Heal th	Financial System:	s Kino	dred Hospital N	Northern Indian	а	In Lie	u of Form CMS-2	2552-10
This r	eport is required	by I aw (42 USC 1395g; 42 CFI	R 413.20(b)). F	ailure to repo	rt can result	in all interim	FORM APPROVED	
<u> </u>		beginning of the cost repor-	<u> </u>		payments (42 U	SC 1395g).	OMB NO. 0938-	0050
		EALTH CARE COMPLEX COST REPORT	RT CERTIFICATIO	DN Provider		eriod:	Worksheet S	
AND SE	TTLEMENT SUMMARY					rom 09/01/2014 o 08/31/2015		nared
					1	0 00/31/2015	1/21/2016 12:	
PART I	- COST REPORT ST	ATUS			· · ·			
Provi d	ler 1.[X]E	lectronically filed cost rep	ort			Date: 1/21/20	)16 Time: 12	2:01 pm
use on		Manually submitted cost repor						
	3. [ 0 ] I 4. [ F ] M	f this is an amended report Medicare Utilization. Enter "	enter the numb F" for full or	er of times the "L" for low.	e provider resu	ubmitted this c	ost report	
Contra	5 5		Recei ved:		10. NPR			
use on	I y (1) As	s Submitted 7. Contra ettled without Audit 8. [ N ]	actor No.	for this Provi	dor CCN 12 [ C	tractor's Vendo	or Code: olump 1 is 4: E	4 ntor
		ettled with Audit 9. [N]	Final Report f	or this Provide	er CCN		mes reopened =	
		eppened					lies reopened -	0 7.
	(4) Re (5) Am							
	(0) /							
	I - CERTIFICATION							
		LSIFICATION OF ANY INFORMATIC						
		FINE AND/OR IMPRISONMENT UND						
		ROUGH THE PAYMENT DI RECTLY O		- A KICKBACK OR	WERE OTHERWIS	E ILLEGAL, CRIM	MINAL, CIVIL AN	D
ADMI NI	STRATIVE ACTION,	FINES AND/OR IMPRISONMENT MAY	Y RESULT.					
	CERTI F	ICATION BY OFFICER OR ADMINIS	STRATOR OF PROV	/IDER(S)				
		Y that I have read the above						
		filed or manually submitted						
		red by Kindred Hospital North						
		ending 08/31/2015 and to the ete and prepared from the boo						
		except as noted. I further c						
		alth care services, and that						
		such laws and regulations.				t were provide	u in	
		i odon rano and rogaratronor						
			(Si gn	(he				
			(Si gii	·	er or Administ	rator of Provic	ler(s)	
				01110				
				Title				
				Date				
				Title				
	Cost Center	Description	Title V	Part A	Part B	HIT	Title XIX	
			1.00	2.00	3.00	4.00	5.00	
1 00	PART III - SETTLE		0	20, 142	1	0	1 7/0	1 00
1.00 2.00	Hospital Subprovider - IP	-	0	29, 143 0	1 0	0	4, 760 0	1.00 2.00
2.00	Subprovider - TR		0	0	0		0	2.00
3.00 5.00	Swing bed - SNF		0	0	0		0	5.00
6.00	Swing bed - NF		0	U	0		0	6.00

200.00 Total 29, 143 0 0 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.

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7.00

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4, 760 200. 00

7.00 SKILLED NURSING FACILITY

PLD	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DAT	A	Provi o	der CCN:	152018	Period: From 09/0	1/2014	Workshe Part I	et S-2	
									Date/Ti		
	1.00	2.0	00	3	. 00			4.00	1/21/20	16 11:	13 a
-	Hospital and Hospital Health Care Co							1100			
	Street: 215 W 4th St, Ste 200	P0 Box:									1
0	City: Mishawaka	State: IN		p Code:			ty: St. Jo:				2
		Component Nam		CCN   mber	CBSA Number	Provi del Type	- Date Certifie		ent Syste , 0, or		
								V	XVIII	XIX	1
	r	1.00	2	. 00	3.00	4.00	5.00	6.00	) 7.00	8.00	
	Hospital and Hospital-Based Componen		10	2010	40700	2	00 (04 (20)			0	
0	•	Kindred Hospital Northern Indiana	15	2018	43780	2	08/04/200	00 N	P	0	3
0	Subprovider - IPF										4
	Subprovider - IRF										5
	Subprovider - (Other)										6
	Swing Beds - SNF										7
	Swing Beds - NF Hospital-Based SNF										8
	Hospi tal -Based NF										10
00	Hospi tal -Based OLTC										11
00	Hospital-Based HHA										12
	Separately Certified ASC										13
	Hospi tal -Based Hospi ce										14
00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15   16
00	Hospital-Based (CMHC) I										17
	Renal Dialysis									1	18
00	Other										19
							Fro		To:		-
00	Cost Reporting Period (mm/dd/yyyy)						09/01		2.0 08/31/		20
	Type of Control (see instructions)						07701	4		2010	21
	Inpatient PPS Information										1
00	Does this facility qualify and is it								N		22
	share hospital adjustment, in accorda										
	for yes or "N" for no. Is this facili amendment hospital?) In column 2, en <sup>.</sup>				.06(C)(	2) (PI CKI 6					
01	Did this hospital receive interim und				cost re	eporting	N		N		22
	period? Enter in column 1, "Y" for ye		2			. 0					
	reporting period occurring prior to (										
	for no for the portion of the cost re (see instructions)	eporting period oc	curring or	n or af	ter Octo	ober 1.					
02	is this a newly merged hospital that	requires final un	compensate	ed care	paymen	ts to be	N		N		22
	determined at cost report settlement										
	or "N" for no, for the portion of the										
	in column 2, "Y" for yes or "N" for i	no, for the portio	on of the o	cost re	porting	period o	n				
	or after October 1. Did this hospital receive a geographi	c reclassificatio	n from ur	an to	rural a	a rosul	t N		N		22
	of the OMB standards for delineating								11		22
	in column 1, "Y" for yes or "N" for i	no for the portion	n of the co	ost rep	orting p	oeri od					
	prior to October 1. Enter in column 2						ie				
	cost reporting period occurring on o		•		,		- h				
	hospital contain at least 100 but no <sup>.</sup> 42 CFR 412.105)? Enter in column 3, '			unted I	n accord	Jance wit	.n				
	Which method is used to determine Me			/or 25	bel ow?	n columr	1	2	N		23
	1, enter 1 if date of admission, 2 in										
	method of identifying the days in thi										
	used in the prior cost reporting peri	<u>od? In column 2,</u>	In-State	In-Sta		<u>ut-of</u>	0ut-of	Medi ca	d Ot	her	
			Medi cai d	Medica		State	State	HMO da		i cai d	
			paid days	eligib	ole Me	di cai d	Medi cai d		da	ays	
				unpai		d days	eligible				
			1.00	days		2.00	unpai d	F 01		00	
00	If this provider is an IPPS hospital,	enter the	1.00	2.00	0	3.00	4.00	5.00	0 6.	. 00 0	24
	in-state Medicaid paid days in colum		0		7	9	0			J	24
	Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co										
	out-of-state Medicaid eligible unpaid										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in If this provider is an IRF, enter the		0		0	o	o		o		25
	Medicaid paid days in column 1, the i		0		7	9	0				20
	Medicaid eligible unpaid days in colu										
					1						
	out-of-state Medicaid days in column										
	out-of-state Medicaid days in column Medicaid eligible unpaid days in colu HMO paid and eligible but unpaid days	umn 4, Medicaid									

			lorthern Indian	a	1	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der		eriod: rom 09/01/ p 08/31/		Workshe Part I Date/Ti 1/21/20	me Pre	pared:
					Urban/Rur 1.00			Geogr	
26.00	Enter your standard geographic classification (not			ginning of the	1.00	1	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" f Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban	wage) sta or "2" fo	atus at the end or rural. If ap	d of the cost oplicable,		1			27.00
35.00	enter the effective date of the geographic reclassi If this is a sole community hospital (SCH), enter t effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00	-	Endi ng: 2.00		
36.00	Enter applicable beginning and ending dates of SCH of periods in excess of one and enter subsequent da		Subscript line	36 for number					36.00
	If this is a Medicare dependent hospital (MDH), entiss in effect in the cost reporting period.	er the nu				0			37.00
38.00	If line 37 is 1, enter the beginning and ending dat greater than 1, subscript this line for the number enter subsequent dates.								38.00
								N )O	
39.00	Does this facility qualify for the inpatient hospit hospitals in accordance with 42 CFR §412.101(b)(2)( or "N" for no. Does the facility meet the mileage r CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for ye	(ii)? Énte requiremen	er in column 1 nts in accordar	"Y" for yes nce with 42	1.00 N		N		39.00
40.00	Is this hospital subject to the HAC program reducti "N" for no in column 1, for discharges prior to Oct no in column 2, for discharges on or after October	on adjus <sup>.</sup> ober 1. l	tment? Enter "\ Enter "Y" for y	(" for yes or	N		N		40. 00
						V 1.00	XVIII 2.00	XI X 3.00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paym	ont for	di oproporti opot	to oboro in oos	ardanaa	N	N	N. 00	45.00
	with 42 CFR Section §412.320? (see instructions)								
46.00	Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete WHPt. III.	st. L, P	t. III and Wkst	t. L-1, Pt. I t	hrough	N	N	N	46.00
47.00 48.00	Is this a new hospital under 42 CFR §412.300 PPS ca Is the facility electing full federal capital payme Teaching Hospitals				10.	N N	N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents i or "N" for no.	n approve	ed GME programs	s? Enter "Y" f	for yes	N			56.00
57.00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" f is "Y" did residents start training in the first mo for yes or "N" for no in column 2. If column 2 is	for yes ou onth of th "Y", comp	r "N" for no ir his cost report plete Worksheet	n column 1. If ting period? E	column 1 Inter "Y"				57.00
58.00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. If line 56 is yes, did this facility elect cost rei defined in CMS Pub. 15-1, chapter 21, §2148? If yes	mburseme	nt for physicia	ans' services a	IS				58.00
	Are costs claimed on line 100 of Worksheet A? If y Are you claiming nursing school and/or allied healt					N N			59.00 60.00
00.00	provider-operated criteria under §413.85? Enter ")	/" for yes	<u>s or "N" for no</u>	<u>p. (see instruc</u>			Discost	CHE	00.00
		Y/N	IME	Direct GME	IME		Di rect		
61.00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	0.00	5. C		61.00
(1.01	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		0.00	0.00					61.01
01.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					01.01
61. 02	instructions) Enter the current year total unweighted primary car FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	ге	0.00	0.00					61.02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see	-	0.00	0.00					61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61. 04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (lin	he	0. OC	0.00					61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00					61.06

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DA	ТА	Provi der	F	Period: rom 09/01/2014 o 08/31/2015	Worksheet S-2 Part I Date/Time Pre 1/21/2016 11:	pared:
		Progran	Name	Program Code	Unweighted IME FTE Count		
		1.0	0	2.00	3.00	4.00	
<ul> <li>1.10 Of the FTEs in line 61.05, specify each specialty, if any, and the number of F for each new program. (see instruction column 1, the program name, enter in column 3, the l unweighted count and enter in column 4, FTE unweighted count.</li> <li>1.20 Of the FTEs in line 61.05, specify each program specialty, if any, and the num residents for each expanded program. (instructions) Enter in column 1, the p enter in column 2, the program code, each expanded program. (a, direct GME FTE unweighted count.</li> </ul>	TE residents s) Enter in olumn 2, the ME FTE , direct GME h expanded ber of FTE see rogram name, nter in column				0.00		61.
						1.00	
ACA Provisions Affecting the Health Re					od for which	0.00	62
2.00 Enter the number of FTE residents that your hospital received HRSA PCRE fundi			uns cost	reporting per	IOU IOI WHICH	0.00	62.
.01 Enter the number of FTE residents that during in this cost reporting period o Teaching Hospitals that Claim Resident	rotated from a f HRSA THC prog	a Teaching H gram. (see i			your hospital	0.00	62.
8.00 Has your facility trained residents in "Y" for yes or "N" for no in column 1.	nonprovider se	ettings duri		instructions)	'	N	63.
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	<u></u>			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE period that begins on or after July 1,				This base year	is your cost r	eporting	
4.00 Enter in column 1, if line 63 is yes, in the base year period, the number of resident FTEs attributable to rotation settings. Enter in column 2 the numbe resident FTEs that trained in your hos of (column 1 divided by (column 1 + co	or your facilit unweighted non s occurring in r of unweighted pital. Enter in lumn 2)). (see	trained r p-primary ca all nonprov non-primar n column 3 t	esidents re ider y care he ratio	0.00			
Pr	ogram Name	Progran	Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.0	0	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column				0.00	0.00	0. 000000	

	nancial Systems		pital North			١n	Li eu	of Form CMS-2	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE COMPI	_EX IDENTIFICATION DA	ΤA	Provi der	F	Period: From 09/01/2 To 08/31/2		Worksheet S-2 Part I Date/Time Pre 1/21/2016 11:	pared:
					Unweighted FTEs Nonprovider Site	Unweight FTEs ir Hospita	n	Ratio (col. 1/ (col. 1 + col. 2))	
Sec	ction 5504 of the ACA Current	Year FTE Residents in	n Nonprovide	er Setting	1.00 sEffective f	<u>2.00</u> or cost rep	ortir	3.00 ng periods	
66.00 Ent FTE Ent FTE	ginning on or after July 1, 20 ter in column 1 the number of Es attributable to rotations o ter in column 2 the number of Es that trained in your hospit olumn 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	i ngs. dent	0.00		0. 00	0. 000000	66.00
(00		Program Name	Program		Unweighted FTEs Nonprovider Site	Unweight FTEs ir Hospita	n	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00 5.1		1.00	2.0	00	3.00	4.00	0.00	5.00	(7.00
nan you whi Ent cor nun car to nor col unw ress you 5, di \	ter in column 1, the program me associated with each of ur primary care programs in ch you trained residents. ter in column 2, the program de. Enter in column 3, the mber of unweighted primary re FTE residents attributable rotations occurring in all n-provider settings. Enter in umn 4, the number of weighted primary care sident FTEs that trained in ur hospital. Enter in column the ratio of (column 3 vided by (column 3 + column ). (see instructions)				0.00		0.00	0. 000000	67.00
						_	1 00	2.00 2.00	
Int	patient Psychiatric Facility P	PS					1.00	2.00 3.00	
70.00 Is	this facility an Inpatient Ps	ychiatric Facility (I	PF), or doe	s it conta	ain an IPF subp	provi der?	Ν		70.00
71.00 If rec 42 prc Col (se	ter "Y" for yes or "N" for no line 70 yes: Column 1: Did th cent cost report filed on or b CFR 412.424(d)(1)(iii)(c)) Co ogram in accordance with 42 CF umn 3: If column 2 is Y, indi ee instructions) patient 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 ye residents "Y" for ye	es or "N" for i in a new teacl es or "N" for i	no. (see hi ng no.		0	71.00
75.00 Is	this facility an Inpatient Re	habilitation Facility	y (IRF), or	does it co	ontain an IRF		N		75.00
76.00 If rec no. CFF	oprovider? Enter "Y" for yes line 75 yes: Column 1: Did th cent cost reporting period end Column 2: Did this facility R 412.424 (d)(1)(iii)(D)? Ente dicate 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 of in accordance column 2 is Y	r "N" for with 42		0	76.00
							ŀ	1.00	
80.00 Is 81.00 Is "Y"	ng Term Care Hospital PPS this a long term care hospita this a LTCH co-located within ' for yes and "N" for no.					period? En	ter	Y N	80. 00 81. 00
85.00 Is 86.00 Dic	FRA Providers this a new hospital under 42 d this facility establish a ne 13.40(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"		Ν	87.00
for	r yes or "N" for no.					V		XIX	
						1.00		2.00	
90.00 Doe	tle V and XIX Services es this facility have title V		hospital se	rvi ces? Ei	nter "Y" for	N		Y	90.00
91.00 Ís	s or "N" for no in the applica this hospital reimbursed for	title V and/or XIX th				N		N	91.00
	or in part? Enter "Y" for y e title XIX NF patients occupy							N	92.00
i ns	structions) Enter "Y" for yes es this facility operate an IC	or"N" for no in the	appl i cabl e	column.		N		N	93.00
" Y"	' for yes or "N" for no in the	applicable column.							
	es title V or XIX reduce capit blicable column.	ai cost? Enter "Y" fo	yes, and	N TOP N	o in the	N		Ν	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	hern Indiar Provider	CCN: 152018	Peri od:	n Lieu	J of Form CMS- Worksheet S-2	
		0011. 102010	From 09/01/ To 08/31/		Part I Date/Time Pre	epared:
			V		1/21/2016 11: XI X	<u>13 am</u>
95.00 If line 94 is "Y", enter the reduction percentage in the applic		-	1.00		2.00	95.00
<ul> <li>95.00 If line 94 is "Y", enter the reduction percentage in the applic</li> <li>96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.</li> </ul>			N	0. 00	N 0. 00	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the applic Rural Providers	able column	ו.		0. 00	0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inc		nod of paymen	nt N			105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost re training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 reimbursed. If yes complete Wkst. D-2, Pt. II.	(see inst	ructions) If	t			107.00
108.00 Is this a rural hospital qualifying for an exception to the CRN CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	IA fee schee	dule? See 42	N			108.00
	Physi cal 1.00	Occupationa 2.00	I Speec 3.00		Respi ratory 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		N	109.00
					1.00	
110.00 Did this hospital participate in the Rural Community Hospital D the current cost reporting period? Enter "Y" for yes or "N" for		on project (4	10A Demo)fo	r	N	110.00
				1.00	2.00 3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N is yes, enter the method used (A, B, or E only) in column 2. If 3 either "93" percent for short term hospital or "98" percent f psychiatric, rehabilitation and long term hospitals providers)	column 2 i for long ter	s "E", enter rm care (incl	in column udes	N	0	115.00
Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for 117.00 Is this facility legally-required to carry malpractice insuranc			"N" for	N Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policy claim-made. Enter 2 if the policy is occurrence.	? Enter 1 i	f the policy	is	1		118.00
		Premi ums	Losse	S	Insurance	
		1.00	2.00		2.00	-
118.01 List amounts of malpractice premiums and paid losses:			2.00			
		26, 2		0	3.00 45,812	2 118. 01
		26, 2		0		2 118. 01
Administrative and General? If yes, submit supporting schedule		than the	96	0	45, 812	2 118. 01 - 118. 02
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00D NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments?	e listing co mrmless prov Jumn 1, "Y' fies for th	than the ost centers vision in ACA ' for yes or ne Outpatient	96 1.00 N	0	45, 812	118. 02
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.	e listing co nrmless prov plumn 1, "Y" fies for th Y (see instr	than the ost centers /ision in ACA ' for yes or ne Outpatient ructions)	96 1.00 N	0	45, 812 2.00	_
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for y	elisting co nrmless prov Jumn 1, "Y fies for th (see instr ble devices	than the ost centers /ision in ACA ' for yes or ne Outpatient ructions) s charged to	96 1.00 N	0	45, 812 2.00	118. 02 119. 00 120. 00
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter	e listing co numless prov olumn 1, "Y' fies for th c (see instr able devices res and "N"	than the ost centers ' for yes or ne Outpatient ructions) s charged to	96 1.00 N N N	0	45, 812 2.00	118. 02 119. 00 120. 00 121. 00
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. 125.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	e listing co ormless prov olumn 1, "Y' fies for th (see instr ble devices res and "N"	than the ost centers ' for yes or ne Outpatient ructions) s charged to for no. If fication date	96 1.00 N N N	0	45, 812 2.00	118. 02 119. 00 120. 00 121. 00 125. 00
<ul> <li>Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> </ul>	e listing co ormaless prov- olumn 1, "Y' fies for the (see instru- ble devices res and "N" the certifi	than the ost centers ' for yes or ne Outpatient ructions) s charged to for no. If fication date cation date	96 1.00 N N N	0	45, 812 2.00	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00
<ul> <li>Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> </ul>	e listing co urmless prov- olumn 1, "Y fies for th (see instr ble devices res and "N" the certifi the certifi he certific	than the ost centers ' for yes or ne Outpatient ructions) s charged to for no. If fication date cation date cation date i	96 1.00 N N N N	0	45, 812 2.00	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00
<ul> <li>Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified liver transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> </ul>	e listing co ormaless prov- olumn 1, "Y' fies for the construction (see instru- ble devices res and "N" the certific the certific the certific the certific the certific the certific the certific the certific	than the ost centers ' for yes or ne Outpatient ructions) s charged to for no. If fication date cation date cation date i tification	96 1.00 N N N N	0	45, 812 2.00	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00
<ul> <li>Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>121.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified liver transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>120.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>120.00 If this is a Medicare certified liver transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>120.00 If this is a Medicare certified liver transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified intestinal transplant center, enter that in column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified intestinal transplant center, enter that in column 1 and termination date, if applicable, in column 2.</li> </ul>	e listing co mmless prov- olumn 1, "Y' fies for the constru- able devices res and "N" the certific the certific the certific the certific er the certific action the certific action the certific the certific the certific the certific the certific the certific the certific the certific the certific the certific	than the ost centers 'for yes or ne Outpatient ructions) s charged to for no. If fication date cation date cation date i tification ertification	96 1.00 N N N N	0	45, 812 2.00	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00
<ul> <li>and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha \$3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA \$3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>121.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lug transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter to column 1 and termination date, if applicable, in column 1.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter to column 1 and termination date, if applicable, in column 1.</li> <li>131.00 If this is a Medicare certified intestinal transplant center, enter to column 1 and termination date, if applicable, in column 1.</li> <li>132.00 If this is a Medicare certified intestinal transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> </ul>	e listing co ummless prov- olumn 1, "Y' fies for the (see instru- ble devices res and "N" the certific the certific the certific the certific er the certific a 2. the certific	than the ost centers ' for yes or he Outpatient ructions) s charged to for no. If fication date cation date cation date i tification ertification cation date	96 1.00 N N N N	0	45, 812 2.00	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00 132. 00
<ul> <li>Administrative and General? If yes, submit supporting schedule and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with &lt; 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for y yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified lung transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified lung transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified lung transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter to column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified intestinal transplant center, enter to column 1 and termination date, if applicable, in column 3.</li> <li>131.00 If this is a Medicare certified intestinal transplant center, enter to column 1 and termination date, if applicable, in column 3.</li> </ul>	e listing co mmless prov- olumn 1, "Y' fies for the content of the second res and "N" the certific the certific the certific er the certific enter the certific the certific the certific the certific	than the ost centers 'ision in ACA 'for yes or ne Outpatient ructions) s charged to for no. If fication date cation date cation date i tification ertification cation date cation date	96 1.00 N N N N	0	45, 812 2.00	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00

