatient					44.00
45.00 Total Hospital (sum of lines 43 and 44)	0	line 22	0		45.00
46.00 SUBPROVIDER - IPF					46.00
47.00 SUBPROVIDER - IRF					47.00
48. 00 SUBPROVI DER					48.00
49.00 SKILLED NURSING FACILITY	0	line 22	0		49.00

Health Financial Systems Kindred Hospital Norther	n Indiar	na	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 152018	Peri od:	Worksheet D-3	
			From 09/01/2015 To 08/31/2016	Date/Time Pre	nared
			10 00/01/2010	1/18/2017 2:3	2 pm
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	15, 963, 039		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		1. 4345	65 222, 720	319, 506	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1772	74 957, 468	169, 734	54.00
60. 00 06000 LABORATORY		0. 1085			
65. 00 06500 RESPI RATORY THERAPY		0. 0906			
66. 00 06600 PHYSI CAL THERAPY		0. 3143		509, 738	
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
68.00 06800 SPEECH PATHOLOGY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3755			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2585			
74. 00 07400 RENAL DI ALYSI S		0.4032	95 842, 602	339, 817	74.00
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00_09000 CLI NI C		0.0000	0 00	0	90.00
91. 00 09100 EMERGENCY		0.0000		0	
OTHER REIMBURSABLE COST CENTERS		0.0000	0	0	91.00
95. 00 09500 AMBULANCE SERVICES					95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS		0.0000	0 00	0	
200.00 Total (sum of lines 50-94 and 96-98)			16, 380, 538	3, 709, 049	
201.00 Less PBP Clinic Laboratory Services-Program only charges (li	ne 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			16, 380, 538		202.00

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 152018	Period: From 09/01/2015 To 08/31/2016	Worksheet E-1 Part I Date/Time Pre 1/18/2017 2:3	pared
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		8, 314, 5	55 0	0 0	
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	ADJUSTMENTS TO PROVIDER	11/23/2016	12, 5		0	
02				0	0	
03 04				0	0	
05				0	0	
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM	10/10/2016	1, 100, 0		0	
51				0	0	
52 53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-1, 087, 5	00	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7, 227, 0	55	0	4.
~~	TO BE COMPLETED BY CONTRACTOR					1 -
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
02				0	0	
03				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
99 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
	the cost report. (1)				-	
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		E	0 62	0	
J2 D0	Total Medicare program liability (see instructions)		7, 226, 4	-	0	
			,,220,4	Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1,00	2.00	

CULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 152018	Period: From 09/01/2015 To 08/31/2016	Date/Time Prep 1/18/2017 2:32	pared
	Title XVIII	Hospi tal	PPS	
			1 00	<u> </u>
PART IV - MEDICARE PART A SERVICES - LTCH PPS			1.00	
Net Federal PPS Payments (see instructions)			7, 193, 775	1 1.
00 Outlier Payments			436, 063	
00 Total PPS Payments (sum of lines 1 and 2)			7, 629, 838	
00 Nursing and Allied Health Managed Care payments	(see instructions)		7,027,030	
00 Organ acquisition (DO NOT USE THIS LINE)			0	5.
Cost of physicians' services in a teaching hosp	ital (see instructions)		0	
00 Subtotal (see instructions)			7, 629, 838	
00 Primary payer payments			0	
00 Subtotal (line 7 less line 8).			7, 629, 838	
00 Deductibles			24, 164	
00 Subtotal (line 9 minus line 10)			7,605,674	
00 Coinsurance			309, 722	
00 Subtotal (line 11 minus line 12)			7, 295, 952	
00 Allowable bad debts (exclude bad debts for prof	essional services) (see instructions)		120, 030	
00 Adjusted reimbursable bad debts (see instruction			78, 020	
00 Allowable bad debts for dual eligible beneficia			103, 566	
00 Subtotal (sum of lines 13 and 15)			7, 373, 972	
00 Direct graduate medical education payments (fro	m Wkst. F-4. line 49)		0	
00 Other pass through costs (see instructions)			0	
00 Outlier payments reconciliation			0	
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50 Pioneer ACO demonstration payment adjustment (s	ee instructions)		0	
99 Recovery of Accel erated Depreciation			Ő	
00 Total amount payable to the provider (see instr	ructions)		7, 373, 972	
01 Sequestration adjustment (see instructions)			147, 479	
00 Interim payments			7, 227, 055	
00 Tentative settlement (for contractor use only)			0	
00 Balance due provider/program (line 22 minus lin	es 22.01, 23 and 24)		-562	
00 Protested amounts (nonallowable cost report ite §115.2		chapter 1,	0	
TO BE COMPLETED BY CONTRACTOR				
00 Original outlier amount from Wkst. E-3, Pt IV,	line 3 (see instructions)		0	50
00 Outlier reconciliation adjustment amount (see i			0	
00 The rate used to calculate the Time Value of Mc			0.00	
00 Time Value of Money (see instructions)			0	