Health Financial Systems	Kindred Hospital No	rthern Indiana		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provider CC		eriod:	Worksheet S-2	
				rom 09/01/2014 o 08/31/2015	Part I Date/Time Pre	pared:
					1/21/2016 11:	
				1.00	2.00	-
All Providers					2100	
140.00 Are there any related organization or				Y	189003	140.00
chapter 10? Enter "Y" for yes or "N" f are claimed, enter in column 2 the hom						
1.00	2.00			3.00		
If this facility is part of a chain or				me and address	of the	
home office and enter the home office 141.00 Name: KINDRED HEALTHCARE OPERATING	Contractor name and cor			's Number 0590	1	141.00
I NC.		VICES		3 Number . 0070		
142.00 Street: 680 SOUTH FOURTH AVENUE	PO Box:					142.00
143.00 City: LOUI SVI LLE	State: KY		Zip Code:	4020	2	143.00
					1.00	-
144.00 Are provider based physicians' costs i	ncluded in Worksheet A?	?			Y	144.00
				1.00	2.00	-
145.00 If costs for renal services are claime	d on Wkst A line 74	are the costs i	for	1.00 Y	2.00	145.00
inpatient services only? Enter "Y" for	yes or "N" for no in c	column 1. If col	lumn 1 is			
no, does the dialysis facility include		for this cost re	eporting			
period? Enter "Y" for yes or "N" for 146.00 Has the cost allocation methodology ch		sly filed cost i	report?	N		146.00
Enter "Y" for yes or "N" for no in col						
yes, enter the approval date (mm/dd/yy	yy) in column 2.					
					1.00	-
147.00 Was there a change in the statistical					N	147.00
148.00 Was there a change in the order of all					N	148.00
149.00 Was there a change to the simplified c	cost finding method? Ent	Part A	or "N" for r Part B	no. Title V	N Title XIX	149.00
		1.00	2.00	3.00	4.00	
Does this facility contain a provider						
or charges? Enter "Y" for yes or "N" f 155.00Hospital	for no for each componer	<u>nt for Part A a</u> N	<u>nd Part B. (</u> S N	See 42 CFR §413	. 13) N	155.00
156.00 Subprovi der – IPF		N	N	N	N	156.00
157.00 Subprovi der – IRF		N	Ν	N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N	N	N	N	158.00 159.00
160.00 HOME HEALTH AGENCY		N	N	N	N	160.00
161.00 CMHC			N	N	N	161.00
					1.00	-
Multicampus					1.00	
165.00 Is this hospital part of a Multicampus	hospital that has one	or more campuse	es in differe	ent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State Zip	Code CBSA	FTE/Campus	
	0	1.00		00 4.00	5.00	
166.00 If line 165 is yes, for each					0.00	166. 00
campus enter the name in column O, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions) 166.01					0.00	166. 01
166.02						166. 02
166.03					0.00	166. 03
					1.00	-
Health Information Technology (HIT) ir				Act		
167.00 Is this provider a meaningful user und					N	167.00
168.00 If this provider is a CAH (line 105 is reasonable cost incurred for the HIT a			10/ IS "Y"),	enter the	C	168.00
168.01 If this provider is a CAH and is not a	meaningful user, does	this provider of		a hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Ent				///		140.00
169.00 If this provider is a meaningful user transition factor. (see instructions)	(THE TOP IS I ) and I	S HUL A CAM (11		, enter the	0.00	169. 00

Health Financial Systems	Kindred Hospital North	nern Indiana	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	DENTIFICATION DATA	Provider CCN: 152018	Period:	Worksheet S-2	2
			From 09/01/2014 To 08/31/2015		narod
			10 00/31/2013	1/21/2016 11:	13 am
			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)	nning date and ending date	for the reporting			170.00
				1.00	
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst.				Ν	171.00
(see instructions)					

PI T/	Financial Systems Kinc AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	dred Hospital Nor STIONNAIRE		CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Date/Time Pr	2 epared
	· · · · · · · · · · · · · · · · · · ·				Y/N	1/21/2016 11 Date	: 13 ar
					1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Drawider Oracei action and Operation	onses. Enter N fo	r all NO re	esponses. Ente	er all dates in <sup>.</sup>	the	_
0	<u>Provider Organization and Operation</u> Has the provider changed ownership immediatel reporting period? If yes, enter the date of t				N		1.
				Y/N	Date 2.00	V/I 3.00	
0	Has the provider terminated participation in	the Medicare Prod	ram?lf	1.00 N	2.00	3.00	2.
	yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.	n and in column 3	8, "V" for				
0	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f	, chain home offi l to the provider , or members of t	ces, drug or its he board	Y			3.
	relationships? (see instructions)	-		Y/N	Turpo	Date	
				1.00	Type 2.00	3.00	
	Financial Data and Reports						_
D	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for enter date availa	Compiled,	Y	A	03/31/2016	4.
0	Are the cost report total expenses and total		nt from	N			5.
	those on the filed financial statements? If y	es, submit recond	iliation.		Y/N	Logal Oper	
					1.00	Legal Oper. 2.00	
С	Approved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	ol?Column 2: If	<sup>°</sup> yes, is th	ne provider is	5 N		6.
с С	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	rams approved and		during the	N N		7
o l	cost reporting period? If yes, see instructic Are costs claimed for Interns and Residents i	ns. n an approved gra	duate medic	al education	N		9
00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr		enewed in t	he current	N		10
00	cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center	s other than I &	R in an App	proved	Ν		11.
	Teaching Program on Worksheet A? If yes, see	Thstructions.				Y/N	
	Bad Debts					1.00	_
	Is the provider seeking reimbursement for bad	l debts? If yes, s	ee instruct	i ons.		Y	12.
00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	t collection poli	cy change c	luring this co	ost reporting	N	13.
00	If line 12 is yes, were patient deductibles a	nd/or co-payments	s wai ved? I f	<sup>°</sup> yes, see ins	structions.	N	14.
	Bed Complement					N	115
00 ]	Did total beds available change from the pric	or cost reporting	periou? II	1	art A	N Part B	15.
		Descripti	on	Y/N	Date	Y/N	
	PS&R Data	0		1.00	2.00	3.00	
	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			Y	11/30/2015	Y	16.
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			N		Ν	17.
00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional			N		N	18.
	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			NI		N	19
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		N	20.

	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der CC		Period: From 09/01/2014 To 08/31/2015	Date/Time Pre 1/21/2016 11:	epare
		Decerinti		Pa	art A	Part B Y/N	
		Descripti 0	on	1.00	Date 2.00	3.00	
р	Was the cost report prepared only using the provider's records? If yes, see nstructions.	0		N	2.00	N N	21.
						1.00	
	OMPLETED BY COST REIMBURSED AND TEFRA HOSPIT apital Related Cost	ALS UNLY (EXCEPT	CHILDRENS HUS	PITALS)			-
	lave assets been relifed for Medicare purpose	es?lfves.seeir	nstructions				22.
00 H	ave changes occurred in the Medicare depreci reporting period? If yes, see instructions.			s made duri	ng the cost		23.
	Were new leases and/or amendments to existing fyes, see instructions	g leases entered i	nto during th	is cost rep	oorting period?		24
i i	lave there been new capitalized leases entere nstructions.	0		0 1	5		25
i i	Vere assets subject to Sec.2314 of DEFRA acquinstructions.	0			5		26
С	Has the provider's capitalization policy char popy. ptoract Exponse	igea auring the co	st reporting	period? If	yes, submit		27
oo 🛛	nterest Expense Were new Loans, mortgage agreements or Letten Deriod? If yes, see instructions.	rs of credit enter	ed into durin	g the cost	reporting		28
20 D	bid the provider have a funded depreciation account? If			Service Re	eserve Fund)		29
о н	las existing debt been replaced prior to its nstructions.			bt? If yes,	see		30
i	las debt been recalled before scheduled matur nstructions.	rity without issua	nce of new de	bt? If yes,	see		31
	urchased Services					1	
	lave changes or new agreements occurred in pa arrangements with suppliers of services? If v			through con	itractual		32.
00   I · n	fline 32 is yes, were the requirements of 5 no, see instructions.			to competit	ive bidding? If	N	33
	rovi der-Based Physi ci ans						
	Are services furnished at the provider facili	ty under an arrar	ngement with p	rovi der-bas	ed nhysicians?		
	f yes, see instructions. f line 34 is yes, were there new agreements		5 1		sea physicians:	N	34
		or amondod ovisti		with the r	1 5		
00 I <sup>-</sup>	5		ng agreements	with the p	1 5	N	
00 I <sup>-</sup>	physicians during the cost reporting period?		ng agreements	; with the p	1 5		34 35
00   I  p	physicians during the cost reporting period?		ng agreements	; with the p	provi der-based	N	
00   1  p   Hc	ohysicians during the cost reporting period? ome Office Costs	lf yes, see instr	ng agreements	; with the p	Y/N 1.00	N Date	35
1 00 1 9 1 9 1 9 1 9 0 0 1	one Office Costs Were home office costs claimed on the cost re fline 36 is yes, has a home office cost sta	<u>If yes, see instr</u> eport?	ng agreements ructions.		provi der-based	N Date	35
Hc 00 1 00 1 00 1 00 1 00 1 00 1 00 1	ome Office Costs Were home office costs claimed on the cost re f line 36 is yes, has a home office cost sta f yes, see instructions. f line 36 is yes , was the fiscal year end of	If yes, see instr eport? atement been prepa	ng agreements ructions. ared by the ho	ome office?	Y/N 1.00 Y	N Date	35 36 37
Hc DO Hc Hc DO Hc Hc DO Hc Hc DO Hc Hc Hc DO Hc Hc Hc Hc Hc Hc Hc Hc Hc Hc	ome Office Costs Were home office costs claimed on the cost re f line 36 is yes, has a home office cost sta f yes, see instructions. f line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the to f line 36 is yes, did the provider render see	If yes, see instr eport? atement been prepa of the home office fiscal year end of	ng agreements ructions. ared by the ho e different fr f the home off	ome office? rom that of Tice.	Y/N 1.00 Y Y Y Y	N Date 2.00	35 36 37 38
00   1 p 00   4 00   1 00   1 1 00   1 5 00   1	ome Office Costs Were home office costs claimed on the cost re f line 36 is yes, has a home office cost sta f yes, see instructions. f line 36 is yes , was the fiscal year end of the provider? If yes, enter in column 2 the fi	If yes, see instr eport? atement been prepa of the home office fiscal year end of ervices to other c	ared by the ho different fr the home off chain componen	ome office? Toom that of Tice. Tice.	Y/N 1.00 Y Y Y Y	N Date 2.00	35 36 37 38 39
DO     I       pl       pl       DO     Ho       DO     I	ome Office Costs Were home office costs claimed on the cost re f line 36 is yes, has a home office cost sta f yes, see instructions. f line 36 is yes , was the fiscal year end of the provider? If yes, enter in column 2 the f f line 36 is yes, did the provider render se see instructions. f line 36 is yes, did the provider render se state instructions.	If yes, see instr eport? atement been prepa of the home office fiscal year end of ervices to other c	ared by the ho different fr the home off chain componen	ome office? Tom that of Tice. Its? If yes,	Y/N 1.00 Y Y Y Y N N	N Date 2.00	
DO         I         pl           DO         Hc         pl           DO         W         l         l           DO         I         l </td <td>ome Office Costs Were home office costs claimed on the cost re f line 36 is yes, has a home office cost sta f yes, see instructions. f line 36 is yes , was the fiscal year end of the provider? If yes, enter in column 2 the to f line 36 is yes, did the provider render se see instructions. f line 36 is yes, did the provider render se</td> <td>If yes, see instr eport? atement been prepa of the home office fiscal year end of ervices to other of ervices to the hom ervices to the hom</td> <td>ared by the ho e different fr the home off chain componen ne office? If</td> <td>ome office? Tom that of Tice. Its? If yes,</td> <td>Y/N 1.00 Y Y Y Y N N</td> <td>N Date 2.00 12/31/2015</td> <td>35 36 37 38 39</td>	ome Office Costs Were home office costs claimed on the cost re f line 36 is yes, has a home office cost sta f yes, see instructions. f line 36 is yes , was the fiscal year end of the provider? If yes, enter in column 2 the to f line 36 is yes, did the provider render se see instructions. f line 36 is yes, did the provider render se	If yes, see instr eport? atement been prepa of the home office fiscal year end of ervices to other of ervices to the hom ervices to the hom	ared by the ho e different fr the home off chain componen ne office? If	ome office? Tom that of Tice. Its? If yes,	Y/N 1.00 Y Y Y Y N N	N Date 2.00 12/31/2015	35 36 37 38 39
000	ome Office Costs Were home office costs claimed on the cost re f line 36 is yes, has a home office cost sta f yes, see instructions. f line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the to f line 36 is yes, did the provider render se see instructions. f line 36 is yes, did the provider render se nstructions. ost Report Preparer Contact Information Enter the first name, last name and the title	If yes, see instr eport? atement been prepa of the home office fiscal year end of ervices to other c ervices to the hom e/position 1, 2, and 3,	ng agreements suctions. ared by the ho e different fr the home off chain componen ne office? If 1.00	ome office? rom that of fice. hts? If yes, f yes, see	Y/N 1.00 Y/N Y Y Y N N N HOURI GAN	N Date 2.00 12/31/2015	35 36 37 38 39 40

Heal th	Financial Systems Kin	dred Hospital N	lorthern India	ana	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	- CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet S-2 Part II Date/Time Pre 1/21/2016 11:	epared:
		Part B					
		Date					
		4.00					
	PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see	11/30/2015					16.00
17.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						18.00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						19.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.00
		-	3	. 00			
	Cost Report Preparer Contact Information		5				
	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		REIMBURSEMENT	DI RECTOR			41.00
42.00	Enter the employer/company name of the cost r preparer.	report					42.00
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.00

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 152018		eriod: com 09/01/2014 o 08/31/2015	Worksheet S Part I Date/Time F 1/21/2016	Pre	pare
	Component	Worksheet A	No.	of Beds	Bed Days			I/P Days / C <u>Visits / Tri</u> Title V		
		Line Number		2.00	Avai I abl e		4.00	F 00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1.00		2.00	3.00	00	4.00	5.00	0	1.
. 00 . 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	30.00		32	11,0	00	0.00		U	2.
00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF								0	4. 5.
. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF								0	6
. 00	Total Adults and Peds. (exclude observation			32	11, 6	80	0.00		0	7
. 00	beds) (see instructions) INTENSIVE CARE UNIT	31.00		0		0	0.00		0	8
00	CORONARY CARE UNI T									9
. 00	BURN INTENSIVE CARE UNIT									10
1.00 2.00	SURGI CAL I NTENSI VE CARE UNI T									11
2.00 3.00	OTHER SPECIAL CARE (SPECIFY) NURSERY									13
1.00	Total (see instructions)			32	11, 6	80	0.00		0	14
5.00	CAH visits			02			0100		0	15
. 00	SUBPROVIDER - IPF								-	16
. 00	SUBPROVIDER - IRF									17
. 00	SUBPROVI DER				1					18
. 00	SKILLED NURSING FACILITY	44.00		0		0			0	19
. 00	NURSING FACILITY									20
. 00	OTHER LONG TERM CARE									21
2. 00	HOME HEALTH AGENCY									22
. 00	AMBULATORY SURGICAL CENTER (D. P. )									23
. 00	HOSPI CE									24
. 10	HOSPICE (non-distinct part)	30. 00								24
5.00	CMHC – CMHC RURAL HEALTH CLINIC									25 26
5.00 5.25	FEDERALLY QUALIFIED HEALTH CENTER									26
7.00	Total (sum of lines 14-26)			32						27
3.00	Observation Bed Days			52					0	28
). 00 ). 00	Ambul ance Trips								5	29
. 00	Employee discount days (see instruction)									30
. 00	Employee discount days - IRF									31
2. 00	Labor & delivery days (see instructions)			0		0				32
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)									32
2 00	LTCH non-covered days									33

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der		Period: From 09/01/2014 To 08/31/2015	Worksheet S-3 Part I Date/Time Pre 1/21/2016 11:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	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 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	6, 665	2				1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	577	28				2.00
2.00 3.00	HMO IPF Subprovider	0	28				3.00
3.00 4.00	HMO I RF Subprovider	0	0				4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed Ski Hospital Adults & Peds. Swing Bed NF	0	0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6, 665	2	8, 97	-		7.00
8.00	INTENSIVE CARE UNIT	0	0		0		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	6, 665	2	8, 97	1 0.00	87.00	
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF	-			-		16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0		0.00	0, 00	
20.00	NURSING FACILITY		0		0.00	0100	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		0		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	87.00	
28.00	Observation Bed Days		0		0		28.00
29.00	Ambul ance Trips	0	0				29.00
30.00	Employee discount days (see instruction)	Ű			0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	0		0		32.00
32.00	Total ancillary labor & delivery room	Ŭ	0		Ő		32.00
02.01	outpatient days (see instructions)						52.01
22 00	LTCH non-covered days	42					33.00

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet S-3 Part I Date/Time Pre 1/21/2016 11:	pared:
		Full Time Equivalents	·	Di s	scharges		
	Component	Nonpai d 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	2	61 1	367	1.00
2.00 3.00 4.00 5.00 6.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF				25 3 0 0		2.00 3.00 4.00 5.00 6.00
8.00 7.00 8.00 9.00	Total Adults and Peds. Swing bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT						8.00 7.00 8.00 9.00
10.00 11.00 12.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						10.0 11.0 12.0
<ol> <li>13. 00</li> <li>14. 00</li> <li>15. 00</li> <li>16. 00</li> <li>17. 00</li> <li>18. 00</li> </ol>	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF	0. 00	0	2	61 1	367	13.0 14.0 15.0 16.0 17.0 18.0
9.00 0.00 1.00 2.00 3.00 4.00 4.10 5.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0. 00					19.0 20.0 21.0 22.0 23.0 24.0 24.1 25.0
26.00         26.25         27.00         28.00         29.00         30.00         31.00         32.00         32.00         32.00         32.00	RURAL HEALTH CLINIC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary Labor & delivery room	0. 00					25. 0 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 32. 0

Heal th	Financial Systems	Kind	dred Hospital	Northern Indian	ia	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der	F	Period: From 09/01/2014 To 08/31/2015		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200. 00	5, 574, 330	0	5, 574, 330	180, 646. 40	30. 86	1.00
2.00	instructions) Non-physician anesthetist Part		C	0	C	0.00	0.00	2.00
3.00	A Non-physician anesthetist Part B		C	0	С	0.00	0.00	3. 00
4.00	Physician-Part A - Administrative		C	0	С	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		C	0	C	0.00		
5.00 6.00	Physician-Part B Non-physician-Part B					0.00		1
7.00	Interns & residents (in an	21.00	C	0		0.00		
7.01	approved program) Contracted interns and		C	0	C	0.00	0.00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		C	0	C	0.00		
9.00 10.00	SNF Excluded area salaries (see	44.00	C		C 151, 767	0.00 4,078.00		
10.00	instructions) OTHER WAGES & RELATED COSTS			151,707	151, 707	4,078.00	57.22	10.00
11.00	Contract Labor: Direct Patient Care		914, 665	0	914, 665	12, 182. 00	75.08	11.00
12.00	Contract labor: Top level management and other management and administrative		С	0	С	0.00	0. 00	12.00
13.00	services Contract Labor: Physician-Part		286, 919	0	286, 919	3, 853. 00	74.47	13.00
14.00	A - Administrative Home office salaries &		560, 909	0	560, 909	12, 464. 65	45.00	14.00
15.00	wage-related costs Home office: Physician Part A		C	0	C	0.00	0.00	15.00
16.00	- Administrative Home office and Contract		C	0	C	0.00	0.00	16.00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see		704, 477	0	704, 477	7		17.00
18.00	instructions) Wage-related costs (other) (see instructions)		C	0	С			18.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		19, 717 C		19, 717 (	,		19.00 20.00
21.00	A Non-physician anesthetist Part		C	0	C			21.00
22.00	B Physician Part A -		C	0	C			22.00
22. 01	Administrative Physician Part A - Teaching		ſ	0	C			22.01
23.00	Physician Part B		C	0				23.00
24.00	Wage-related costs (RHC/FQHC)		C		C			24.00
25.00	Interns & residents (in an approved program)		C	0	C	)		25.00
	OVERHEAD COSTS - DIRECT SALARIE	S						
26.00	Employee Benefits Department	4.00	44, 639		44, 639			
27. 00 28. 00	Administrative & General Administrative & General under	5.00	913, 985 3, 776		913, 985 3, 776			
29.00	contract (see inst.) Maintenance & Repairs	6. 00	C	0	c	0.00	0.00	29.00
30.00	Operation of Plant	7.00	C	0	C	0.00		
31.00 32.00 33.00	Laundry & Linen Service Housekeeping Housekeeping under contract	8.00 9.00	0 88, 822		0 88, 822	0. 00 7, 078. 00 0. 00	12. 55	32.00
34.00	(see instructions) Dietary	10. 00	67, 408		67, 408			
35.00	Dietary under contract (see instructions)		C	0	C	0.00		
36.00	Cafeteri a	11.00	C	0	0	0.00		
37.00 38.00	Maintenance of Personnel Nursing Administration	12.00 13.00	396, 212	0	396, 212	0.00 10,393.00		37.00 38.00
39.00	Central Services and Supply	14.00	61, 381	0	61, 381	4, 224. 00	14. 53	39.00
40.00	Pharmacy	15.00	399, 237	0	399, 237	10, 712. 00	37.27	40.00

Health Financial Systems	Kind	dred Hospital	Northern Indiar	na	In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
					From 09/01/2014		nored.
					To 08/31/2015	Date/Time Pre 1/21/2016 11:	
	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	239, 610	o 0	239, 616	5 7, 618. 00	31.45	41.00
42.00 Social Service	17.00	308, 154	4 -151, 767	156, 387	4, 202. 00	37.22	42.00
43.00 Other General Service	18.00	(	o  0		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	i	Period: From 09/01/2014		
						Го 08/31/2015	Date/Time Prep 1/21/2016 11:	
		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	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		5, 578, 106	0	5, 578, 10	5 180, 702. 40	30. 87	1.00
	instructions)							
2.00	Excluded area salaries (see		0	151, 767	151, 76	4, 078. 00	37.22	2.00
	instructions)							
3.00	Subtotal salaries (line 1		5, 578, 106	-151, 767	5, 426, 33	9 176, 624. 40	30. 72	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 762, 493	0	1, 762, 49	3 28, 499. 65	61.84	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		704, 477	0	704, 47	0.00	12. 98	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		8, 045, 076	-151, 767	7, 893, 30	205, 124. 05	38.48	6.00
7.00	Total overhead cost (see		2, 523, 230	-151, 767	2, 371, 46	64, 353. 40	36.85	7.00
	instructions)							
		·				-		

	Financial Systems Kindred Hospital Nor AL WAGE RELATED COSTS	thern Indiana Provider CCN:	152018	Peri od:	u of Form CMS-2 Worksheet S-3	
00111			102010	From 09/01/2014		
				To 08/31/2015		
					1/21/2016 11:	13 an
					Amount	
					Reported	
					1.00	
	PART I V - WAGE RELATED COSTS					-
	Part A - Core List RETIREMENT COST					-
00					0	1 1
. 00	401K Employer Contributions				0	
. 00	Tax Sheltered Annuity (TSA) Employer Contribution				0	
. 00	Nonqualified Defined Benefit Plan Cost (see instructions)				0	
. 00	Qualified Defined Benefit Plan Cost (see instructions)				0	4.
~ ~	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)					
. 00	401K/TSA Plan Administration fees				0	
. 00	Legal /Accounting/Management Fees-Pension Plan				0	
. 00	Employee Managed Care Program Administration Fees				0	7.
	HEALTH AND INSURANCE COST					
00	Health Insurance (Purchased or Self Funded)				231, 930	
00	Prescription Drug Plan				0	
0. 00	Dental, Hearing and Vision Plan				-1, 941	
	Life Insurance (If employee is owner or beneficiary)				3, 562	
	Accident Insurance (If employee is owner or beneficiary)				0	
3.00	Disability Insurance (If employee is owner or beneficiary)				19, 202	
	Long-Term Care Insurance (If employee is owner or beneficiary)	)			0	
5.00	'Workers' Compensation Insurance				25, 945	
6.00	Retirement Health Care Cost (Only current year, not the extract	ordinary accrual	requi re	d by FASB 106.	0	16.
	Non cumulative portion)					
	TAXES					
	FICA-Employers Portion Only				384, 653	
	Medicare Taxes - Employers Portion Only				0	
	Unemployment Insurance				0	
D. 00	State or Federal Unemployment Taxes				35, 977	20.
	OTHER					
1.00	Executive Deferred Compensation (Other Than Retirement Cost Reinstructions))	eported on lines	1 throu	gh 4 above. (see	0	21.
2.00	Day Care Cost and Allowances				0	22.
	Tuition Reimbursement				5, 149	
	Total Wage Related cost (Sum of lines 1 -23)				704, 477	
4.00	Part B - Other than Core Related Cost				/04, 4//	24.
	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.