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 152018	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part VII Date/Time Pre 1/18/2017 2:3	epare
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR 2	KIX SERVICES		-
~~	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		0	0	1.
00	Medical and other services		0	0	
00 00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		0	0	3.
00	Inpatient primary payer payments		0	0	5.
00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES				1 1
	Reasonabl e Charges				1
00	Routi ne servi ce charges		0		8
00	Ancillary service charges		0	0	
	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
00	Total reasonable charges (sum of lines 8 through 11)		0	0	12
	CUSTOMARY CHARGES				
00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13
	basi s				
. 00	Amounts that would have been realized from patients liable for		on 0	0	14
~ ~	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
	Total customary charges (see instructions)		0	0	
. 00	Excess of customary charges over reasonable cost (complete only Line 4) (and instructions)	IT IT NE 16 exceeds	0	0	17
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 4 exceeds li		0	18
	16) (see instructions)			Ū	
. 00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see instruct	ctions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line 16))	0	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provi	ders.		
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	23
	Program capital payments		0		24
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	1 20
	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
	Deductibles		0	0	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	0	0	
	OTHER ADJUSTMENTS		0	0	
	OTHER ADJUSTMENTS		0	0	
. 00	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	Ū	39
. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
	Interim payments		0	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
					43

	Financial Systems Kindred Hospital N E SHEET (If you are nonproprietary and do not maintain	Provi der	CCN: 152018	Period: From 09/01/2015	u of Form CMS- Worksheet G	
na-t	ype accounting records, complete the General Fund column onl	y)		To 08/31/2016	Date/Time Pre 1/18/2017 2:3	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	11, 759		0 0	0	1.0
00	Temporary investments	11, 739		0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	2, 960, 977		0 0	0	4. (
00	Other receivable	3, 162		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-796, 199		0 0	0	
00 00	Inventory Prepaid expenses	128, 382 50, 762		0 0	0	
00	Other current assets	0		0 0	0	
. 00	Due from other funds	0		0 0	0	
. 00	Total current assets (sum of lines 1-10)	2, 358, 843		0 0	0	11.
	FIXED ASSETS			_		4
. 00	Land	0		0 0	0	
. 00 . 00	Land improvements Accumulated depreciation	126, 200 -63, 743		0 0	0	
. 00	Buildings	-03, 743		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	
. 00	Leasehold improvements	807, 350		0 0	0	
00	Accumulated depreciation	-520, 606		0 0	0	18.
. 00	Fixed equipment	0		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	
. 00 . 00	Automobiles and trucks Accumulated depreciation	0		0 0	0	
. 00	Major movable equipment	1, 918, 524		0 0	0	
. 00	Accumulated depreciation	-1, 226, 081		0 0	0	
00	Minor equipment depreciable	0		0 0	0	
00	Accumulated depreciation	0		0 0	0	26
00	HIT designated Assets	0		0 0	0	
00	Accumulated depreciation	0		0 0	0	
. 00	Minor equipment-nondepreciable	1 041 444		0 0	0	
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	1, 041, 644		0 0	0	30.
. 00	Investments	0		0 0	0	31.
. 00	Deposits on leases	0		0 0	0	32.
00	Due from owners/officers	0		0 0	0	
00	Other assets	3, 162, 500		0 0	0	
00	Total other assets (sum of lines 31-34)	3, 162, 500		0 0	0	
00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	6, 562, 987		0 0	0	36
00	Accounts payable	441, 387	1	0 0	0	37
00	Salaries, wages, and fees payable	383, 541		0 0	0	
00	Payroll taxes payable	12, 628		0 0	0	39
00	Notes and loans payable (short term)	0		0 0	0	
00	Deferred income	0		0 0	0	
00	Accelerated payments Due to other funds	0		0	0	42 43
00	Other current liabilities	231, 500		0 0	0	
00	Total current liabilities (sum of lines 37 thru 44)	1, 069, 056		0 0	0	
	LONG TERM LIABILITIES	, ,				
00	Mortgage payable	0		0 0	0	46.
00	Notes payable	0		0 0	0	
00	Unsecured Loans	0		0 0	0	
00 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	-8, 483, 901 -8, 483, 901		0 0	0	
00	Total liabilities (sum of lines 45 and 50)	-7, 414, 845		0 0	0	
00	CAPITAL ACCOUNTS	7, 414, 043	1	0 0	0	
00	General fund balance	13, 977, 832				52
00	Specific purpose fund			0		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0	-	56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
						1 50
00	Total fund balances (sum of lines 52 thru 58)	13, 977, 832		0 0	0	59.