Heal th	Financial Systems Kindred Hospital M	lorthern Indian	na	In Lie	u of Form CMS-2	2552-10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 152018	Peri od:	Worksheet S-1	0
				From 09/01/2014	Data /Tima Dra	norod.
				To 08/31/2015	Date/Time Pre 1/21/2016 11:	
	L				1.00	
4 00	Uncompensated and indigent care cost computation		000 1	0)	0.000040	1 00
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 Medicaid (see instructions for each line)	divided by II	ne 202 columr	18)	0. 238848	1.00
2.00	Net revenue from Medicaid				0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				0	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or suppleme		from Medicaid	1?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments				0	5.00
6.00	Medi cai d charges				0	6.00
7.00	Medicaid cost (line 1 times line 6)				0	7.00
8.00	Difference between net revenue and costs for Medicaid progr	am (line 7 min	us sum of lir	nes 2 and 5; if	0	8.00
	< zero then enter zero)					
0.00	State Children's Health Insurance Program (SCHIP) (see inst	ructions for ea	ach line)			0.00
9.00 10.00	Net revenue from stand-al one SCHIP Stand-al one SCHIP charges				0	9.00 10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)					
12.00	Difference between net revenue and costs for stand-alone SC	HIP (line 11 m	inus line 9 <sup>.</sup>	if < zero then	0	
12.00	enter zero)		indo inno <i>y</i> ,		Ŭ	12.00
	Other state or local government indigent care program (see	instructions fo	or each line)		•	
13.00	Net revenue from state or local indigent care program (Not				0	
14.00	Charges for patients covered under state or local indigent	care program (	Not included	in lines 6 or	0	14.00
45 00		442				45 00
15.00 16.00	State or local indigent care program cost (line 1 times lin Difference between net revenue and costs for state or local		program (Lir	o 1E minue lino	0	15.00 16.00
10.00	13; if < zero then enter zero)	Thurgent care	program (TT		0	10.00
	Uncompensated care (see instructions for each line)				<u> </u>	
17.00	Private grants, donations, or endowment income restricted t	o funding char	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support	of hospital op	erations		0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and	local indigent	care program	ns (sum of lines	0	19.00
	8, 12 and 16)				<b>T L L L L</b>	
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity c	are (at full	1.00	0 0		20.00
	charges excluding non-reimbursable cost centers) for the en					
21.00	Cost of initial obligation of patients approved for charity	care (line 1		0 0	0	21.00
	times line 20)				_	
22.00	Partial payment by patients approved for charity care			0 0	-	
23.00	Cost of charity care (line 21 minus line 22)			0 0	0	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for pat	ient davs bevo	nd a length o	of stav limit	1.00	24.00
	imposed on patients covered by Medicaid or other indigent c					
25.00	If line 24 is "yes," charges for patient days beyond an in	digent care pr	ogram's lengt	h of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see				0	26.00
27.00	Medicare bad debts for the entire hospital complex (see ins				209, 554	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense			22)	-209, 554	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt	expense (line	i times líne	28)	-50, 052	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plu	s line 20)			-50, 052 -50, 052	
51.00	Trotal and encompensated care cost (TTHE 19 plu	3 11110 30)			-50,052	1 31.00

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 152018	Peri od:	Worksheet A	
					From 09/01/2014 To 08/31/2015	Date/Time Pre 1/21/2016 11:	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)		
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	I I I	720, 187	720, 1	87 5, 857	726, 044	1.00
00	00200 CAP REL COSTS-BLDG & TTXT		399, 189				
00	00300 OTHER CAP REL COSTS		19, 513				
00	00400 EMPLOYEE BENEFITS DEPARTMENT	44,639	785, 380			830, 019	
00	00500 ADMINI STRATI VE & GENERAL	913, 985	1, 928, 467			2, 842, 452	
00	00700 OPERATION OF PLANT	0	216, 536			216, 536	
00	00800 LAUNDRY & LINEN SERVICE	0	105, 125	105, 1	25 0	105, 125	8.0
00	00900 HOUSEKEEPI NG	88, 822	133, 425		47 0	222, 247	9.0
0. 00	01000 DI ETARY	67, 408	281, 608	349, 0	16 0	349, 016	10.00
. 00	01100 CAFETERI A	0	0		0 0	0	11.0
8.00	01300 NURSING ADMINISTRATION	396, 212	11, 384	407, 5	96 0	407, 596	13.0
	01400 CENTRAL SERVICES & SUPPLY	61, 381	15, 495	76, 8	76 0	76, 876	14.0
. 00	01500 PHARMACY	399, 237	27, 225	426, 4	62 0	426, 462	15.0
. 00	01600 MEDICAL RECORDS & LIBRARY	239, 616	52, 007			291, 623	
. 00	01700 SOCI AL SERVI CE	308, 154	28, 394	336, 5	48 -165, 751	170, 797	17.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	2, 399, 393	1, 459, 858				
	03100 I NTENSI VE CARE UNI T	0	160		60 - 160		
. 00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0	0	44.0
	ANCI LLARY SERVICE COST CENTERS	(0.024	200 4/2	250.4	0/	250,404	1 50 0
	05000 OPERATING ROOM	60, 034	298, 462			358, 496	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	164, 837	88, 777			253, 614 399, 819	
). 00 5. 00	06500 RESPIRATORY THERAPY	0	399, 819 11, 919			442, 531	
. 00	06600 PHYSI CAL THERAPY	430, 612 0	701, 924			701, 924	
	06700 OCCUPATI ONAL THERAPY	0	01, 924		0 0	01, 924	
. 00 3. 00	06800 SPEECH PATHOLOGY	0	0			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	408, 820	408, 8	20 0	408, 820	
	07300 DRUGS CHARGED TO PATIENTS	0	699, 520			699, 520	
	07400 RENAL DIALYSIS	0	305, 357			305, 357	
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	000,007	00070		000,007	1
0. 00	09000 CLINIC	0	0		0 0	0	90.0
. 00	09100 EMERGENCY	0	0		0 0	0	91.0
	OTHER REIMBURSABLE COST CENTERS	· · · · ·		•			1
	09500 AMBULANCE SERVI CES	0	0		0 0	0	95.0
. 00	09850 OTHER REIMBURSABLE CC'S	0	0		0 0	0	98.0
	SPECIAL PURPOSE COST CENTERS						
8.00		5, 574, 330	9, 098, 551	14, 672, 8	81 -165, 751	14, 507, 130	118. 0
	NONREI MBURSABLE COST CENTERS	1		1			
0.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 0
2.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.0
	07950 NONALLOWABLE CASE MANAGER	0	0		0 165, 751	165, 751	
	07951 I DLE SPACE	0	0		0 0	0	194.0
	07952 REGIONAL OFFICE	0	0		0 0	0	194.0
	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 DATA CTR SUBLEASE (XODIAC)	0	0		0 0		194. C
	07957 CENTRALIZED ADMISSIONS DEPT	0	0		0 0		194. C
	07959 OTHER NONREIMBURSABLE - OPEN		0		0 0		194. C
	07958 VISITOR MEALS 07962 OTHER NONREIMBURSABLE CC'S	0	0		0 0		194.0
1 10	IULZUZIULDEK NUNKELWDUKSABLE UU S	0	0	1	0 0	ı 0	1174.
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		0		194.1

	ndred Hospital I				u of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der	CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet A Date/Time Pr 1/21/2016 11	
Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00				
GENERAL SERVICE COST CENTERS	0.00	7.00				
1. 00 00100 CAP REL COSTS-BLDG & FIXT	-46, 419	679, 625				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P	-19, 159					2.00
3. 00 00300 OTHER CAP REL COSTS	0					3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 766					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-571, 324					5.00
7. 00 00700 OPERATION OF PLANT	-692					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0					8.00
9. 00 00900 HOUSEKEEPING	0					9.00
10. 00 01000 DI ETARY	0	349, 016				10.00
11. 00 01100 CAFETERIA	0	010				11.00
13. 00 01300 NURSING ADMINI STRATI ON	0					13.00
	0					14.00
	92, 757					15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-197					16.00
17.00 01700 SOCIAL SERVICE	0	170, 797				17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.00.074	0.000.450				-
30. 00 03000 ADULTS & PEDI ATRI CS	-849, 961					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0				44.00
ANCI LLARY SERVI CE COST CENTERS	1	I	I			
50.00 05000 OPERATING ROOM	0					50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
60. 00 06000 LABORATORY	0					60.00
65. 00 06500 RESPI RATORY THERAPY	1, 154					65.00
66. 00 06600 PHYSI CAL THERAPY	-47,984	653, 940				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	408, 820				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	699, 520				73.00
74.00 07400 RENAL DIALYSIS	330	305, 687				74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
OTHER REIMBURSABLE COST CENTERS			-			
95. 00 09500 AMBULANCE SERVICES	0	0				95.00
98.00 09850 OTHER REIMBURSABLE CC'S	0	0				98.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	-1, 445, 261	13, 061, 869				118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
194.0007950 NONALLOWABLE CASE MANAGER	0	165, 751				194.00
194. 01 07951 I DLE SPACE	0	0				194.01
194. 02 07952 REGIONAL OFFICE	0	0				194.02
194. 03 07953 DI STRI CT OFFI CE	0	0				194.03
194.0407954 NON MCR CERTIFIED UNIT	0	0				194.04
194.0507955 REG NURSG OFFICE	0	0				194.05
194.0607956 DATA CTR SUBLEASE (XODIAC)	0	0				194.06
194. 07 07957 CENTRALIZED ADMISSIONS DEPT	0	0				194.07
194.08 07959 OTHER NONREI MBURSABLE - OPEN	0	0				194.08
194. 09 07958 VI SI TOR MEALS	0	0				194.09
194. 10 07962 OTHER NONREI MBURSABLE CC' S	0					194.10
194. 11 07961 NONREI MB NEW BUSI NESS I MPLEMENTATI ON	0	-				194.11
200.00 TOTAL (SUM OF LINES 118-199)	-1, 445, 261	-				200.00
	1,775,201	1 10,227,020	I			1200.00

Heal th	Financial Systems	Ki r	ndred Hospital	Northern India	ina	In Lie	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provi der	CCN: 152018	Period: From 09/01/2014	Worksheet A-	6
						To 08/31/2015	Date/Time Pr 1/21/2016 11	epared: : <u>13 am</u>
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - RECLASS NON ALLOWABLE CAS	SE MANAGER						
1.00	NONALLOWABLE CASE MANAGER	194.00	151, 767	13, 984				1.00
	TOTALS		151, 767	13, 984				
	C - RECLASS I CU EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	0	160				1.00
	TOTALS		0	160				
500.00	Grand Total: Increases		151, 767	14, 144	]			500.00

Heal th	Financial Systems	Kir	ndred Hospital	Northern India	na	In Lie	u of Form CMS-	2552-10
RECLASS	SEFECATIONS			Provi der	CCN: 152018	Period: From 09/01/2014	Worksheet A-	6
						To 08/31/2015	Date/Time Pro 1/21/2016 11:	epared: 13 am
		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	151, 767	13, 984		0		1.00
	TOTALS		151, 767	13, 984				
	C - RECLASS I CU EXPENSE							1
1.00	INTENSIVE CARE UNIT	31.00	0	160		0		1.00
	TOTALS		0	160		7		
500.00	Grand Total: Decreases		151, 767	14, 144		$\neg$		500.00

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       684,289       1,250       0       1,250       0       4.00         5.00       Fixed Equipment       0	Heal th	Financial Systems Kin	dred Hospital N	lorthern Indiar	าล	In Lie	eu of Form CMS-	2552-10
Beginning Balances         Purchases         Donation         Total         Disposal s and Retirements           1.00         2.00         3.00         4.00         5.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         0         0         0         0         0         1.00           2.00         Land         0         0         0         0         0         1.00           2.00         Land Improvements         126,200         0         0         0         2.00           3.00         Buildings and Fixtures         0         0         0         0         2.00           4.00         Building Improvements         684,289         1,250         0         1,250         0         4.00           5.00         Fixed Equipment         0 </td <td>RECONC</td> <td>CILIATION OF CAPITAL COSTS CENTERS</td> <td></td> <td>Provi der</td> <td></td> <td>From 09/01/2014</td> <td>Part I Date/Time Pre</td> <td>pared:</td>	RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		From 09/01/2014	Part I Date/Time Pre	pared:
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         Retirements           1.00         2.00         3.00         4.00         5.00           1.00         Land         0         0         0         0         1.00           2.00         Land         0         0         0         0         0         2.00           3.00         Buil dings and Fixtures         0         0         0         0         0         2.00           3.00         Buil dings and Fixtures         0         0         0         0         0         0         0         3.00           4.00         Buil ding Improvements         684, 289         1, 250         0         1, 250         0         4.00         5.00           5.00         Fixed Equipment         1, 852, 898         39, 703         0         39, 703         0         6.00         7.00           11 designated Assets         0         0         0         0         0         0         0         0         0         0         9.00           8.00         Subtotal (sum of lines 1-7)         2, 663, 387         40, 953         0         40, 953         0         10.00           10.00					Acqui si ti ons	5		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         I.00         2.00         3.00         4.00         5.00           1.00         Land         0			Begi nni ng	Purchases	Donation	Total	Disposals and	
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         0			Bal ances				Retirements	
1.00       Land       0 </td <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>			1.00	2.00	3.00	4.00	5.00	
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       684,289       1,250       0       1,250       0       4.00         5.00       Fixed Equipment       0		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES		_			
3.00       Buildings and Fixtures       0       0       0       0       3.00         4.00       Building Improvements       684, 289       1, 250       0       1, 250       0       4.00         5.00       Fixed Equipment       0 </td <td>1.00</td> <td>Land</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>1.00</td>	1.00	Land	0	0		0 0	0	1.00
4.00       Building Improvements       684,289       1,250       0       1,250       0       4.00         5.00       Fixed Equipment       0	2.00	Land Improvements	126, 200	0		0 0	0 0	2.00
5.00       Fixed Equipment       0       0       0       0       0       5.00         6.00       Movable Equipment       1,852,898       39,703       0       39,703       0       6.00         7.00       HIT designated Assets       0       0       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       2,663,387       40,953       0       40,953       0       8.00         9.00       Reconciling Items       0       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       2,663,387       40,953       0       40,953       0       10.00         10.00       Total (line 8 minus line 9)       2,663,387       40,953       0       40,953       0       10.00         10.00       Total (line 8 minus line 9)       2,663,387       40,953       0       40,953       0       10.00         10.00       Land       Ending Balance       Full y       Depreciated       Assets       6.00       7.00       1.00         2.00       Land       Movements       126,200       0       0       2.00       3.00         3.00 <td>3.00</td> <td>Buildings and Fixtures</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>3.00</td>	3.00	Buildings and Fixtures	0	0		0 0	0	3.00
6.00       Movable Equipment       1,852,898       39,703       0       39,703       0       6.00         7.00       HIT designated Assets       0	4.00	Building Improvements	684, 289	1, 250		0 1, 250	0	4.00
7.00       HIT designated Assets       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       2,663,387       40,953       0       40,953       0       8.00         9.00       Reconciling Items       0       0       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       2,663,387       40,953       0       40,953       0       10.00         Ending Balance         Fully       Depreciated       Assets       6.00       7.00       10.00 </td <td>5.00</td> <td>Fixed Equipment</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>5.00</td>	5.00	Fixed Equipment	0	0		0 0	0	5.00
8.00       Subtotal (sum of lines 1-7)       2,663,387       40,953       0       40,953       0       8.00         9.00       Reconciling Items       0	6.00	Movable Equipment	1, 852, 898	39, 703		0 39, 703	0	6.00
9.00         Reconciling Items         0         0         0         0         0         9.00           10.00         Total (line 8 minus line 9)         2,663,387         40,953         0         40,953         0         10.00           Image: Second seco	7.00	HIT designated Assets	0	0		0 0	0	7.00
10.00         Total (line 8 minus line 9)         2,663,387         40,953         0         40,953         0         10.00           Ending Balance         Fully         Depreciated         Assets         0         40,953         0         10.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         6.00         7.00         1.00         1.00           1.00         Land         0         0         0         2.00         3.00         Buildings and Fixtures         0         0         0         3.00	8.00	Subtotal (sum of lines 1-7)	2, 663, 387	40, 953		0 40, 953	0	8.00
PART I     - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES       1.00     Land       2.00     Land Improvements       3.00     Buildings and Fixtures	9.00	Reconciling Items	0	0		0 0	0	9.00
PART I     - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES       1.00     Land       2.00     Land Improvements       3.00     Buildings and Fixtures	10.00	Total (line 8 minus line 9)	2, 663, 387	40, 953		0 40, 953	0	10.00
Assets         6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         1.00         1.00           1.00         Land         0         0         1.00           2.00         Land Improvements         126,200         0         2.00         3.00			Ending Balance					
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			Ŭ	Depreci ated				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES1.00Land002.00Land Improvements126,20003.00Buildings and Fixtures003.00				Assets				
1.00         Land         0         0         1.00           2.00         Land Improvements         126,200         0         2.00         2.00           3.00         Buildings and Fixtures         0         0         0         3.00				7.00				
2.00         Land Improvements         126,200         0         2.00         3.00         Buildings and Fixtures         0         0         3.00         3.00		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES					
3.00 Buildings and Fixtures 0 0 0 3.00	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 685,539 0 4.00	4.00	Building Improvements	685, 539	0				4.00
5.00 Fixed Equipment 0 0 5.00	5.00	Fixed Equipment	0	0				5.00
6.00 Movable Equipment 1,892,601 0 6.00	6.00	Movable Equipment	1, 892, 601	0				6.00
7.00 HIT designated Assets 0 0 0 7.00	7.00	HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7) 2,704,340 0 8.00	8.00	Subtotal (sum of lines 1-7)	2, 704, 340	0				8.00
9.00 Reconciling Items 0 0 9.00	9.00	Reconciling Items	0	0				9.00
10.00         Total (line 8 minus line 9)         2,704,340         0         10.00	10.00	Total (line 8 minus line 9)	2, 704, 340	0				10.00

Health Financial Systems Kindred Hospital Northern Indiana In Lieu of Form									
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 152018	Period: From 09/01/2014 To 08/31/2015				
SUMMARY OF CAPITAL									
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)			
		9.00	10.00	11.00	12.00	13.00			
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FIXT	111, 627	608, 560		0 0	0	1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	227, 277	171, 912		0 0	0	2.00		
3.00	3.00 Total (sum of lines 1-2) 338,904 780,472 0 0 0								
SUMMARY OF 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	720, 187				1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	399, 189				2.00		
3.00	Total (sum of lines 1-2)	0	1, 119, 376				3.00		

RECONCILIATION OF CAPITAL COSTS CENTERS         Provider CN: 152018         Period: From 09/01/2014 To 08/31/2015         Worksheet A-7 (From 09/01/2014 To 08/31/2015           Cost Center Description         COMPUTATION OF RATIOS         ALLCATION OF OTHER CAPITAL Cost Center Description         ALLCATION OF OTHER CAPITAL Gross Assets (Col. 1 - col. 2)         Ratio (see instructions)         Insurance instructions)         Insurance instructions)           0         CAP REL COSTS-BLDG & FIXT         B11, 739         0         811, 739         0.300162         717         1.00           1.00         CAP REL COSTS-BLDG & FIXT         B11, 739         0         811, 739         0.4000000         2.903.00         4.00         5.00           1.00         CAP REL COSTS-MUBLE EQUIP         1.892, 601         0         1.892, 601         0.999838         1, 673         2.00           3.00         Total (sum of lines 1-2)         2.704, 340         0         2.704, 340         1.0000000         2.903         3.00           0         Total (sum of lines 1-2)         6.00         7.00         8.00         9.00         10.00         10.00           2.00         CAP REL COSTS-NUBLE EQUIP         11.983         0         13.656         206.118         171, 11.2           2.00         CAP REL COSTS-BLDG & FIXT         5.140	Heal th	n Financial Systems Kin	dred Hospital 1	Northern Indian	าล	In Lie	u of Form CMS-2	2552-10	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         Other Capital and Capit	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	From 09/01/2014	Part III Date/Time Prep	pared:	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         for Ratio (col . 1 - col . 2)         instructions)         instructions)           1.00         2.00         3.00         4.00         5.00           1.00         CAP REL COSTS-BLDG & FIXT         811,739         0         811,739         0.300162         717         1.00           2.00         CAP REL COSTS-MUBLE EQUIP         1,892,601         0         2,704,340         1.000000         2,390         3.00           3.00         Total (sum of lines 1-2)         2,704,340         0         0.00000         2,390         3.00           Cost Center Description         Taxes         Other Capital-Relate d Costs         Total (sum of col s. 5 through 7)         Depreciation         Lease           1.00         CAP REL COSTS-MUBLE EQUIP         1,983         0         13,656         208,118         171,912         2.00           0         Taxes         Other clast al-Relate d Costs         Total (sum of col s. 5         1.00         1.00         1.00         1.00         1.00         1.00           1.00         CAP REL COSTS-MUBLE EQUIP         11,983         0         13,656         208,118         171,912         2.00           3.00         Total (sum of lines 1-2)         17,123         0 </td <td></td> <td></td> <td>COM</td> <td>PUTATION OF RAT</td> <td>FI OS</td> <td>ALLOCATION OF</td> <td>OTHER CAPI TAL</td> <td></td>			COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         2.00         3.00         4.00         5.00           1.00         CAP REL COSTS-BLDG & FIXT         811,739         0         811,739         0.300162         717         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         1,892,601         0         1,892,601         0.699838         1,673         2.00           3.00         Total (sum of lines 1-2)         2,704,340         0         2,704,340         1.000000         2,390         3.00           Cost Center Description         Taxes         Other Capital - Relate d Costs         Total (sum of Depreciation cols.5 through 7)         Lease         1.00           1.00         CAP REL COSTS-BLDG & FIXT         5,140         0         5,857         66,068         608,560         1.00           2.00         CAP REL COSTS-BLDG & FIXT         5,140         0         5,857         66,068         608,560         1.00           2.00         CAP REL COSTS-BLDG & FIXT         5,140         0         5,857         66,068         608,560         1.00           3.00         Total (sum of lines 1-2)         17,123         0         19,513         274,186         780,472         3.00		Cost Center Description	Gross Assets		for Ratio (col. 1 - col.		Insurance		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         811, 739         0         811, 739         0.300162         717         1.00           1.00         CAP REL COSTS-BLDG & FIXT         811, 739         0         811, 739         0.300162         717         1.00           3.00         Total (sum of lines 1-2)         2, 704, 340         0         2, 704, 340         1.000000         2, 390         3.00           3.00         Total (sum of lines 1-2)         2, 704, 340         0         2, 704, 340         1.000000         2, 390         3.00           Cost Center Description         Taxes         Other Capital-Relate d Costs         Total (sum of cols. 5         Depreciation through 7)         Lease         1.00           1.00         CAP REL COSTS-BLDG & FIXT         6.00         7.00         8.00         9.00         10.00           1.00         CAP REL COSTS-MVBLE EQUIP         11,983         0         13,656         208,118         171,912         2.00           3.00         Total (sum of lines 1-2)         17,123         0         13,656         208,118         171,912         2.00           2.00         CAP REL COSTS-MUBLE EQUIP         11,983         0         13,656         208,118         171,912         3.00			1.00	2.00		4.00	F 00		
1.00       CAP REL COSTS-BLDG & FIXT       811,739       0       811,739       0.300162       717       1.00         2.00       CAP REL COSTS-MVBLE EQUIP       1,892,601       0       1,892,601       0.699838       1,673       2.00         3.00       Total (sum of lines 1-2)       2.04,340       0       2,704,340       1.000000       2,390       3.00         Cost Center Description         Taxes       0 ther         Cost Center Description         Taxes       0 ther         Cost Center Description         Cost Center Description         Taxes       0 ther         Cost Center Description         Summary of CAPITAL         Summary of Cost Center Description         Interest         Insurance (see         Instructions)         Cost Center Description         Interest       Insurance (see       Instruc		PART III - RECONCILIATION OF CAPITAL COSTS OF		2.00	3.00	4.00	5.00		
3.00         Total (sum of lines 1-2)         2, 704, 340         0         2, 704, 340         1.00000         2, 390         3.00           Cost Center Description         ALLOCATION OF OTHER CAPITAL         SUMMARY OF CAPITAL         SUMMARY OF CAPITAL         SUMMARY OF CAPITAL           Cost Center Description         Taxes         Other Capital -Relate d Costs         Total (sum of cols. 5 through 7)         Depreciation         Lease           1.00         CAP REL COSTS-BLDG & FIXT         6.00         7.00         8.00         9.00         10.00           CAP REL COSTS-BLDG & FIXT         5,140         0         5,857         66,068         608,560         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         11,983         0         13,656         208,118         171,912         2.00           Cost Center Description         Interest         Insurance (see instructions)         Taxes (see instructions)         Other instructions)         Total (2) (sum of cols. 9 through 14)           11.00         12.00         13.00         14.00         15.00         10.00           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         0         -143         5,140         0         679,625         1.00           CAP REL COSTS-BLDG & FIXT         0         -143         5,140<	1.00			0	811, 739	0. 300162	717	1.00	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS       Other CAPITAL       Total (sum of cols. 5 through 7)       Depreciation       Lease         1.00       CAP REL COSTS-BLDG & FIXT       5,140       0       5,857       66,068       608,560       1.00         2.00       CAP REL COSTS-BLDG & FIXT       5,140       0       13,656       208,118       171,912       2.00         3.00       Total (sum of lines 1-2)       17,123       0       19,513       274,186       780,472       3.00         SUMMARY OF CAPI TAL         Cost Center Description         Interest       Insurance (see instructions)       Total (sum of lines 1-2)       11.00       12.00       13.00       14.00       15.00         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         Cost Center Description       Interest       Insurance (see instructions)       Total (2) (sum of cols. 9 through 14)         Insurance (see instructions)         It.00       12.00       13.00       14.00       15.00         CAP REL COSTS-BLDG & FIXT       0       -143       5,140       0       679,625       1.00         O       -143       5,140       0       679,625       1.00	2.00	CAP REL COSTS-MVBLE EQUIP	1, 892, 601	0	1, 892, 601	0. 699838	1, 673	2.00	
Cost Center Description         Taxes         Other Capital-Relate d Costs         Total (sum of col s. 5 through 7)         Depreciation         Lease           1.00         CAP REL COSTS-BLDG & FLXT         6.00         7.00         8.00         9.00         10.00           2.00         CAP REL COSTS-BLDG & FLXT         5,140         0         5,857         66,068         608,560         1.00           2.00         CAP REL COSTS-MUBLE EQUIP         11,983         0         13,656         208,118         171,912         2.00           3.00         Total (sum of lines 1-2)         17,123         0         19,513         274,186         780,472         3.00           SUMMARY OF CAPITAL           Cost Center Description         Interest         Insurance (see instructions)         Taxes (see instructions)         Total -Relate d Costs (see instructions)	3.00	Total (sum of lines 1-2)	2, 704, 340	0	2, 704, 340	1.000000	2, 390	3.00	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         Col s. 5 through 7)         col s. 5 through 7)         col s. 5 through 7)         col s. 5 through 7)           1.00         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         6.00         7.00         8.00         9.00         10.00           2.00         CAP REL COSTS-BLDG & FIXT         5,140         0         5,857         66,068         608,560         1.00           3.00         Total (sum of lines 1-2)         11,983         0         13,656         208,118         171,912         2.00           3.00         Total (sum of lines 1-2)         17,123         0         19,513         274,186         780,472         3.00           Cost Center Description           Interest         Insurance (see instructions)         Taxes (see instructions)         0         14.00         15.00           Interest         Insurance (see instructions)         Taxes (see instructions)         0         14.00         15.00           Interest         Insurance (see instructions)         Taxes (see instructions)         0         6.03, 9           Interest         Interest         Interest         Interest         Interest         13.00         14.00         15.00			ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         6.00         7.00         8.00         9.00         10.00           1.00         CAP REL COSTS-BLDG & FIXT         5,140         0         5,857         66,068         608,560         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         11,983         0         13,656         208,118         171,912         2.00           3.00         Total (sum of lines 1-2)         17,123         0         19,513         274,186         780,472         3.00           SUMMARY OF CAPITAL           Cost Center Description         Interest         Insurance (see instructions)         Taxes (see of ther of costs (see instructions)         Total (2) (sum of costs (see instructions)         of costs (see instructions)         of costs (see instructions)         through 14)         of costs (see instructions)         through 14,00         15.00           CAP REL COSTS-BLDG & FIXT         0         -143         5,140         0         679,625         1.00           CAP REL COSTS-BLDG & FIXT         0         -143         5,140         0         679,625         1.00           2.00         CAP REL COSTS-BLDG & FIXT         0         -143         5,140         0         679,625         1.00 <t< td=""><td></td><td>Cost Center Description</td><td></td><td></td><td></td><td>Depreciation</td><td>Lease</td><td></td></t<>		Cost Center Description				Depreciation	Lease		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         CAP REL COSTS-BLDG & FIXT         5, 140         0         5, 857         66, 068         608, 560         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         11, 983         0         13, 656         208, 118         171, 912         2.00           3.00         Total (sum of lines 1-2)         17, 123         0         19, 513         274, 186         780, 472         3.00           SUMMARY OF CAPITAL           Cost Center Description         Interest         Insurance (see instructions)         Taxes (see instructions)         Other d Costs (see instructions)         Total (2) (sum of col s. 9 through 14)           1.00         12.00         13.00         14.00         15.00         100									
1.00       CAP REL COSTS-BLDG & FIXT       5,140       0       5,857       66,068       608,560       1.00         2.00       CAP REL COSTS-MVBLE EQUIP       11,983       0       13,656       208,118       171,912       2.00         3.00       Total (sum of lines 1-2)       17,123       0       19,513       274,186       780,472       3.00         SUMMARY OF CAPITAL         Cost Center Description         Interest Insurance (see instructions)       Taxes (see instructions)       0       11.00       12.00       13.00       14.00       15.00         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00       CAP REL COSTS-BLDG & FIXT       0       -143       5,140       0       679,625       1.00         2.00       CAP REL COSTS-MVBLE EQUIP       0       1,673       11,983       0       393,686       2.00				7.00	8.00	9.00	10.00		
2.00         CAP REL COSTS-MVBLE EQUIP         11,983         0         13,656         208,118         171,912         2.00           3.00         Total (sum of lines 1-2)         17,123         0         19,513         274,186         780,472         3.00           SUMMARY OF CAPITAL           Cost Center Description           Interest Insurance (see instructions)         Taxes (see instructions)         Other of cols.9         Other of c				t	1	1			
3.00       Total (sum of lines 1-2)       17,123       0       19,513       274,186       780,472       3.00         SUMMARY OF CAPITAL         Cost Center Description         Interest Insurance (see instructions)       Taxes (see instructions)       0       0       10       10       11.00       12.00       13.00       14.00       15.00         PART III - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00       CAP REL COSTS-BLDG & FIXT       0       -143       5,140       0       679,625       1.00         2.00       CAP REL COSTS-MVBLE EQUIP       0       1,673       11,983       0       393,686       2.00									
SUMMARY OF CAPITAL         SUMMARY OF CAPITAL         Cost Center Description         Interest       Insurance (see instructions)       Taxes (see instructions)       Other Capital -Relate instructions)       Total (2) (sum of cols. 9 through 14)         11.00       12.00       13.00       14.00       15.00         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00       CAP REL COSTS-BLDG & FIXT       0       -143       5,140       0       679,625       1.00         2.00       CAP REL COSTS-MVBLE EQUIP       0       1,673       11,983       0       393,686       2.00									
Cost Center Description       Interest       Insurance (see instructions)       Taxes (see instructions)       Other Capital -Relate d Costs (see instructions)       Total (2) (sum of col s. 9 through 14)         11.00       12.00       13.00       14.00       15.00         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS       0       -143       5,140       0       679,625       1.00         2.00       CAP REL COSTS-MVBLE EQUIP       0       1,673       11,983       0       393,686       2.00	3.00	Iotal (sum of lines 1-2)	17, 123				/80, 472	3.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS     0     -143     5,140     0     679,625       1.00     CAP REL COSTS-BLDG & FIXT     0     -143     5,140     0     679,625     1.00       2.00     CAP REL COSTS-MVBLE EQUIP     0     1,673     11,983     0     393,686     2.00				SU	JMMARY OF CAPI	IAL			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS         0         -143         5, 140         0         679, 625         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         0         1, 673         11, 983         0         393, 686         2.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS         11.00         12.00         13.00         14.00         15.00           1.00         CAP REL COSTS-BLDG & FIXT         0         -143         5,140         0         679,625         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         0         1,673         11,983         0         393,686         2.00				instructions)	instructions)		of cols. 9		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         12.00         13.00         14.00         15.00           2.00         CAP REL COSTS-BLDG & FIXT         0         -143         5,140         0         679,625         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         0         1,673         11,983         0         393,686         2.00							through 14)		
1. 00         CAP REL COSTS-BLDG & FI XT         0         -143         5, 140         0         679, 625         1. 00           2. 00         CAP REL COSTS-MVBLE EQUIP         0         1, 673         11, 983         0         393, 686         2. 00									
2. 00 CAP REL COSTS-MVBLE EQUI P 0 1, 673 11, 983 0 393, 686 2. 00	-	PART III - RECONCILIATION OF CAPITAL COSTS CE							
			0						
3.00         Total (sum of lines 1-2)         0         1,530         17,123         0         1,073,311         3.00			0						
	3.00	Total (sum of lines 1-2)	0	1, 530	17, 123	3  0	1, 073, 311	3.00	

nancial Systems	Kindred Hospital	North	ern Indiana
TS TO EXPENSES			Provider CCN: 152018

Health Fina ADJUSTMENTS TO EXPENSES

02575-BLDC & FIXT (chapter 2)         0CAP RFL COSTS-WBLE FOULP         0	Heal th	Financial Systems	Ki na	dred Hospital N	Northern Indiana	In Lie	u of Form CMS-2	552-10
To         Buttorities Prepare Lize 2001         Description         Descripion         Descripion         Description <td>ADJUST</td> <td>MENTS TO EXPENSES</td> <td></td> <td>·</td> <td></td> <td></td> <td>Worksheet A-8</td> <td></td>	ADJUST	MENTS TO EXPENSES		·			Worksheet A-8	
Expense Class Fi Catt on on Xorkeet A Indiversity of the Amount 1s to the Adjusted           Cost Center Description         Basi s/Code (2)         Amount         Cost Center         Line #         Mcst. A-7 Ref.           1.00         2.00         2.00         0.04 REL Cost-2.005 & FIXT         1.00         0							Date/Time Prep	pared:
Cost Center Description         Isst s/Code (2)         Anount         Cost Center         Line #         Mest A-7 Meft           1.00         Investment I income - CAP REL 1.00         1.00         2.00         3.00         4.00         5.00         1.00           2.00         Investment I FLMT, CodP REL COSTS-MPLE EQUIP         0.04 REL COSTS-MPLE EQUIP         2.00         0         2.00           2.01         Investment I Income - Other Costs server I Income - other Costs server I Income - other Costs server I Income - other Computer 20         0         0.03         0         0         3.00           3.00         Investment I Income - other Costs server I Income - other Computer 20         0         0.00         0 <td< td=""><td></td><td></td><td></td><td></td><td>Expense Classification on</td><td>Worksheet A</td><td>1/21/2016 11: 1</td><td><u>13 am</u></td></td<>					Expense Classification on	Worksheet A	1/21/2016 11: 1	<u>13 am</u>
Investment income - AP REL COSTS-BLUG & ITAT (chapter 2) COSTS-BLUG & ITAT (chapter 2) COSTS-MUGE EQUIP (chapter 2) COSTS COSTS (chapter 1) COSTS (chapter 2) COSTS (chapter 1) COSTS (chapter 2) COSTS (chapter 1) COSTS (chapter 1) COSTS (chapter 2) COSTS (c								
Investment income - AP REL COSTS-BLUG & ITAT (chapter 2) COSTS-BLUG & ITAT (chapter 2) COSTS-MUGE EQUIP (chapter 2) COSTS COSTS (chapter 1) COSTS (chapter 2) COSTS (chapter 1) COSTS (chapter 2) COSTS (chapter 1) COSTS (chapter 1) COSTS (chapter 2) COSTS (c								
Incol         Incol         2.00         R.00         4.00         5.00           1.00         Investment Income - CAP REL COSTS-BUG6 & INT (chapter 2) Investment Income - CAP REL COSTS-MRDE EQUIP (chapter 2)         0								
Incol         Incol         2.00         R.00         4.00         5.00           1.00         Investment Income - CAP REL COSTS-BUG6 & INT (chapter 2) Investment Income - CAP REL COSTS-MRDE EQUIP (chapter 2)         0								
1.00         Investment Income - CAP REL         0CAP REL COSIS-BLUG & FIXT         1.00         0         1.           2.00         Investment Income - CAP REL         0CAP REL COSIS-MOBLE FOULP (CAPTER 2)         0         0         0.00         0         0.00         0         0.00         0         0.00         0         0.00         0         0         0.00         0		Cost Center Description						
2.00         Investment income - CAP REL COSTS-WBLE COUP (chapter 2) (chapter 2)         0         0.00         0         3.           3.00         Investment income - other (chapter 2)         0         0.00         0         3.           4.00         Trade, quantity, and time expenses (chapter 8)         0         0.00         0         4.           5.00         Refunds and reactes of expenses (chapter 8)         0         0.00         0         6.           7.01         Trade, quantity, and 9         0         0.00         0.00         6.           8.00         Refunds and reactes of expenses (chapter 8)         0         0.00         0.00         6.           8.00         Telephone Services (pay stations excluded) (chapter 21)         0         0         0.00         9.           9.00         Provider-tagion and realizes of expenses (chapter 21)         0         0.00         0.00         0.           10.00         Provider-tagion (chapter 21)         0         0         0.00         0.         11.           10.00         Expense (chapter 2)         0         0.00         0.         12.         12.         12.         12.         12.         12.         12.         12.         12.         13.         12.	1.00	Investment income - CAP REL	1.00					1.00
COSTS-MWBLE FOUND (chapter 2)         0								
3.00         Investment income - other (chepter 2)         0         0.00         0         3.           4.00         Trade, quantity, and time discourds (chapter 8)         0         0.00         0.00         4.           5.00         Refunds and rebates of expenses (chapter 8)         0         0.00         0.00         0.00         0.00           6.00         Refunds and rebates of expenses (chapter 8)         0         0.00         0.00         0         6.           7.00         Telephone services (pay stations excluded) (chapter 21)         0         -4.095 ADMINISTRATIVE & GENERAL (chapter 21)         5.00         0         9.         0         0.00         0         6.           8.00         Derking lot (chapter 21)         0         -4.095 ADMINISTRATIVE & GENERAL (chapter 2)         0.00         0         9.         0         10.         0         9.         0         0.00         0         11.         0.00         0.00         0.00         0         11.         11.00         Sale of cost         0         0.00         0         12.           13.00         Laundry and linen service         0         0.00         0.00         0         14.           14.00         Cafter doraga to other than supplies to other than         0	2.00			0	CAP REL COSIS-MVBLE EQUIP	2.00	0	2.00
4.00         Trade, quantity, and time         B         -1.038ADMINISTRATIVE & GENERAL         5.00         0         4.           5.00         Refunds and rebates of expenses (chapter 8)         0         0.00         0         5.           6.00         Rental of provider space by supplers (chapter 8)         0         0.00         0.00         0         6.           7.00         Reital of provider space by supplers (chapter 2)         0         4.095ADMINISTRATIVE & GENERAL         5.00         0         7.           8.00         Iel evision and radio service (chapter 21)         0         -692DPERATION OF PLANT         7.00         0         8.           9.00         Parking Iot (chapter 21)         0         0.00         0.	3.00			0		0.00	0	3.00
discount's (chapter 8) expenses (chapter 8)       0       0.00       0       5.         0.00       0.00       0.00       0.00       0       5.         0.00       0.00       0.00       0.00       0       6.         0.00       0.00       0.00       0.00       0       6.         0.00       0.00       0.00       0.00       0       6.         0.00       10.00       10.00       Following Structure       A       -6920PERATION OF PLANT       7.00       0       8.         0.00       Provider-based physician       A-8-2       -755,721       0	4 00		P	1 020		F 00		1 00
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suppliers         Chapter 9         A         -4.095 ADM INISTRATIVE & GENERAL         5.00         0         7.           8.00         Television and radio service (chapter 21)         A         -6920PERATION 0F PLANT         7.00         0         8.           9.00         Parking 1dt (chapter 21)         0         0         0.00         0.00         0         9.           9.00         Parking 1dt (chapter 21)         0         0         0.00         0.00         0         9.           9.00         Parking 1dt (chapter 21)         0         0         0.00         0.00         0         10.           adjustment	6 00			0		0.00	0	6.00
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9.00         Parking lot (chapter 21)         0         0.00	8.00		А	-692	OPERATION OF PLANT	7.00	0	8.00
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physicians' compensation (chapter 21)occap Reloccap Rel COSTS-BLDG & FIXT1.0026.26.00Depreciation - CAP REL COSTS-BLDG & FIXToccap Rel COSTS-BLDG & FIXT1.00026.27.00Depreciation - CAP REL COSTS-MVBLE EQUIPoccap Rel COSTS-MVBLE EQUIP2.00027.28.00Non-physician Anesthetistof*** Cost Center Deleted ***19.0028.29.00Physicians' assistantof029.	25 00			0	*** Cost Center Deleted ***	114 00		25.00
26. 00Depreciation - CAP REL COSTS-BLDG & FIXT0026.27. 00Depreciation - CAP REL COSTS-MVBLE EQUIP0CAP REL COSTS-BLDG & FIXT1.00026.27. 00Depreciation - CAP REL COSTS-MVBLE EQUIP0CAP REL COSTS-MVBLE EQUIP2.00027.28. 00Non-physician Anesthetist 29. 000*** Cost Center Deleted ***19.0028.29. 00Physicians' assistant00029.	20.00	physicians' compensation		0		114.00		20.00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUI POCAP REL COSTS-MVBLE EQUI P2.00O27.28.00Non-physician Anesthetist 29.00O*** Cost Center Deleted ***19.0028.29.00Physicians' assistantO029.	26 00				CAD DEL COSTS DIDO O ELVT	1 00		26 00
27. 00 COSTS-MVBLE EQUI PDepreciation - CAP REL COSTS-MVBLE EQUI P0 CAP REL COSTS-MVBLE EQUI P2.00 2.000 27.28. 00 29. 00Non-physician Anesthetist Physicians' assistant0 *** Cost Center Deleted *** 019. 00 29.28.	∠0. UU			0	VAF KEL UUSIS-BLUG & FIXI	1.00	0	26.00
28.00         Non-physician Anesthetist         0         *** Cost Center Deleted ***         19.00         28.           29.00         Physicians' assistant         0         0         0         29.         0         0         0         29.         0         0         0         29.         0         0         0         29.         0         0         0         29.         0         0         0         29.         0         0         0         29.         0         0         0         0         29.         0         0         0         0         29.         0         0         0         0         0         0         29.         0         0         0         0         0         29.         0 <t< td=""><td>27.00</td><td></td><td></td><td>0</td><td>CAP REL COSTS-MVBLE EQUIP</td><td>2.00</td><td>0</td><td>27.00</td></t<>	27.00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
29.00         Physicians' assistant         0         0.00         0         29.	28 00			0	*** Cost Center Deleted ***	19 00		28.00
30.00 Adjustment for occupational A-8-3 OOCCUPATIONAL THERAPY 67 00 30				0	cost center bereted		0	29.00
	30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
therapy costs in excess of limitation (chapter 14)								
30. 99         Hospice (non-distinct) (see         0         ADULTS & PEDIATRICS         30. 00         30.	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
instructions)	21 00		٨٥٦	~		40.00		21 00
31. 00 Adjustment for speech A-8-3 0 SPEECH PATHOLOGY 68. 00 31.	31.00		H-0-3	0	SILLOII FAIRULUUT	08.00		31.00
limitation (chapter 14)		limitation (chapter 14)						
32. 00 CAH HIT Adjustment for 0 0.00 0 32. Depreciation and Interest	32.00			0		0.00	0	32.00
33.00 0.00 0 33.	33.00			0		0.00	0	33.00
33. 01         MI SCELLANEOUS         I NCOME         B         -2, 873         ADMI NI STRATI VE & GENERAL         5. 00         0         33.	33. 01	MI SCELLANEOUS I NCOME	В	-2, 873	ADMI NI STRATI VE & GENERAL	5.00	0	33.01