STATEM	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 152018	Period: From 09/01/2015 To 08/31/2016		pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3,00	4,00	5,00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 431, 791 1, 546, 046 13, 977, 837 0 13, 977, 837 5 13, 977, 832			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING	0	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) INTERCOMPANY TRANSFERS\ROUNDING	0 0	0 0 0 0 0 0 0		0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0 0		18.00 19.00

STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 152018		iod: m 09/01/2015 08/31/2016	Worksheet G-2 Parts I & II Date/Time Pre 1/18/2017 2:3	pared
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
. 00	Hospi tal		25, 161, 0	07		25, 161, 007	
2.00	SUBPROVIDER - IPF						2.0
3.00	SUBPROVIDER - IRF						3. (
1.00	SUBPROVI DER						4.0
5.00	Swing bed - SNF			0		0	
o. 00	Swing bed - NF			0		0	
. 00	SKILLED NURSING FACILITY			0		0	1
8.00	NURSING FACILITY						8. (
9.00	OTHER LONG TERM CARE						9.0
0.00	Total general inpatient care services (sum of lines 1-9)		25, 161, 0	07		25, 161, 007	10. (
	Intensive Care Type Inpatient Hospital Services		1				
1.00	INTENSIVE CARE UNIT			0		0	
2.00	CORONARY CARE UNIT						12. (
3.00	BURN INTENSIVE CARE UNIT						13.
4.00	SURGI CAL INTENSI VE CARE UNI T						14.0
5.00	OTHER SPECIAL CARE (SPECIFY)						15.
6.00	Total intensive care type inpatient hospital services (sum of li	nes		0		0	16.
	11-15)					05 4/4 007	
7.00	Total inpatient routine care services (sum of lines 10 and 16)		25, 161, 0			25, 161, 007	
8.00	Ancillary services		26, 697, 0		0	26, 697, 093	
9.00	Outpatient services			0	0	0	
20.00				0	0	0	
21.00				0	0	0	
22.00	HOME HEALTH AGENCY AMBULANCE SERVICES			0	0	0	22.0
23.00				0	0	0	23.0
24.00	AMBULATORY SURGICAL CENTER (D. P.)						24.0
26.00	HOSPICE						26.0
27.00	OTHER (SPECIFY)			0	0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wket	51, 858, 1	00	0	51, 858, 100	
0.00	G-3, line 1)	WKSL.	51,050,1	00	0	51, 050, 100	20.0
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				13, 882, 064		29.0
30.00	ADD (SPECIFY)			0			30.0
31.00				0			31.
32.00				0			32.
3.00				0			33.
34.00				0			34.
5.00				0			35.
86.00	Total additions (sum of lines 30-35)				0		36.
7.00	DEDUCT (SPECI FY)			0			37.
8. 00				0			38.
39.00				0			39.
0.00				0			40.
1.00				0			41.
2.00	Total deductions (sum of lines 37-41)				0		42.
3.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	transfer			13, 882, 064		43.
	to Wkst. G-3, line 4)						

Heal th	Financial Systems Kindred Hospital North	hern Indiana	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 152018	Peri od:	Worksheet G-3	
			From 09/01/2015	Data /Tima Dra	oorod.
			To 08/31/2016	Date/Time Pre 1/18/2017 2:33	
				17 10/ 2017 210	- 011
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		51, 858, 100	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5		36, 895, 855	2.00
3.00	Net patient revenues (line 1 minus line 2)			14, 962, 245	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		13, 882, 064	4.00
5.00	Net income from service to patients (line 3 minus line 4)			1, 080, 181	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			746	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				0	14.00
15.00	J			0	15.00
16.00		an patients		0	16.00
17.00				0	17.00
18.00				311	18.00
19.00				0	19.00
20.00	5			0	20.00
21.00				0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			464, 808	
25.00	Total other income (sum of lines 6-24)			465, 865	
26.00	Total (line 5 plus line 25)			1, 546, 046	
27.00	OTHER EXPENSES			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			1, 546, 046	29.00