Health Financial Systems	Kindred Hospital Northern Indiana

	Financial Systems MENTS TO EXPENSES	KI HUI	ed Hospital i	Northern Indiana Provider CCN: 152018	Peri od:	u of Form CMS-: Worksheet A-8	
5051					From 09/01/2014 To 08/31/2015	Date/Time Pre	pared
				Expense Classification c To/From Which the Amount is		1/21/2016 11:	13 ar
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
. 02		1.00	2.00	3. 00	4.00	5.00	33.
. 02 . 03			0		0.00		
. 04			0		0.00	0	33.
. 05	OCCUPATIONAL INCENTIVE INCOME	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.
. 06	PATIENT PERSONAL SERVICES	A	-175	ADMI NI STRATI VE & GENERAL	5.00	0	33.
. 07	EAPENSE		0		0.00	o	33.
. 08	MEDICARE BAD DEBT - PART A	A	-309, 094	ADMI NI STRATI VE & GENERAL	5.00	0	33.
. 09			0		0.00	0	33.
. 10	OTHER MEDICARE NON ALLOWABLE	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.
. 11	OTHER OPERATING - PATIENT RELATIONS	A	-20, 943	ADMI NI STRATI VE & GENERAL	5.00	0	33.
. 12	OTHER OPERATING - PUBLIC	A	-337	ADMI NI STRATI VE & GENERAL	5.00	o	33.
	RELATIONS					-	
. 13	OTHER OPERATING - MARKETING	A		ADMI NI STRATI VE & GENERAL	5.00	0	
. 14	OTHER OPERATING - INTEREST	A	-704	ADMI NI STRATI VE & GENERAL	5.00		33.
15 16			0		0.00 0.00	0	
17			0		0.00	0	
18			0		0.00	0	33
19			0		0.00	0	33
20			0		0.00	0	33
21			0		0.00	0	33
22 23			0		0.00 0.00	0	33 33
23			0		0.00		33
25	OTHER OPERATING - PENALTIES	A	-84	ADMI NI STRATI VE & GENERAL	5.00	0	
	OTHER						
26			0		0.00	0	
27 28	AGGREGATE CAPITAL EROSION	A	-5 475	ADMI NI STRATI VE & GENERAL	0.00 5.00		33
20 29	AGGREGATE CAFTTAL EROSTON	A	-5, 475	ADMINISTRATIVE & GENERAL	0.00		33
30			0		0.00	0	
31	MARKETING BONUS	A	-6, 828	ADMINISTRATIVE & GENERAL	5.00	0	
32			0		0.00	0	
33	EMP BEN - ADMISSION BONUS	A		ADMI NI STRATI VE & GENERAL	5.00	0	33
34 35	MALPRACTICE TAIL LIABILITY	A	-276	ADMI NI STRATI VE & GENERAL	5.00 0.00	0	33
35 36			0		0.00	0	
	PHYSICIAN BILLING COLLECTION	A	-37, 316	ADMI NI STRATI VE & GENERAL	5.00		
	FEES						
38			0		0.00		
39 40			0		0.00 0.00	0	
40	MEDICARE VS BOOK BLDG	A	-46 809	CAP REL COSTS-BLDG & FIXT	1.00	9	
01	MEDI CARE VS BOOK MOV EQUI P	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	34
02	ASSET ADD-ON BLDG	A		CAP REL COSTS-BLDG & FIXT	1.00	9	
03	ASSET ADD-ON MOV EQUIP	A	23, 951	CAP REL COSTS-MVBLE EQUIP	2.00	9	
04 05			0		0.00	0	34 34
05	NON ALLOWABLE LOBBYING FEES	A	-1. 179	ADMI NI STRATI VE & GENERAL	0.00 5.00	0	
. 07			0		0.00	0	
. 08	BUSINESS INTERRUPTIONS INS	A	-860	CAP REL COSTS-BLDG & FIXT	1.00	12	34
09	PREMI UM		0		0.00	0	34
10			0		0.00	0	
11			0		0.00	0	34
12			0		0.00	0	34
13			0		0.00	0	34
14 15			0		0.00	0	34
15 16			0		0.00 0.00		
17			0		0.00	0	
. 18			0		0.00	0	
. 19			0		0.00	0	
. 20			0		0.00	0	
. 21		Δ	0		0.00	0	
. 22	DISTRICT OFFICE SALES AND MARKETING	A	-34,0/1	ADMI NI STRATI VE & GENERAL	5.00		34

Heal th	Financial Systems	Kin	dred Hosnital	Northern Indiana	Inlie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provider CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet A-8	pared:
				Expense Classification or To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.23	DISTRICT OFC SALES AND MKT BENEFITS	A	-3, 766	EMPLOYEE BENEFITS DEPARTMEN	F 4.00	0	34. 23
34.24			0		0.00	0	34.24
34.25			0		0.00	0	34.25
34.26			0		0.00	0	34.26
34.27			0		0.00	0	34.27
34.28			0		0.00	0	34.28
35.00			0		0.00	0	35.00
35.01			0		0.00	0	35.01
35.02			0		0.00	0	35.02
35.03			0		0.00	0	35.03
35.04			0		0.00	0	35.04
35.05			0		0.00		•
35.06			0		0.00		35.06
35.07			0		0.00		
35.08	PHYSICIAN FEE ADJUSTMENT	А	02 757	PHARMACY	15.00		35.08
35.00		~	72, 737		0.00		
35.10			0		0.00		35.10
35.10	PHYSICIAN FEE ADJUSTMENT	А		ADULTS & PEDIATRICS	30.00		
35.11	PHISICIAN FEE ADJUSIMENT	A	-93, 794	ADULIS & PEDIATRICS	0.00		35.11
			0				
35.13			0		0.00		
35.14			0		0.00		35.14
35.15			0		0.00		001.10
35.16			0		0.00		35.16
35.17	PHYSICIAN FEE ADJUSTMENT	A	2, 363	RESPI RATORY THERAPY	65.00		00.17
35.18			0		0.00		35.18
35.19			0		0.00		001.17
35.20			0		0.00		35.20
35. 21	PHYSICIAN FEE ADJUSTMENT	A	675	RENAL DIALYSIS	74.00		
35.22			0		0.00		35.22
35.23			0		0.00		
35.24			0		0.00	0	35.24
35.25			0		0.00	0	35.25
50.00	TOTAL (sum of lines 1 thru 49)		-1, 445, 261				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional environment of the set of the set

(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.

Heal th	Financial Systems	Kindred Hospital	Northern Indiana	eu of Form CMS-2	2552-10			
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 152018	Period: From 09/01/2014	Worksheet A-8	-1		
OFFICE				To 08/31/2014		pared: 13 am		
	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	937, 212	1, 060, 948	1.00		
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	25, 757	25, 757	2.00		
3.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	50, 176	50, 176	3.00		
4.00	0.00		5	0	0	4.00		
4.01	66.00	PHYSI CAL THERAPY	Therapy Services	653, 728	701, 712	4.01		
5.00	0		0	1, 666, 873	1, 838, 593	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)	Name	Percentage of	Name	Percentage of			
		Ownership		Ownershi p			
1.00	2.00	3.00	4.00	5.00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00	В	KHOI	100.00 Admin & Gen	100.00	6.00
7.00	В	KHOI	100.00Cornerstone	100.00	7.00
8.00	В	KHOI	100.00Cornerstone	100.00	8.00
9.00			0.00	0.00	9.00
10.00	В	KHOI	100.00 RehabCare	100.00	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	nern Indiana	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELAT OFFICE COSTS	ED ORGANIZATIONS AND HOME	Provider CCN: 152018	Period: From 09/01/2014	Worksheet A-8-1
			To 08/31/2015	Date/Time Prepared:

									1/21/2016 11:	<u>13 am</u>
	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 REL	LATED O	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO	STS:								
1.00	-123, 736	0								1.00
2.00	0	0								2.00
3.00	0	0								3.00
4.00	0	0								4.00
4.01	-47, 984	0								4.01
5.00	-171, 720									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.

nas not	been posted to worksheet A,	cordinas r and/or z, the amount arrowable should be that cated th cordinar 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	5.		
	6.00		
	B INTERPRIATIONSHIP TO PELAT	ED 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.

I CI IIIDU			
6.00	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00			9.00
10.00	Therapy Svcs		10.00
100.00		1	00.00
<i></i>			

(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 Syste	ems		Ki	ndred Hospital	Northe	ern India	ina	In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN	ADJU:	STMENT	·		Provi der	CCN: 152018	Period: From 09/01/2014		
									To 08/31/2015	Date/Time Pre 1/21/2016 11:	
	Wkst. A Line #		Cost	Center/Physician	Total		ssi onal	Provi der	RCE Amount	Physi ci an/Prov	
				Identifier	Remuneration	Com	ponent	Component		ider Component Hours	
	1.00			2.00	3.00	4	. 00	5.00	6.00	7.00	
1.00	0.00				0		0		0 0	0	1.00
2.00	30.00				3, 019		0				2.00
3.00	30.00				9, 179		0	.,			
4.00	30.00				16, 815		16, 815		171, 400		4.00
5.00	74.00		E		675		0	-			5.00
6.00	0.00		~		0		0		-	-	
7.00	65.00				1, 663		0	1, 66			7.00
8.00	30. 00 30. 00				54, 657		54, 657		171, 400		8.00
9. 00 10. 00	30.00				226, 345 674, 700		0 674, 700	226, 34			9.00 10.00
11.00	65.00				700		074,700	70			11.00
200.00	05.00	DR.	ĸ		987, 753		746, 172			3, 551	
200.00	Wkst. A Line #		Cost	Center/Physician	Unadjusted RCE		cent of	Cost of	Provi der	Physician Cost	200.00
	intot: A Erno #		0051	I denti fi er	Limit			Memberships &		of Malpractice	
							imit	Conti nui ng	Share of col.	Insurance	
								Education	12		
	1.00			2.00	8.00		. 00	12.00	13.00	14.00	
1.00	0.00		_		0		0		0	-	
2.00	30.00				1, 401		70		0 0	-	
3.00	30.00				2, 802		140		0	-	3.00
4.00	30.00				0		0			-	4.00
5.00 6.00	74.00 0.00	DR.	E		330		17 0			-	5.00 6.00
7.00	65.00	np	C		824		41			°,	7.00
8.00	30.00				024		41			-	
9.00	30.00				286, 930		14, 347			0	9.00
10.00	30.00				0		0		ol o	0	10.00
11.00	65.00				330		17		0 0	0	11.00
200.00					292, 617		14, 632		o o	0	200.00
	Wkst. A Line #		Cost	Center/Physician	Provi der	Adj us	ted RCE	RCE	Adjustment		
				ldenti fi er	Component	Li	imit	Di sal I owance			
					Share of col.						
	1.00			2.00	14	1	( 00	17.00	10.00		
1.00	1.00			2.00	15.00 0		<u>5.00</u> 0	17.00	18.00 0 0		1.00
2.00	30,00	np	в		0		1, 401				2.00
3.00	30.00				0		2, 802				3.00
4.00	30.00				0		2,002		16, 815		4.00
5.00	74.00				0		330				5.00
6.00	0.00				0		000	01			6.00
7.00	65.00	DR.	G		0		824	83	839		7.00
8.00	30.00	DR.	Н		0		0		54, 657		8.00
9.00	30.00				0		286, 930		0 0		9.00
10.00	30.00				0		0		674, 700		10.00
11.00	65.00	DR.	Κ		0		330				11.00
200.00					0		292, 617	9, 54	9 755, 721		200.00

0001.74	Financial Systems Kir LLOCATION - GENERAL SERVICE COSTS	ndred Hospital N		CCN: 152018	Period: From 09/01/2014	u of Form CMS-: Worksheet B Part I	
					To 08/31/2015	Date/Time Pre 1/21/2016 11:	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation (from Wkst A			DEPARTMENT		
		col . 7)					
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
	00100 CAP REL COSTS-BLDG & FIXT	679, 625	679, 625				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	393, 686		393, 68			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	826, 253	6, 168	3, 57			4.00
5.00	00500 ADMINI STRATI VE & GENERAL	2, 271, 128	118, 843	68, 84		2, 596, 992	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	215, 844 105, 125	173, 125 6, 073	100, 28 3, 51		489, 255 114, 716	
	00900 HOUSEKEEPING	222, 247	2, 942	1, 70		240, 321	
	01000 DI ETARY	349, 016	4, 840	2, 80		366, 851	
11.00	01100 CAFETERI A	0	0		0 0	0	11.00
	01300 NURSING ADMINISTRATION	407, 596	0		0 59, 901	467, 497	
	01400 CENTRAL SERVICES & SUPPLY	76, 876	6, 548	3, 79		96, 497	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	519, 219 291, 426	45, 551 15, 215	26, 38 8, 81		651, 514 351, 681	
	01700 SOCIAL SERVICE	170, 797	4,650	2, 69		201, 784	
	INPATIENT ROUTINE SERVICE COST CENTERS		1,000	2,0,	20,010	2017701	
	03000 ADULTS & PEDI ATRI CS	3, 009, 450	255, 591	148, 05		3, 775, 842	
	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	
	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	44.00
	05000 OPERATING ROOM	358, 496	0		0 9,076	367, 572	50.00
	05400 RADI OLOGY-DI AGNOSTI C	253, 614	0		0 24, 921	278, 535	
60.00	06000 LABORATORY	399, 819	0		0 0	399, 819	60.00
	06500 RESPI RATORY THERAPY	443, 685	0		0 65, 101	508, 786	
	06600 PHYSI CAL THERAPY	653, 940	15, 943	9, 23		679, 118	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	408, 820	0		0 0	408, 820	
	07300 DRUGS CHARGED TO PATIENTS	699, 520	0		0 0	699, 520	
	07400 RENAL DI ALYSI S	305, 687	24, 136	13, 98	1 0	343, 804	
	OUTPATIENT SERVICE COST CENTERS	r			1		
	09000 CLINIC 09100 EMERGENCY	0	0		0 0 0 0	0	
	OTHER REIMBURSABLE COST CENTERS	0			0 0	0	91.00
	09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
98.00	09850 OTHER REIMBURSABLE CC'S	0	0		0 0	0	98.00
	SPECIAL PURPOSE COST CENTERS		(70.05		(	10,000,001	1
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	13, 061, 869	679, 625	393, 68	6 813, 049	13, 038, 924	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 NONALLOWABLE CASE MANAGER	165, 751	0		0 22, 945	188, 696	
194.01	07951 I DLE SPACE	0	0		0 0	0	194.01
	07952 REGIONAL OFFICE	0	0		0 0		194. 02
	07953 DI STRI CT OFFI CE	0	0		0 0		194.03
	07954 NON MCR CERTIFIED UNIT 07955 REG NURSG OFFICE	0	0				194.04 194.05
	07955 DATA CTR SUBLEASE (XODIAC)	0	0				194.05
	07957 CENTRALI ZED ADMI SSI ONS DEPT	0	0		0 0		194.07
194.07	07959 OTHER NONREIMBURSABLE - OPEN	0	0		0 0		194.08
	07958 VISITOR MEALS	0	0		0 0		194.09
194. 08 194. 09					a a	0	194.10
194. 08 194. 09 194. 10	07962 OTHER NONREI MBURSABLE CC'S	0	0		0 0		
194. 08 194. 09 194. 10 194. 11	07962 OTHER NONREIMBURSABLE CC'S 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0 0		0 0	0	194. 11
194. 08 194. 09 194. 10	07962 OTHER NONREIMBURSABLE CC'S 07961 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments	0	0 0			0 0	

Health Financial Systems Kin	ndred Hospital M	Northern Indian	าล	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 09/01/2014	Worksheet B Part I	
			T.		Date/Time Pre	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	1/21/2016 11: DI ETARY	13 am
cost center bescription	& GENERAL	PLANT	LINEN SERVICE	HOUSEREELTING	DILIAN	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS	1					
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	2, 596, 992					5.00
7.00 00700 OPERATION OF PLANT	119, 522					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	28, 024	9, 692				8.00
9.00 00900 HOUSEKEEPI NG	58, 709					9.00
10. 00 01000 DI ETARY	89, 619			3, 946	468, 139	10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	114 206	-	0	0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	114, 206 23, 574		0	5, 339	0	13.00 14.00
15. 00 01500 PHARMACY	159, 160			37, 143	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	85, 913				0	16.00
17.00 01700 SOCIAL SERVICE	49, 294				0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	-		1			
30. 00 03000 ADULTS & PEDI ATRI CS	922, 416				426, 269	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0				0	31.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	44.00
50. 00 05000 OPERATI NG ROOM	89, 795	C	0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	68,044	0		-	0	54.00
60. 00 06000 LABORATORY	97,673	C	0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	124, 293		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	165, 904	25, 441	0	13,000	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00
68. 00  06800  SPEECH PATHOLOGY 71. 00  07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	99, 872		0	0	0	68.00 71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	170, 888	0	0	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	83, 989			-	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0				0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0	0	0		0	
95. 00 09500 AMBULANCE SERVICES 98. 00 09850 OTHER REIMBURSABLE CC'S	0				0	
SPECIAL PURPOSE COST CENTERS	0		1 <u> </u>	<u> </u>	0	70.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 550, 895	608, 777	152, 432	303, 725	426, 269	118.00
NONREI MBURSABLE COST CENTERS				· · · · ·		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0			190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192.00
194.0007950 NONALLOWABLE CASE MANAGER 194.0107951 IDLE SPACE	46, 097	0	0	0		194. 00 194. 01
194. 02 07952 REGIONAL OFFICE	0		0	0		194.01
194. 03 07953 DI STRI CT OFFI CE	0	0	0	0		194.02
194.0407954 NON MCR CERTIFIED UNIT	0	0	0	0		194.04
194.0507955 REG NURSG OFFICE	0	C	0	0	0	194.05
194.0607956DATA CTR SUBLEASE (XODIAC)	0	C	0	0		194.06
194. 07 07957 CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194.07
194.08 07959 OTHER NONRELMBURSABLE - OPEN	0		0	0		194.08
194. 09 07958 VISITOR MEALS 194. 10 07962 OTHER NONREIMBURSABLE CC'S	0		0	0		194. 09 194. 10
194. 10/07962 OTHER NONRETMBORSABLE CC S 194. 11/07961 NONRETMB NEW BUSINESS IMPLEMENTATION			0			194.10
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	C	0	0		201.00
202.00 TOTAL (sum lines 118-201)	2, 596, 992	608, 777	152, 432	303, 725	468, 139	202.00

OST A	ALLOCATION - GENERAL SERVICE COSTS		Provi de	r CCN: 152018	Peri od:	Worksheet B	
					From 09/01/2014 To 08/31/2015	Part I Date/Time Pre	epare
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	1/21/2016 11: MEDI CAL	: 13 a
			ADMI NI STRATI (	ON SERVICES 8 SUPPLY	2 Contraction of the second	RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
~~	GENERAL SERVICE COST CENTERS						
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.
. 00 . 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.
. 00	00500 ADMINISTRATIVE & GENERAL						4.
. 00	00700 OPERATION OF PLANT						7.
00	00800 LAUNDRY & LINEN SERVICE						8.
. 00	00900 HOUSEKEEPI NG						9.
D. 00	01000 DI ETARY						10.
1.00	01100 CAFETERIA		0				11.
3.00	01300 NURSI NG ADMI NI STRATI ON		0 581, 70	03			13.
4.00	01400 CENTRAL SERVICES & SUPPLY		ol	0 135, 8	359		14.
5.00	01500 PHARMACY		0	0 1,3			15.
6.00	01600 MEDI CAL RECORDS & LI BRARY		0	0	0 0	474, 281	1 16.
7.00	01700 SOCIAL SERVICE		o	0	0 0	(	) 17.
	INPATIENT ROUTINE SERVICE COST CENTERS	·		•			
00 .C	03000 ADULTS & PEDIATRICS		0 568, 77	76 2, 1	50 9	214, 368	30.
1.00	03100 I NTENSI VE CARE UNI T		0	0	0 0	(	31.
4.00	04400 SKILLED NURSING FACILITY		0	0	0 0	(	2 44.
	ANCILLARY SERVICE COST CENTERS	T	-	- 1			
0. 00	05000 OPERATING ROOM		0 12, 92	27	11 0	4, 172	
4.00	05400 RADI OLOGY-DI AGNOSTI C		0	0	0 0	15, 445	
0. 00	06000 LABORATORY		0	0	0 0	40, 581	
5.00	06500 RESPI RATORY THERAPY		0	0 E	313 0	75, 315	
6.00	06600 PHYSI CAL THERAPY		0	0	0 0	24, 592	
7.00	06700 OCCUPATIONAL THERAPY		0	0	0 0	(	
B. 00	06800 SPEECH PATHOLOGY			0 101 5	0 0	(	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			0 131,5		34, 796	
3.00 4.00	07400 RENAL DI ALYSI S			0	0 921, 803 0 0	57, 801	
4.00	OUTPATIENT SERVICE COST CENTERS		0	<u> </u>	0 0	7, 211	1 /4.
D. 00	09000 CLINIC	1	0	0	0 0	(	0 90.
1.00	09100 EMERGENCY		0	0	0 0	(	
1.00	OTHER REIMBURSABLE COST CENTERS		<u>о</u> ј	<u> </u>	0 0		5 71.
5.00	09500 AMBULANCE SERVICES	1	0	0	0 0	(	0 95.
3.00	09850 OTHER REI MBURSABLE CC' S		0	0	0 0		) 98.
	SPECIAL PURPOSE COST CENTERS		<u> </u>				
8.00			0 581, 70	135, 8	921, 812	474, 281	1 118.
	NONREI MBURSABLE COST CENTERS						
<del>9</del> 0. OC	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0 0	(	0 190.
	19200 PHYSI CLANS' PRI VATE OFFI CES		0	0	0 0	(	3 192.
	07950 NONALLOWABLE CASE MANAGER		0	0	0 0		3 194.
	07951 I DLE SPACE		0	0	0 0		D 194.
	07952 REGIONAL OFFICE		0	0	0 0		3 194.
	07953 DI STRI CT OFFI CE		0	0	0 0		0 194.
	07954 NON MCR CERTIFIED UNIT		0	0	0 0		0 194.
	07955 REG NURSG OFFICE		U	0	0 0		) 194.
	07956 DATA CTR SUBLEASE (XODIAC)			U	U 0		) 194.
	07957 CENTRALIZED ADMISSIONS DEPT			U	0 0		0 194.
	07959 OTHER NONREI MBURSABLE - OPEN			0	0 0		) 194.
	07958 VISITOR MEALS			0	0 0		) 194.
	07962 OTHER NONREI MBURSABLE CC'S				0 0		) 194.
	07961 NONREI MB NEW BUSI NESS I MPLEMENTATI ON		4	U I	0	(	0 194.
0. 00						,	200. 201.
01.00							

CUSI ALLU	CATION - GENERAL SERVICE COSTS		Provi der	CCN: 152018	Peri od:	Worksheet B
					From 09/01/2014 To 08/31/2015	
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		
		17.00	24.00	25.00	26.00	
	VERAL SERVICE COST CENTERS			1		
	100 CAP REL COSTS-BLDG & FIXT					1.0
	200 CAP REL COSTS-MVBLE EQUIP					2.0
	400 EMPLOYEE BENEFITS DEPARTMENT					4.0
	500 ADMINISTRATIVE & GENERAL					5.0
	700 OPERATION OF PLANT					7.0
1	300 LAUNDRY & LINEN SERVICE					8.0
	900 HOUSEKEEPI NG					9.0
	DOO DI ETARY					10.0
	100 CAFETERI A					11.0
	300 NURSI NG ADMI NI STRATI ON					13.0
	400 CENTRAL SERVICES & SUPPLY					14.0
	500 PHARMACY					15. C
	600 MEDI CAL RECORDS & LI BRARY					16.0
	700 SOCIAL SERVICE	262, 290				17.0
	PATIENT ROUTINE SERVICE COST CENTERS	a.c. a.a.a		.1	al ( a.a. a.d	
	DOO ADULTS & PEDIATRICS	262, 290	6, 940, 84		0 6, 940, 841	30.0
	100 INTENSIVE CARE UNIT	0			0 0	31.0
	400 SKILLED NURSING FACILITY	0	(		0 0	44. C
	CILLARY SERVICE COST CENTERS	0	474 47	7	0 474 477	FO (
	400 RADI OLOGY-DI AGNOSTI C	0	474, 477		0 474, 477 0 362 024	50.0
	DOO LABORATORY	0	362, 024 538, 073		0 362, 024 0 538, 073	54. 0 60. 0
	500 RESPIRATORY THERAPY	0	709, 207		0 709, 207	65.0
	500 PHYSI CAL THERAPY	0	908, 055		0 908, 055	66.0
	700 OCCUPATI ONAL THERAPY	0	900, 030 (		0 700,000	67.0
	BOO SPEECH PATHOLOGY	0	(		0 0	68.0
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	675, 068		0 675,068	71.0
	BOO DRUGS CHARGED TO PATIENTS	0	1, 850, 012		0 1, 850, 012	73.0
	400 RENAL DIALYSIS	0	493, 200		0 493, 200	74.0
	IPATIENT SERVICE COST CENTERS	1 1				
	DOO CLINIC	0	(		0 0	90. C
91.00 09 <sup>-</sup>	100 EMERGENCY	0	(		0 0	91.0
OTH	HER REIMBURSABLE COST CENTERS					
95.00 095	500 AMBULANCE SERVICES	0	(	D	0 0	95.0
	350 OTHER REIMBURSABLE CC'S	0	(	)	0 0	98.0
	ECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	262, 290	12, 950, 957	7	0 12, 950, 957	118. C
	NREI MBURSABLE COST CENTERS			1		
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0	
	200 PHYSI CI ANS' PRI VATE OFFI CES	0			0 0	172.0
	950 NONALLOWABLE CASE MANAGER	0	234, 793	3	0 234, 793	194. C
	951 I DLE SPACE	0	(	)	0 0	194. C
	952 REGIONAL OFFICE	0	(	)	0 0	194. C
	953 DI STRI CT OFFI CE	0	(	)	0 0	194. C
	P54 NON MCR CERTIFIED UNIT	0	(	2	0 0	194.0
	955 REG NURSG OFFICE	0	(	2	0 0	194.0
	P56 DATA CTR SUBLEASE (XODIAC)	0	(	2	0 0	194.0
	957 CENTRALIZED ADMISSIONS DEPT	0	(	2	0 0	194.0
	959 OTHER NONREI MBURSABLE - OPEN	0	(	2	0 11 070	194.0
	958 VISITOR MEALS	0	41, 870	2	0 41, 870	194.0
	P62 OTHER NONREI MBURSABLE CC'S	0	(	2	0 0	194. 1
	P61 NONREIMB NEW BUSINESS IMPLEMENTATION	0	(		0 0	194. 1
200. 00 201. 00	Cross Foot Adjustments		(		0 0	200. 0
	Negative Cost Centers	0	(	4	U 0	201.0
202.00	TOTAL (sum lines 118-201)	262, 290	13, 227, 620		0 13, 227, 620	202.0

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 09/01/2014 Fo 08/31/2015	Worksheet B Part II Date/Time Pre 1/21/2016 11:	
			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 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 168	3, 573	9, 741	9, 741	
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	109.778	118, 843	68, 842		1, 610	
7.00	00700 OPERATION OF PLANT	0	173, 125	100, 286		0	
8.00	00800 LAUNDRY & LINEN SERVICE	0	6, 073	3, 518		0	
9.00	00900 HOUSEKEEPI NG	0	2, 942	1, 704		157	9.00
10.00	01000 DI ETARY	0	4, 840	2, 804		119	
11.00	01100 CAFETERI A	0	0	(	0 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	(	0 0	698	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	6, 548	3, 793	3 10, 341	108	14.00
15.00	01500 PHARMACY	0	45, 551	26, 386	5 71, 937	703	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	15, 215	8, 814	4 24, 029	422	16.00
17.00	01700 SOCIAL SERVICE	0	4, 650	2, 694	4 7, 344	276	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			1 1		
30.00	03000 ADULTS & PEDIATRICS	0	255, 591	148, 056		4, 226	
	03100 I NTENSI VE CARE UNI T	0	0	(	-	0	31.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	(	0 0	0	44.00
50, 00	ANCI LLARY SERVI CE COST CENTERS	0	0	(		106	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0			290	
	06000 LABORATORY	0	0			240	
65.00	06500 RESPI RATORY THERAPY	0	0			759	
66.00	06600 PHYSI CAL THERAPY	0	15, 943	9, 235	25, 178	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(		0	67.00
68.00	06800 SPEECH PATHOLOGY	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 DI ALYSI S	0	24, 136	13, 981	1 38, 117	0	74.00
	OUTPATIENT SERVICE COST CENTERS	-					
	09000 CLINIC	0	0	(		0	
91.00	09100 EMERGENCY	0	0	(	0 0	0	91.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES					0	05 00
	09850 OTHER REIMBURSABLE CC'S	0	0	(		0	
96.00	SPECIAL PURPOSE COST CENTERS	0	0		<u> </u>	0	90.00
118.00		109, 778	679, 625	393, 686	1, 183, 089	9 474	118.00
	NONREI MBURSABLE COST CENTERS	1077770	0777020	0,0,000	1, 100, 00,	,,,,,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	o l	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	(	0 0		192.00
194.00	07950 NONALLOWABLE CASE MANAGER	0	0	(	0 0	267	194.00
194.01	07951 I DLE SPACE	0	0	(	0 0	0	194.01
194.02	07952 REGIONAL OFFICE	0	0	(	0 0	0	194. 02
	07953 DISTRICT OFFICE	0	0	(	0 0		194.03
	07954 NON MCR CERTIFIED UNIT	0	0	(	0 0		194.04
	07955 REG NURSG OFFICE	0	0	(	0		194.05
	07956 DATA CTR SUBLEASE (XODIAC)	0	0	(	) o		194.06
	07957 CENTRALIZED ADMISSIONS DEPT	0	0				194.07
	07959 OTHER NONREI MBURSABLE - OPEN	0	0				194.08
	07958 VISITOR MEALS 07962 OTHER NONREIMBURSABLE CC'S	0	0				194. 09 194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION						194.10
200.00			0				200.00
200.00			0	(	o o		201.00
202.00		109, 778	679, 625	393, 686	1, 183, 089		202.00
		•		•			•

ALLOCA	Financial Systems         Ki           ATION OF CAPITAL RELATED COSTS	ndred Hospital I		CCN: 152018 P	eriod:	u of Form CMS- Worksheet B	
					rom 09/01/2014 o 08/31/2015	Part II Date/Time Pre 1/21/2016 11:	epared:
	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
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 00500 ADMINISTRATIVE & GENERAL	299,073					4.0
5.00 7.00	00700 OPERATION OF PLANT	13, 764					5. C
. 00 3. 00	00800 LAUNDRY & LINEN SERVICE	3, 227					8.0
00 0.00	00900 HOUSEKEEPING	6, 761					9.0
0.00	01000 DI ETARY	10, 321				21, 906	
1.00	01100 CAFETERI A	0, 321			0	21, 700	
3.00	01300 NURSI NG ADMI NI STRATI ON	13, 152		0	0	0	
4.00	01400 CENTRAL SERVICES & SUPPLY	2, 715		0	242	0	
5.00	01500 PHARMACY	18, 329				0	
6.00	01600 MEDI CAL RECORDS & LI BRARY	9, 894				0	
7.00	01700 SOCIAL SERVICE	5, 677				0	
	INPATIENT ROUTINE SERVICE COST CENTERS	1			1 1		
0.00	03000 ADULTS & PEDIATRICS	106, 226	192, 402	17, 390	9, 455	19, 947	30. C
1.00	03100 I NTENSI VE CARE UNI T	0				0	1
4.00	04400 SKILLED NURSING FACILITY	0	C	0	0	0	44. C
	ANCILLARY SERVICE COST CENTERS						
0.00	05000 OPERATING ROOM	10, 341	C	0	0	0	50.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	7,836	C	0	0	0	54.0
0.00	06000 LABORATORY	11, 248	C	0	0	0	60.0
5.00	06500 RESPI RATORY THERAPY	14, 314	C	0	0	0	65.0
6. 00	06600 PHYSI CAL THERAPY	19, 106	12, 001	0	590	0	66. C
7.00	06700 OCCUPATI ONAL THERAPY	0	C	0	0	0	67.0
8.00	06800 SPEECH PATHOLOGY	0	C	0	0	0	68. C
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 501		0	0	0	
3.00	07300 DRUGS CHARGED TO PATIENTS	19, 680		0		0	
4.00	07400 RENAL DI ALYSI S	9, 672	18, 169	0	893	0	74. C
	OUTPATIENT SERVICE COST CENTERS		1				1
0.00	09000 CLINIC	0				0	
1.00	09100 EMERGENCY	0	C	0	0	0	91.0
- 00	OTHER REIMBURSABLE COST CENTERS	0					
5.00	09500 AMBULANCE SERVICES	0				0	
8.00	09850 OTHER REI MBURSABLE CC' S	0		0	0	0	98.0
18.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	293, 764	287, 175	17, 390	13, 779	19, 947	1110 0
10.00	NONREI MBURSABLE COST CENTERS	293,704	207,173	17, 370	13, 777	17, 747	1110.0
90 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190. 0
	19200 PHYSICIANS' PRIVATE OFFICES	0		0			192. 0
	07950 NONALLOWABLE CASE MANAGER	5, 309		0	0		194. 0
	07951 I DLE SPACE	0,007		0	0		194. (
	07952 REGIONAL OFFICE	0		0	0		194. 0
	307953 DI STRI CT OFFI CE	0	0	0	0		194.0
	07954 NON MCR CERTIFIED UNIT	0	-	0	0		194.0
94. 0	07955 REG NURSG OFFICE	0		0	0		194.0
	07956 DATA CTR SUBLEASE (XODIAC)	0	C	0	0		194. C
	07957 CENTRALI ZED ADMI SSI ONS DEPT	0	C	0	0		194. 0
94.08	07959 OTHER NONREIMBURSABLE - OPEN	0	C	0	0		194. 0
94.0	07958 VISITOR MEALS	0	C	0	0	1, 959	194. (
94.10	07962 OTHER NONREIMBURSABLE CC'S	0	C	0	0		194.1
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	C	0	0		194. 1
200.00							200. 0
201.00	Negative Cost Centers	0	C	0	0		201.0
202.00			287, 175	17, 390	13, 779		202.0

LLUCA	ATION OF CAPITAL RELATED COSTS			Provi der	CCN: 152018	Peri od:	Worksheet B	
						From 09/01/2014 To 08/31/2015	Part II Date/Time Pre 1/21/2016 11:	epare
	Cost Center Description	CAFETERI A		IRSI NG I STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	1	3.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	1	-					
. 00	00100 CAP REL COSTS-BLDG & FIXT							1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP							2.
. 00								4.
. 00 . 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT							5.
. 00	00800 LAUNDRY & LINEN SERVICE							7.
. 00	00900 HOUSEKEEPING							9.
0.00	01000 DI ETARY							10.
1.00	01100 CAFETERIA		0					111.
3.00	01300 NURSI NG ADMI NI STRATI ON		0	13, 850				13.
4.00	01400 CENTRAL SERVICES & SUPPLY		o	0	18, 3	35		14.
5.00	01500 PHARMACY		0	0		76 127, 120		15.
6.00	01600 MEDI CAL RECORDS & LI BRARY		0	0		0 0	46, 362	2 16.
7.00	01700 SOCIAL SERVICE		0	0		0 0	C	
	INPATIENT ROUTINE SERVICE COST CENTERS							
0. 00	03000 ADULTS & PEDIATRICS	(	0	13, 542	29	90 1	20, 955	5 30.
1. 00	03100 I NTENSI VE CARE UNI T		0	0		0 0	C	) 31.
4.00	04400 SKILLED NURSING FACILITY		0	0		0 0	C	) 44.
	ANCI LLARY SERVI CE COST CENTERS	1						_
0. 00	05000 OPERATING ROOM		0	308		1 0	408	
4.00	05400 RADI OLOGY-DI AGNOSTI C		0	0		0 0	1, 510	
0.00	06000 LABORATORY		0	0		0 0	3, 967	
5.00	06500 RESPI RATORY THERAPY		0	0	1	10 0	7, 362	
6.00	06600 PHYSI CAL THERAPY		0	0		0 0	2, 404	
7.00	06700 OCCUPATIONAL THERAPY		0	0		0 0	C	
B. 00	06800 SPEECH PATHOLOGY			0	17 7	0 0 58 0	2 401	
1.00 3.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			0	17, 7	0 127, 119	3,401	
4.00	07400 RENAL DIALYSIS		0	0		0 127, 119	5, 650 705	
+. 00	OUTPATIENT SERVICE COST CENTERS		U	0		0 0	700	/4.
0. 00	09000 CLINIC		0	0		0 0	C	90.
1.00	09100 EMERGENCY		0	0		0 0	C	
1.00	OTHER REIMBURSABLE COST CENTERS	· · ·	<u> </u>	0		0 0	C.	1 .
5.00	09500 AMBULANCE SERVICES		0	0		0 0	C	95
3.00	09850 OTHER REI MBURSABLE CC' S		0	0		0 0	C	
	SPECIAL PURPOSE COST CENTERS		<u> </u>					
8.00		(	0	13, 850	18, 3	35 127, 120	46, 362	2 118.
	NONREI MBURSABLE COST CENTERS							
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(	0	0		0 0	C	190.
	19200 PHYSI CLANS' PRI VATE OFFI CES		0	0		0 0	C	) 192.
	07950 NONALLOWABLE CASE MANAGER		0	0		0 0		) 194.
	07951 I DLE SPACE		0	0		0 0		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		U	0		0		) 194.
	07956 DATA CTR SUBLEASE (XODIAC)		U	0		0		) 194.
	07957 CENTRALIZED ADMISSIONS DEPT		U	0		0		194
	07959 OTHER NONREIMBURSABLE - OPEN		0	0		0 0		) 194.
	07958 VISITOR MEALS			0		0		194
	07962 OTHER NONREI MBURSABLE CC'S		0	0				) 194.
94. I 00. 00	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	1	4	0		9	Ĺ	200
	· · · · · · · · · · · · · · · · · · ·	1	1					200.
00.00 01.00	Negative Cost Centers					0 0	r	11.30.12

	ndred Hospital N				u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet B Part II Date/Time Prepared: 1/21/2016 11:13 am
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total st	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS	Т		1		
1.00         00100         CAP         REL         COSTS-BLDG         & FIXT           2.00         00200         CAP         REL         COSTS-MVBLE         EQUI P           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMI NI STRATI VE         & GENERAL					1.00 2.00 4.00 5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00 8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA					9.00 10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY					13.00 14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	16, 969				16. 00 17. 00
30.00 03000 ADULTS & PEDIATRICS	16, 969	805, 050		0 805, 050	30.00
31. 00 03100 INTENSIVE CARE UNIT 44. 00 04400 SKI LLED NURSING FACILITY	0	000,000			31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	11, 164 9, 636		0 11, 164 0 9, 636	50.00 54.00
60. 00 06000 LABORATORY	0	15, 215		0 15, 215	60.00
65. 00 06500 RESPI RATORY THERAPY	0	22, 545		0 22, 545	65.00
66.00 06600 PHYSI CAL THERAPY	0	59, 279		0 59, 279	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	67.00 68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32, 660		0 32, 660	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	152, 449		0 152, 449	73.00
74.00 07400 RENAL DIALYSIS	0	67, 556		0 67, 556	74.00
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0		0 0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	90.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	95.00
98. 00 09850 OTHER REIMBURSABLE CC'S SPECIAL PURPOSE COST CENTERS	0	0		0 0	98.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16, 969	1, 175, 554		0 1, 175, 554	118.00
NONREI MBURSABLE COST CENTERS	-				
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 NONALLOWABLE CASE MANAGER	0	0 5, 576		0 0 0 5,576	192. 00 194. 00
194. 01 07951 I DLE SPACE	0	3, 370 0		0 0	194.00
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 194. 05 07955 REG NURSG OFFICE	0	0	1	0 0	194.04
194. 06 07956 DATA CTR SUBLEASE (XODIAC)	0	0		0 0	194. 05 194. 06
194. 07 07957 CENTRALI ZED ADMI SSI ONS DEPT	0	0		0 0	194. 07
194.0807959 OTHER NONREIMBURSABLE – OPEN	0	0		0 0	194. 08
194. 09 07958 VI SI TOR MEALS	0	1, 959		0 1, 959	194.09
194.10 07962 OTHER NONREIMBURSABLE CC'S 194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0			194. 10 194. 11
200.00 Cross Foot Adjustments	0	0		0 0	200.00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00   TOTAL (sum lines 118-201)	16, 969	1, 183, 089	1	0 1, 183, 089	202.00

	LOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					rom 09/01/2014 o 08/31/2015		
		CAPI TAL REL	ATED COSTS			1/21/2016 11:	13
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	cost center bescription	(SQUARE FEET	(SQUARE FEET	BENEFITS	Reconciliation	& GENERAL	
		#1)	#2)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2.00	SALARIES) 4.00	5A	5.00	-
	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT	21, 485					
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT	195	21, 485 195				
	0500 ADMI NI STRATI VE & GENERAL	3,757	3, 757	913, 985		10, 630, 628	
00 00	0700 OPERATION OF PLANT	5, 473		C		489, 255	
	0800 LAUNDRY & LINEN SERVICE	192	192	C	-	114, 716	
	0900 HOUSEKEEPING	93	93	88, 822		240, 321	
	1000 DI ETARY 1100 CAFETERI A	153 0	153 0	67, 408 C		366, 851 0	
1	1300 NURSI NG ADMI NI STRATI ON	0	0	396, 212		467, 497	
	1400 CENTRAL SERVICES & SUPPLY	207	207	61, 381	0	96, 497	
	1500 PHARMACY	1,440		399, 237		651, 514	
	1600 MEDICAL RECORDS & LIBRARY	481	481	239, 616		351, 681	
	1700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	147	147	156, 387	0	201, 784	1
	3000 ADULTS & PEDIATRICS	8,080	8, 080	2, 399, 393	0	3, 775, 842	3
	3100 INTENSIVE CARE UNIT	0	0	C		0	
	4400 SKILLED NURSING FACILITY	0	0	C	0 0	0	4
	NCI LLARY SERVI CE COST CENTERS 5000 OPERATI NG ROOM	0	0	60, 034	0	367, 572	5
	5400 RADI OLOGY-DI AGNOSTI C	0		164, 837		278, 535	
	6000 LABORATORY	0	0	C		399, 819	
	6500 RESPI RATORY THERAPY	0	0	430, 612	0	508, 786	6
	6600 PHYSI CAL THERAPY	504	504	C	-	679, 118	
	6700 OCCUPATIONAL THERAPY	0	0	0	-	0	
	6800 SPEECH PATHOLOGY 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		-	0 408, 820	
	7300 DRUGS CHARGED TO PATIENTS	0	0		-	699, 520	
	7400 RENAL DIALYSIS	763	763	C		343, 804	
	UTPATIENT SERVICE COST CENTERS	-	-	-		_	4.
	9000 CLI NI C 9100 EMERGENCY	0				0	
	THER REIMBURSABLE COST CENTERS	0	0	U	<u> </u>	0	- 9
	9500 AMBULANCE SERVICES	0	0	C	0 0	0	9
. 00 0	9850 OTHER REIMBURSABLE CC'S	0	0	C	0 0	0	9
	PECIAL PURPOSE COST CENTERS						4
8.00	SUBTOTALS (SUM OF LINES 1-117) ONREIMBURSABLE COST CENTERS	21, 485	21, 485	5, 377, 924	-2, 596, 992	10, 441, 932	1113
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0 0	0	19
2.001	9200 PHYSICIANS' PRIVATE OFFICES	0	0	C	-		19
4.000	7950 NONALLOWABLE CASE MANAGER	0	0	151, 767		188, 696	
	7951 I DLE SPACE	0	0	C	-		19
	7952 REGIONAL OFFICE 7953 DISTRICT OFFICE	0	0		-		19
	7954 NON MCR CERTIFIED UNIT	0	0				19
	7955 REG NURSG OFFICE	0	0	C	0		19
	7956 DATA CTR SUBLEASE (XODIAC)	0	0	C	0 0		19
	7957 CENTRALIZED ADMISSIONS DEPT	0	0	C	-		19
	7959 OTHER NONREIMBURSABLE – OPEN 7958 VISITOR MEALS	0			-		19
	7962 OTHER NONREIMBURSABLE CC'S	0	0		-		19
1	7961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	C	0		19
0. 00	Cross Foot Adjustments						20
1.00	Negative Cost Centers						20
2.00	Cost to be allocated (per Wkst. B,	679, 625	393, 686	835, 994	-	2, 596, 992	20
3.00	Part I) Unit cost multiplier (Wkst. B, Part I)	31. 632534	18. 323761	0. 151183		0. 244293	20
4.00	Cost to be allocated (per Wkst. B,	01.002004	10. 020701	9, 741		299, 073	
		1			1		1
5.00	Part II) Unit cost multiplier (Wkst. B, Part			0.001762		0. 028133	

IST A	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 09/01/2014 o 08/31/2015	Worksheet B-1 Date/Time Pre 1/21/2016 11:	epare
	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				I		
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00	00500 ADMI NI STRATI VE & GENERAL						5.
00	00700 OPERATION OF PLANT	12, 060					7.
00	00800 LAUNDRY & LINEN SERVICE	192					8.
00	00900 HOUSEKEEPI NG	93		11, 775			9.
0. 00	01000 DI ETARY	153	0	153			10.
. 00	01100 CAFETERI A	0	0	0	0	74	11.
. 00	01300 NURSING ADMINISTRATION	0	0	0	0	5	13.
. 00	01400 CENTRAL SERVICES & SUPPLY	207	0	207	0	2	14.
. 00		1,440	0	1, 440	0	5	15.
. 00	01600 MEDICAL RECORDS & LIBRARY	481	0	481	0	4	16
. 00		147	0	147	0	4	17
	INPATIENT ROUTINE SERVICE COST CENTERS						
. 00		8, 080		8, 080		44	
00		0		0	-	0	
. 00		0	0	0	0	0	44
~~	ANCI LLARY SERVI CE COST CENTERS			0	0	1	1 - 0
00		0	-	0	-	1	
00		0	0	0	-	2	
00			0	0	-	0 7	
00		504	-	0 504	0	7	
. 00		504	0	504	0	0	
. 00			0	0	0	0	
. 00					0	0	
. 00				0	0	0	
. 00		763	0	763	-	0	
	OUTPATIENT SERVICE COST CENTERS				· · · · · ·		
. 00		0	0	0	0	0	90
00	09100 EMERGENCY	0	0	0	0	0	91
	OTHER REIMBURSABLE COST CENTERS						
00		0	0	0	0	0	95
00		0	0	0	0	0	98
	SPECIAL PURPOSE COST CENTERS	1	1		1		
3.00		12,060	8, 971	11, 775	22, 296	74	118
	NONREI MBURSABLE COST CENTERS						1.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0			190
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192
	0 07950 NONALLOWABLE CASE MANAGER 1 07951 IDLE SPACE		0	0	0		194 194
	207952 REGIONAL OFFICE		0	0	0		194
	3 07953 DI STRI CT OFFI CE		0	0	0		194
	4 07954 NON MCR CERTIFIED UNIT	0		0	0		194
	5 07955 REG NURSG OFFICE		0	0	0		194
	607956 DATA CTR SUBLEASE (XODIAC)	0	0	0	0		194
	7 07957 CENTRALIZED ADMISSIONS DEPT		n	0	0		194
	8 07959 OTHER NONREI MBURSABLE – OPEN		0	0	0		194
	9 07958 VI SI TOR MEALS	0	0	0	2, 190		194
	0 07962 OTHER NONREIMBURSABLE CC'S	0	0	0	0		194
4. 11	1 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194
0. 00	0 Cross Foot Adjustments						200
1.00	0 Negative Cost Centers						201
2.00	O Cost to be allocated (per Wkst. B,	608, 777	152, 432	303, 725	468, 139	0	202
	Part I)						
3.00		50. 479022		25.794055		0.00000	
4.00		287, 175	17, 390	13, 779	21, 906	0	204
							1
5.00	Part II) O Unit cost multiplier (Wkst. B, Part	23. 812189	1. 938468	1. 170191	0. 894634	0.00000	1-

ST A	Financial Systems Ki LLOCATION - STATISTICAL BASIS		Provi der (	CCN: 152018	Period: From 09/01/2014	Worksheet B-1	
					To 08/31/2015	Date/Time Pre 1/21/2016 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
		(NURSING FTES)	SUPPLY (COSTED	REQUIS.)		(PATIENT DAYS)	
			REQUIS.)		REVENUE)		
		13.00	14.00	15.00	16.00	17.00	
	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 ADMINISTRATIVE & GENERAL						5
0	00700 OPERATION OF PLANT						7
00	00800 LAUNDRY & LINEN SERVICE						8
00	00900 HOUSEKEEPI NG						9
00	01000 DI ETARY						10
00	01100 CAFETERI A						11
00	01300 NURSING ADMINISTRATION	45					13
	01400 CENTRAL SERVICES & SUPPLY	0	422, 113				14
	01500 PHARMACY	0	4, 055	699, 52			15
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 54, 222, 542		16
00	01700 SOCIAL SERVICE	0	0		0 0	8, 971	17
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	44	6, 680		7 24, 508, 061	8, 971	30
	03100 I NTENSI VE CARE UNI T	0	0		0 0		31
00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44
	ANCILLARY SERVICE COST CENTERS				-		
00	05000 OPERATING ROOM	1	33		0 476, 933	0	50
00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 1, 765, 709	0	54
00	06000 LABORATORY	0	0		0 4, 639, 384	0	60
00	06500 RESPI RATORY THERAPY	0	2, 525		0 8, 610, 398	0	65
00	06600 PHYSI CAL THERAPY	0	0		0 2, 811, 425	0	66
00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67
00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68
00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	408, 820		0 3, 978, 071	0	71
00	07300 DRUGS CHARGED TO PATIENTS	0	0	699, 52	6, 608, 134	0	73
00	07400 RENAL DIALYSIS	0	0		0 824, 427	0	74
	OUTPATIENT SERVICE COST CENTERS		· · ·				
00	09000 CLI NI C	0	0		0 0	0	90
00	09100 EMERGENCY	0	0		0 0	0	91
	OTHER REIMBURSABLE COST CENTERS	· · ·	· · ·				
00	09500 AMBULANCE SERVICES	0	0		0 0	0	95
00	09850 OTHER REIMBURSABLE CC'S	0	0		0 0	0	98
	SPECIAL PURPOSE COST CENTERS	· · ·	·				
3. 00	SUBTOTALS (SUM OF LINES 1-117)	45	422, 113	699, 52	54, 222, 542	8, 971	1118
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190
. 00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192
	07950 NONALLOWABLE CASE MANAGER	0	0		0 0		194
	07951 I DLE SPACE	0	o		0 0		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 0		194
	07956 DATA CTR SUBLEASE (XODIAC)	0	0		0 0		194
	07957 CENTRALIZED ADMISSIONS DEPT	0	0		0 0		194
	07959 OTHER NONREL MBURSABLE - OPEN	0	0		0 0		194
	07958 VI SI TOR MEALS	0	0		0 0		194
	07962 OTHER NONREI MBURSABLE CC'S	0	0		0 0		194
	07961 NONREI MB NEW BUSI NESS I MPLEMENTATI ON	0	0		0 0		194
. 00			0				200
. 00							200
2.00		581, 703	135, 859	921, 81	2 474, 281	262, 290	
00	Part I)	561,703	133, 639	721, 81	4/4,201	202, 290	202
3. 00		12, 926. 733333	0. 321855	1 21774	0. 008747	29. 237543	203
				1.31776			
4.00	Cost to be allocated (per Wkst. B, Part II)	13, 850	18, 335	127, 12	46, 362	16, 969	204
5.00		000000	0 042424	0 10170		1 001520	205
	Tomic cost multiplier (wkst. B, Part	307. 777778	0. 043436	0. 18172	0. 000855	1.891539	1205

Health Financial Systems	Kindred Hospital N	orthern Indiar	าล	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 09/01/2014 To 08/31/2015	Worksheet C Part I Date/Time Pre 1/21/2016 11:	
		Ti tl	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)					
UNDATE FAIT DOUTENE OF DUE OOOT OF ATTER	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			( 040 04	1 7 005	( 0.10 00)	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	6, 940, 841		6, 940, 84	1 7, 995	6, 948, 836	30.00
44.00 04400 SKILLED NURSING FACILITY	0				0	31.00 44.00
ANCI LLARY SERVICE COST CENTERS	U			J U	0	44.00
50. 00 05000 OPERATING ROOM	474, 477		474, 47	7 0	474, 477	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	362, 024		362, 02		362, 024	
60. 00 06000 LABORATORY	538, 073		538, 07		538, 073	
65. 00 06500 RESPIRATORY THERAPY	709, 207	0	709, 20		710, 416	
66. 00 06600 PHYSI CAL THERAPY	908, 055	0	908, 05		908, 055	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	,00,000	0	700,00	0	,00,000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS 675, 068	-	675,06	в	675,068	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 850, 012		1, 850, 01		1, 850, 012	
74.00 07400 RENAL DIALYSIS	493, 200		493, 20	345	493, 545	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0			0 0	0	90.00
91.00 09100 EMERGENCY	0			0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
98.00 09850 OTHER REIMBURSABLE CC'S	0			0 0	0	98.00
200.00 Subtotal (see instructions)	12, 950, 957	0	12, 950, 95	7 9, 549		
201.00 Less Observation Beds	0					201.00
202.00  Total (see instructions)	12, 950, 957	0	12, 950, 95	7 9, 549	12, 960, 506	202.00

Health Financial Systems Kir	ndred Hospital N	lorthern India	าล	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				From 09/01/2014	Part I	
				To 08/31/2015	Date/Time Pre 1/21/2016 11:	
		Ti †I	e XVIII	Hospi tal	PPS	
		Charges		liospreur	110	
Cost Center Description	I npati ent	Outpati ent	Total (col. (	Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpatient	
			Í Í		Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	24, 508, 061		24, 508, 06	1		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	476, 933	C	476, 93	3 0. 994850	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 765, 709	0	1, 765, 70		0. 000000	
60. 00 06000 LABORATORY	4, 639, 384	0	4, 639, 38		0. 000000	
65. 00 06500 RESPI RATORY THERAPY	8, 610, 398	0	8, 610, 39		0. 000000	
66. 00 06600 PHYSI CAL THERAPY	2, 811, 425	0	2, 811, 42		0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0.000000	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 978, 071	0	3, 978, 07		0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 608, 134	C	6, 608, 13		0.000000	
74.00 07400 RENAL DIALYSIS	824, 427	C	824, 42	7 0. 598234	0.00000	74.00
OUTPATIENT SERVICE COST CENTERS	1 1					-
90. 00 09000 CLI NI C	0	C	1	0 0. 000000	0.00000	•
91. 00 09100 EMERGENCY	0	0		0 0.00000	0.00000	91.00
OTHER REIMBURSABLE COST CENTERS		-	1			
95. 00 09500 AMBULANCE SERVICES	0	0		0 0.00000	0.00000	
98.00 09850 OTHER REI MBURSABLE CC' S	0	0		0 0.00000	0.000000	
200.00 Subtotal (see instructions)	54, 222, 542	C	54, 222, 54	2		200.00
201.00 Less Observation Beds						201.00
202.00  Total (see instructions)	54, 222, 542	C	54, 222, 54	2		202.00

Health Fin	ancial Systems K	indred Hospital No	orthern Indiana	In Lieu	u of Form CMS-2	2552-10
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES		Provider CCN: 152018	Period: From 09/01/2014 To 08/31/2015	1/21/2016 11:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	ATIENT ROUTINE SERVICE COST CENTERS					
	00 ADULTS & PEDIATRICS					30.00
	00 INTENSIVE CARE UNIT					31.00
	00 SKILLED NURSING FACILITY					44.00
	I LLARY SERVICE COST CENTERS					
	OO OPERATING ROOM	0. 994850				50.00
	00 RADI OLOGY-DI AGNOSTI C	0. 205030				54.00
	00 LABORATORY	0. 115979				60.00
	00 RESPI RATORY THERAPY	0. 082507				65.00
	00 PHYSI CAL THERAPY	0. 322987				66.00
	00 OCCUPATI ONAL THERAPY	0. 000000				67.00
	00 SPEECH PATHOLOGY	0.00000				68.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 169697				71.00
	00 DRUGS CHARGED TO PATIENTS 00 RENAL DIALYSIS	0. 279960				73.00
	PATIENT SERVICE COST CENTERS	0. 598652				74.00
	00 CLINIC	0. 000000				90.00
	00 EMERGENCY	0.000000				91.00
	ER REIMBURSABLE COST CENTERS	0.000000				91.00
	00 AMBULANCE SERVICES	0. 000000				95.00
	50 OTHER REIMBURSABLE CC'S	0, 000000				98.00
200.00	Subtotal (see instructions)	0.00000				200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	Kir	ndred Hospital I	Northern India	าล	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF C	COSTS TO CHARGES				Period: From 09/01/2014 To 08/31/2015	1/21/2016 11:	
			Tit	le XIX	Hospi tal	Cost	
					Costs		
Cost Center [	Description		Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)	0.00			5.00	
	CEDUI OF OOCT OFNITEDO	1.00	2.00	3.00	4.00	5.00	
	SERVICE COST CENTERS	( 040 041		( 040 04	1 7.005	( 040 02(	20.00
30.00 03000 ADULTS & PEDI 31.00 03100 I NTENSI VE CAR		6, 940, 841		6, 940, 84	1 7, 995	6, 948, 836 0	30.00 31.00
44. 00 04400 SKI LLED NURSI		0			0 0	0	44.00
ANCI LLARY SERVICE		0			0 0	0	44.00
50. 00 05000 OPERATI NG R00		474, 477		474, 47	7 0	474, 477	50.00
54, 00 05400 RADI OLOGY-DI		362, 024		362, 02		362, 024	
60. 00 06000 LABORATORY		538, 073		538, 07		538, 073	
65. 00 06500 RESPI RATORY	THERAPY	709, 207		709, 20			
66. 00 06600 PHYSI CAL THEF		908, 055		908, 05		908, 055	
67.00 06700 OCCUPATI ONAL		0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOL		0	C		0 0	0	68,00
71.00 07100 MEDI CAL SUPPL	LIES CHARGED TO PATIENTS	675,068		675, 06	8 0	675, 068	71.00
73.00 07300 DRUGS CHARGEI	D TO PATIENTS	1,850,012		1, 850, 01	2 0	1, 850, 012	73.00
74.00 07400 RENAL DIALYSI	S	493, 200		493, 20	0 345	493, 545	74.00
OUTPATIENT SERVICE	COST CENTERS						
90. 00 09000 CLI NI C		0			0 0	0	90.00
91.00 09100 EMERGENCY		0			0 0	0	91.00
OTHER REI MBURSABLE				1			
95.00 09500 AMBULANCE SEF		0			0 0	0	95.00
98.00 09850 OTHER REI MBUR		0			0 0	0	98.00
	e instructions)	12, 950, 957	C	12, 950, 95	7 9, 549		
201.00 Less Observat		0			0		201.00
202.00  Total (see in	nstructions)	12, 950, 957	C	12, 950, 95	9, 549	12, 960, 506	202.00

Health Financial Systems Kir	ndred Hospital N	lorthern India	าล	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				From 09/01/2014	Part I	
				To 08/31/2015	Date/Time Pre 1/21/2016 11:	
		Ti t	le XIX	Hospi tal	Cost	IS dill
		Charges			0031	
Cost Center Description	I npati ent	Outpatient	Total (col	6 Cost or Other	TEFRA	
oost oontor bescription	inputront	outputront	+ col. 7	Ratio	Inpati ent	
				ind the	Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	24, 508, 061		24, 508, 06	1		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCI LLARY SERVI CE COST CENTERS						1
50. 00 05000 OPERATI NG ROOM	476, 933	C	476, 93	3 0. 994850	0. 000000	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 765, 709	C	1, 765, 70	9 0. 205030	0. 000000	54.00
60. 00 06000 LABORATORY	4, 639, 384	C	4, 639, 38	4 0. 115979	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	8, 610, 398	C	8, 610, 39	8 0. 082366	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 811, 425	C	2, 811, 42	5 0. 322987	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0.000000	0.00000	
68.00 06800 SPEECH PATHOLOGY	0	C		0 0.000000	0.00000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 978, 071	C	3, 978, 07	1 0. 169697	0.00000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 608, 134	C	6, 608, 13			
74.00 07400 RENAL DIALYSIS	824, 427	C	824, 42	7 0. 598234	0.00000	74.00
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLINIC	0	C	1	0 0. 000000		•
91. 00 09100 EMERGENCY	0	C		0 0.00000	0.00000	91.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES	0	C		0 0. 000000		
98.00 09850 OTHER REI MBURSABLE CC' S	0	C		0 0. 000000	0. 000000	
200.00 Subtotal (see instructions)	54, 222, 542	C	54, 222, 54	2		200.00
201.00 Less Observation Beds	<b></b>	-	-			201.00
202.00  Total (see instructions)	54, 222, 542	C	54, 222, 54	2		202.00

Health Financial Systems Kin	ndred Hospital Nor	rthern Indiana	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet C Part I Date/Time Pre 1/21/2016 11:	pared: 13 am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPIRATORY THERAPY	0.00000				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	0.00000				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.00000				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00 07400 RENAL DI ALYSI S	0. 000000				74.00
90.00 09000 CLINIC	0. 000000				90.00
91. 00 09100 EMERGENCY	0.000000				90.00
OTHER REIMBURSABLE COST CENTERS	0.000000				91.00
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
98.00 09850 OTHER REIMBURSABLE CC'S	0. 000000				98.00
200.00 Subtotal (see instructions)	0.000000				200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICI	E CAPITAL COSTS	Provi der		Period: From 09/01/2014	Worksheet D Part I	
				To 08/31/2015	Date/Time Pre	pared:
					1/21/2016 11:	<u>13 am</u>
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
		Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENT				1 1		
30. 00 ADULTS & PEDIATRICS	805, 050	0	805, 050	0 8, 971	89.74	
31.00 INTENSIVE CARE UNIT	0	ļ	I C	0 0	0.00	
44.00 SKILLED NURSING FACILITY	0	1	l C	0 0		44.00
200.00 Total (lines 30-199)	805, 050	!	805, 050	8, 971		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
	(C	col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENT						
30. 00 ADULTS & PEDIATRICS	6, 665	598, 117	I		I	30.0
31.00 INTENSIVE CARE UNIT	0	UI UI	l		I	31.0
44.00 SKILLED NURSING FACILITY	0	0				44.0
200.00 Total (lines 30-199)	6, 665	598, 117	I		I	200. 0

ealth Financial Systems Ki	ndred Hospital	Northern Indiar	าล	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS		CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Date/Time Pre 1/21/2016 11:	pared: 13 am
			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 SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	11, 164	476, 933	0. 02340	259, 283		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 636	1, 765, 709	0.00545	57 1, 270, 665	6, 934	54.00
50. 00 06000 LABORATORY	15, 215	4, 639, 384	0.00328	3, 601, 387	11, 813	60.00
55. 00 06500 RESPI RATORY THERAPY	22, 545	8, 610, 398	0.00261	6, 260, 614	16, 390	65.00
56. 00 06600 PHYSI CAL THERAPY	59, 279	2, 811, 425	0. 02108	1, 989, 284	41, 944	66.00
57.00 06700 OCCUPATIONAL THERAPY	0	0	0.0000	0 0	0	67.00
58.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32,660	3, 978, 071	0.0082	2, 875, 824	23, 611	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	152, 449	6, 608, 134	0. 02307	4, 882, 068	112, 629	73.00
74. 00 07400 RENAL DI ALYSI S	67, 556	824, 427	0. 08194	43 601, 428	49, 283	74.00
OUTPATIENT SERVICE COST CENTERS			·			1
20. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
91.00 09100 EMERGENCY	0	0	0.0000		0	91.00
OTHER REIMBURSABLE COST CENTERS	- 1	1		-		1
95. 00 09500 AMBULANCE SERVICES						95.00
28. 00 09850 OTHER REIMBURSABLE CC' S	0	0	0.0000	0 0	0	
200.00 Total (lines 50-199)	370, 504	29, 714, 481		21, 740, 553	-	

Health Financial Systems Kir	dred Hospital	Northern Indiar	าล	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 09/01/2014 To 08/31/2015	Date/Time Pre 1/21/2016 11:	
			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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0	0	31.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
'	Days	5 ÷ col. 6)	Program Days			
		· · ·		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00	1	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	8, 971	0.00	6, 66	5 0		30.00
31.00 03100 INTENSIVE CARE UNIT	0	0.00		0 0		31.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		o o		44.00
200.00 Total (lines 30-199)	8, 971		6, 66	5 0		200.00

Health Financial Systems         Kindred Hospital Northern Indiana         In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PAS	S Provi der	CCN: 152018	Peri od:	Worksheet D		
THROUGH COSTS				From 09/01/2014 To 08/31/2015		norod.	
				To 08/31/2015	Date/Time Pre 1/21/2016 11:		
	_		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	1		1				
90. 00 09000 CLI NI C	0	0		0 0	0	90.00	
91.00 09100 EMERGENCY	0	0		0 0	0	91.00	
OTHER REIMBURSABLE COST CENTERS			1				
95. 00 09500 AMBULANCE SERVI CES						95.00	
98.00 09850 OTHER REIMBURSABLE CC'S	0	0		0 0	0		
200.00   Total (lines 50-199)	0	0		0 0	0	200. 00	

Health Financial Systems Kindred Hospital Northern Indiana In Lieu of Form CMS-25						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provi der		Period:	Worksheet D	
THROUGH COSTS				From 09/01/2014	Part IV	
				To 08/31/2015	Date/Time Pre 1/21/2016 11:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			I npati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of			to Charges	Charges	
	col. 2, 3 and		7)	(col. 6 ÷ col.	5	
	4)	r		7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		•				
50.00 05000 OPERATING ROOM	0	476, 933	0.00000	0 0. 000000	259, 283	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 765, 709	0.00000	0 0. 000000	1, 270, 665	54.00
60. 00 06000 LABORATORY	0	4, 639, 384	0.00000	0 0. 000000	3, 601, 387	60.00
65. 00 06500 RESPI RATORY THERAPY	0	8, 610, 398	0. 00000	0 0. 000000	6, 260, 614	65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 811, 425	0.00000	0 0. 000000	1, 989, 284	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C	0. 00000	0 0. 000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C	0. 00000	0 0. 000000	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 978, 071	0.00000	0 0. 000000	2, 875, 824	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 608, 134	0.00000	0 0. 000000	4, 882, 068	73.00
74.00 07400 RENAL DIALYSIS	0	824, 427	0.00000	0 0. 000000	601, 428	74.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	0	C	0.00000	0 0. 000000	0	90.00
91.00 09100 EMERGENCY	0	C	0.00000	0 0. 000000	0	91.00
OTHER REIMBURSABLE COST CENTERS		-				
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE CC'S	0	C	0.00000	0 0. 000000	0	98.00
200.00   Total (lines 50-199)	0	29, 714, 481			21, 740, 553	200. 00

Health Financial Systems Kin	indred Hospital Northern Indiana			In Lieu of Form CMS-2552		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	<b>VICE OTHER PASS</b>	Provi der	CCN: 152018	Peri od:	Worksheet D	
THROUGH COSTS				From 09/01/2014		
				To 08/31/2015	Date/Time Pre 1/21/2016 11:	pared:
		Ti †1	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpatient		115	
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	g	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	0		0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	11, 501		0		54.00
60. 00 06000 LABORATORY	0	1, 611		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	10, 423		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 295		0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
74.00 07400 RENAL DIALYSIS	0	1, 303		0		74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0		90.00
91.00 09100 EMERGENCY	0	0		0		91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE CC'S	0	0		0		98.00
200.00 Total (lines 50-199)	0	29, 133		0		200. 00

Health Financial Systems Kir	ndred Hospital	Northern Indiar	าล	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provi der		Period: From 09/01/2014 To 08/31/2015		pared: 13 am
		Titl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0. 994850			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 205030			0 0	2, 358	
60. 00 06000 LABORATORY	0. 115979			0 0	187	
65. 00 06500 RESPI RATORY THERAPY	0. 082366			0 0	859	
66. 00 06600 PHYSI CAL THERAPY	0. 322987	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 169697	4, 295		0 0	729	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 279960	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 598234	1, 303		0 0	779	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS					_	
95. 00 09500 AMBULANCE SERVI CES	0. 000000	)		0		95.00
98.00 09850 OTHER REIMBURSABLE CC'S	0. 000000	0		0 0	0	98.00
200.00 Subtotal (see instructions)	1	29, 133		o o	4, 912	200.00
201.00 Less PBP Clinic Lab. Services-Program				o o		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		29, 133		0 0	4, 912	202.00

Health Financial Systems K	ndred Hospital	ndred Hospital Northern Indiana			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST		CCN: 152018	Period: From 09/01/2014 To 08/31/2015	1/21/2016 11:	epared: 13 am		
		Titl	e XVIII	Hospi tal	PPS			
	Со	sts						
Cost Center Description	Cost	Cost						
	Reimbursed	Reimbursed						
	Servi ces	Services Not						
	Subject To	Subject To						
	Ded. & Coins.	Ded. & Coins.						
	(see inst.)	(see inst.)						
	6.00	7.00						
ANCILLARY SERVICE COST CENTERS						_		
50.00 05000 OPERATI NG ROOM	C	0 0				50.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0 0				54.00		
60. 00 06000 LABORATORY	C	0				60.00		
65. 00 06500 RESPI RATORY THERAPY	C	0				65.00		
66. 00 06600 PHYSI CAL THERAPY	C	0				66.00		
67.00 06700 OCCUPATI ONAL THERAPY	C	0 0				67.00		
68.00 06800 SPEECH PATHOLOGY	C	0 0				68.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0				71.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0				73.00		
74.00 07400 RENAL DIALYSIS	C	0				74.00		
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLI NI C	C	0 0				90.00		
91. 00 09100 EMERGENCY	0	0 0				91.00		
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500 AMBULANCE SERVI CES	C					95.00		
98.00 09850 OTHER REIMBURSABLE CC'S	0	0 0				98.00		
200.00 Subtotal (see instructions)	0	0 0				200.00		
201.00 Less PBP Clinic Lab. Services-Program	0					201.00		
Only Charges								
202.00 Net Charges (line 200 +/- line 201)	0	0				202.00		

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 152018	Period: From 09/01/2014	Worksheet D-1	
			To 08/31/2015	Date/Time Pre 1/21/2016 11:	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days			8, 971	
00	Inpatient days (including private room days, excluding swing-burner room days (excluding swing-bed and observation bed days)		sivata room dave	8, 971	
00	do not complete this line.	s). If you have only pr	rvate room days,	0	3
0	Semi-private room days (excluding swing-bed and observation be	d days)		8, 971	4
0	Total swing-bed SNF type inpatient days (including private room	m days) through Decembe	er 31 of the cost	0	Ę
00	reporting period Total swing-bed SNF type inpatient days (including private roo	m dave) after December	21 of the cost	0	
	reporting period (if calendar year, enter 0 on this line)	i uays) arter December	ST OF THE COST	0	6
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period			_	
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	si of the cost	0	8
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	6, 665	9
	newborn days)	0 1 0			
00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days)	0	10
00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		coom days) after	0	1
00	December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	'
00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	te room days)	0	12
00	through December 31 of the cost reporting period			0	1.
	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yes			0	13
	Medically necessary private room days applicable to the Program			0	14
00	Total nursery days (title V or XIX only)		5 /	0	15
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service:	s through December 31 c	of the cost	0.00	1 1
00	reporting period	s through becomber of e		0.00	
00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	f the cost	0.00	10
00	reporting period	through becomber of or		0.00	
	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	the cost	0.00	20
	reporting period Total general inpatient routine service cost (see instructions	)		6, 948, 836	21
	Swing-bed cost applicable to SNF type services through December		ting period (line	0, 940, 030	
	5 x line 17)			-	
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)			Ū	-
00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		6, 948, 836	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		CTIONS)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	5 517		0.00	
	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	6, 948, 836	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	STMENTS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see			774. 59	38
	Program general inpatient routine service cost per diem (see			5, 162, 642	
. 00	Medically necessary private room cost applicable to the Program	m (line 14 x line 35)		0	40
00	Total Program general inpatient routine service cost (line 39	+ line 40)		5, 162, 642	1 4

		ndred Hospital I					u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi	der		Period: From 09/01/2014	Worksheet D-1	
						08/31/2015		
				∏i tl∉	e XVIII	Hospi tal	1/21/2016 11: PPS	13 am
	Cost Center Description	Total	Total		Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient [	Days			(col. 3 x col.	
		1.00	2.00		<u>col. 2)</u> 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)							42.00
42.00	Intensive Care Type Inpatient Hospital Units		-		0.00		0	42.00
	INTENSIVE CARE UNIT 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						4, 310, 063	
49.00	Total Program inpatient costs (sum of lines	41 through 48)(	see instru	ctior	ns)		9, 472, 705	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (1	from	Wkst. D. sum	of Parts L and	598, 117	50.00
	111)							
51.00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services	(fro	om Wkst. D, su	m of Parts II	268, 673	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)					866, 790	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-	-phys	sician anesthe	tist, and	8, 605, 915	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program di scharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
	Target amount (line 54 x line 55)						0	56.00
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amoun	t (II	ine 56 minus I	ine 53)	0	57.00 58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996	6, up	pdated and com	pounded by the	0.00	
	market basket		0.00					
60.00 61.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					he amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less that						0	01.00
(0.00	amount (line 56), otherwise enter zero (see instructions)							10.00
								62.00 63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						0	00100
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of	the	cost reportir	g period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of th	he co	ost reportina	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 lii	ne 6	5)(title XVIII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 3	31 of	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 31	of	the cost repor	ting period	0	68.00
	(line 13 x line 20)							
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						0	69.00
70.00	Skilled nursing facility/other nursing facil							70.00
	Adjusted general inpatient routine service c		ine 70 ÷ li	ine 2	2)			71.00
	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14)	v lir	ne 35)			72.00 73.00
	Total Program general inpatient routine serv				ne 33)			74.00
75.00	Capital-related cost allocated to inpatient	routine service	e costs (fro	om Wo	orksheet B, Pa	rt II, column		75.00
76.00	26, line 45) 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							78.00
	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		JUSI IIMITA	uon	(IINE /8 MINU	is i i në 79)		80. 00 81. 00
82.00	Inpatient routine service cost per dream rimit Inpatient routine service cost limitation (I		)					82.00
83.00	Reasonable inpatient routine service costs (		is)					83.00
	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	J /					
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ling 2)				0	87.00 88.00
	Observation bed cost (line 87 x line 88) (se							88.00 89.00

Health Financial Systems Kir	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 09/01/2014 To 08/31/2015	Date/Time Pre 1/21/2016 11:	pared: 13 am
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	805,050	6, 948, 836	0. 11585	4 0	0	90.00
91.00 Nursing School cost	(	6, 948, 836	0.00000	0 0	0	91.00
92.00 Allied health cost	(	6, 948, 836	0.00000	0 0	0	92.00
93.00 All other Medical Education	(	6, 948, 836	0. 00000	0 0	0	93.00

IPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet D-1 Date/Time Pre 1/21/2016 11:	pare
		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
0	INPATIENT DAYS	avaluding nawharn)		0.071	1 1
)0 )0	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			8, 971 8, 971	
00	Private room days (excluding swing-bed and observation bed days		rivate room davs	0, 771	
	do not complete this line.		, varo i com dajo,	0	
00	Semi-private room days (excluding swing-bed and observation bed			8, 971	4
00	Total swing-bed SNF type inpatient days (including private room	n days) through Decembe	er 31 of the cost	0	5
~	reporting period		21 - 6 + 6 +	0	
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) arter December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period			0	
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to	the Program (excluding	g swing-bed and	2	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including privato )	coom dave)	0	10
00	through December 31 of the cost reporting period (see instructi		Uulii uays)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII onl		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, ent	ter 0 on this line)	5,7		
00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	te room days)	0	12
~~	through December 31 of the cost reporting period				1 4 0
00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13
00	Medically necessary private room days applicable to the Program			0	14
00	Total nursery days (title V or XIX only)		uujo)	0	
00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 d	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of	the cost	0.00	10
00	reporting period	salter becenber 51 01	the cost	0.00	
00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	f the cost	0.00	19
	reporting period	-			
00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of	the cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instructions)			6, 940, 841	21
00 00	Swing-bed cost applicable to SNF type services through December		ting period (line	0, 940, 841 0	
00	5 x line 17)	ST OF the cost report	ting period (The	0	22
00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	ng period (line 6	0	23
	x line 18)				
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'	1 of the cost reporting	n period (line 8	0	25
00	x line 20)			0	20
00	Total swing-bed cost (see instructions)			0	26
00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		6, 940, 841	27
~~	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				
00 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cr	harges)	0	28
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	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 minu		ctions)	0.00	
00 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	e 31)		0. 00 0	
00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	0 6, 940, 841	
50	27 minus line 36)			0, 740, 041	''
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
	Adjusted general inpatient routine service cost per diem (see i	nstructions)		773.70	38
00		202	1		1 0 0
00 00 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	-		1, 547 0	

		ndred Hospital I			In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 09/01/2014	Worksheet D-1	
					To 08/31/2015		
			Ti	tle XIX	Hospi tal	1/21/2016 11: Cost	<u>13 am</u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Day	sDiem (col. 1	÷	(col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 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
40.00	Intensive Care Type Inpatient Hospital Units						40.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0		0.0	0 0	0	43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						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)			3, 625	48.00
49.00	Total Program inpatient costs (sum of lines	41 through 48)(	see instructi	ons)		5, 172	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D sum	of Parts L and	0	50.00
00.00				in intot. D, Suin			00.00
	Pass through costs applicable to Program inp and IV)		ry services (f	rom Wkst. D, s	um of Parts II	0	51.00
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non ph	ucicion anacth	atist and	0	52.00 53.00
53.00	TARGET AMOUNT AND LIMIT COMPUTATION	5 1	erated, non-pri	ysi ci an anestn	etist, and	0	53.00
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)	ing eact and to	waat amount (	line E( minue	line E2)	0	56.00 57.00
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	inger amount (	inne so minus	TThe 53)		57.00
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	
40.00	market basket	cost coport un	dated by the	markat backat		0.00	60.00
60.00 61.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	61.00
	which operating costs (line 53) are less that	n expected cost					
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
(	instructions) (title XVIII only)						(( 00
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	i oniy). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost re	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [	ecember 31 of	the cost repo	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY		1	
	Skilled nursing facility/other nursing facil	-					70.00 71.00
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		The 70 ÷ Tine	2)			71.00
	Medically necessary private room cost applic		n (line 14 x l	ine 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 (from	Worksheet B, P	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		rovi dor rocor	de)			78.00 79.00
80.00	Total Program routine service costs for comp			· ·	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi			,	,		81.00
82.00	Inpatient routine service cost limitation (I						82.00
	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)			0.00	
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89.00

Health Financial Systems Kin	dred Hospital	Northern Ind	ana	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi d	er CCN: 152018	Peri od:	Worksheet D-1	
				From 09/01/2014 To 08/31/2015		pared: 13 am
		. 1	itle XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routi ne Cos	t column 1 ÷	Total	Observati on	
		(from line 2	7) 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	805, 050	6, 940, 8	41 0. 1159	37 0	0	90.00
91.00 Nursing School cost	(	6, 940, 8	41 0.0000	0 00	0	91.00
92.00 Allied health cost	(	6, 940, 8	41 0.0000	0 00	0	92.00
93.00 All other Medical Education	(	6, 940, 8	41 0.0000	00 00	0	93.00

th Financial Systems Ki RTIONMENT OF COST OF SERVICES RENDERED BY INTE	ndred Hospital N RNS AND RESIDENT		CCN: 152018 P	eri od:	u of Form CMS-2 Worksheet D-2	
			F T	rom 09/01/2014 o 08/31/2015	Date/Time Pre 1/21/2016 11:	
					Health Care	
					Program Inpatient Days	
Cost Center Description	Percent of	Expense	Total	Average Cost	Title V	
	Assigned Time	Allocation	Inpatient Day	Per Day		
	1.00	2.00	All Patients 3.00	4.00	5.00	<u> </u>
PART I - NOT IN APPROVED TEACHING PROGRAM	1.00	2.00	3.00	4.00	5.00	-
Total cost of services rendered	0.00	(	ו			] 1.
Hospital Inpatient Routine Services:			-1		-	
ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0. 00 0. 00	(		0. 00 0. 00		
CORONARY CARE UNIT	0.00	(		0.00	0	4
BURN INTENSIVE CARE UNIT						5
SURGICAL INTENSIVE CARE UNIT						6
OTHER SPECIAL CARE (SPECIFY) NURSERY						7
Subtotal (sum of lines 2 through 8)	0.00	(				9
0 SUBPROVIDER - IPF						10
0 SUBPROVIDER - IRF						11
0  SUBPROVIDER 0  SKILLED NURSING FACILITY	0.00	(	0	0.00	0	12
0 NURSING FACILITY	0.00	(		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 Deparintian			Tatal Charges	Datia of Coat	Charges Title V	<u> </u>
Cost Center Description			(from	Ratio of Cost to Charges	ntie v	
				$(col \cdot 2 \div col \cdot$		
			Part I, column	3		
			8, lines 88 through 93)			
	1.00	2.00	3.00	4.00	5.00	
Hospital Outpatient Services:			1			1 21
0  RURAL HEALTH CLINIC 0  FEDERALLY QUALIFIED HEALTH CENTER						21
0 CLINIC	0.00	(	o o	0.00000	0	
0 EMERGENCY	0.00	(	0 0	0.00000	0	
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 cost centers	Amount	(column 1 plus column 2)	Inpatient Days - All Patients		
	on Worksheet			An attents	5 . 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 (	TITLE XVIII, PAR	T B INPATIENT	ROUTINE COSTS (	ONLY)		
Hospital Inpatient Routine Services: 0 ADULTS & PEDIATRICS	0	(	0	8, 971	0.00	29
0 Swing Bed - SNF	0	(				
0 Swing Bed - NF		(		_		31
	0		0	0	0.00	
0 CORONARY CARE UNIT 0 BURN INTENSIVE CARE UNIT						33
0 SURGI CAL INTENSI VE CARE UNI T						35
0 OTHER SPECIAL CARE (SPECIFY)						36
0 Subtotal (sum of lines 28, and 29 through	0		0			37
						38
	1					38
0  SUBPROVIDER - IPF 0  SUBPROVIDER - IRF						1 34
0 SUBPROVIDER - TPF 0 SUBPROVIDER - TRF 0 SUBPROVIDER						40
0 SUBPROVIDER - IRF	О		0	0	0.00	40

Health Financial Systems Ki	ndred Hospital North	nern Indian	a	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTE	RNS AND RESIDENTS	Provi der	CCN: 152018	Peri od:	Worksheet D-2	2
				From 09/01/2014 To 08/31/2015	Data /Tima Dra	nored.
				10 08/31/2015	Date/Time Pre 1/21/2016 11:	
	Not In Approv	ed Teachi n	g Program	In Approved Te		
			0		0 0	
			-			-
Cost Center Description	(from Part	1:)	Amount	(from Part II	, col. 7, - )	
	1.00		2.00	3.	00	-
PART III - SUMMARY FOR TITLE XVIII (TO BE C			AND II ARE U	-	00	
Hospital	OWNEETED ONET IT DOT			3LD)		-
43.00 Inpatient	col. 9, line 9.00			0line 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 SUBPROVIDER - IPF						46.00
47.00 SUBPROVIDER - IRF						47.00
48. 00 SUBPROVI DER						48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00			0col. 9, line 41	1.00	49.00

To         08/31/2015         DutyThe P           Cost Center Description         Tritle XVIII Tritle XVIII Tri	th Financial Systems Kind RTIONMENT OF COST OF SERVICES RENDERED BY INTERI	dred Hospital N NS AND RESIDENT		CCN: 152018 F	Period:	worksheet D-2	
Bis It h Care Program Inpustion Days         Title VIII Fact B both Down Part B Coverage but no Part B         Title VIII Fact B both Down Part B Down Part B Down Part B Down Part B Down Part B Down Part B both Down Part B both Part B both					From 09/01/2014 To 08/31/2015	Date/Time Pre	parec
MART I - NOT IN APPROVED TEACHING PROGRAM         4 x col. 5)         (col. 4 x col. 6)         (col. 4 x col. 7)         (col. 7)						1/21/2010 11.	
PART I - NOT IN APPROVED TEACHING PROCEAU           Total cost of services rendered         Imaginal Impatient Routine Services:           ADULTS & PEDIATRICS         6,665           0 ADULTS & PEDIATRICS         6,665           0 Total cost of services:         0           0 ADULTS & PEDIATRICS         6,665           0 CORRNARY CARE UNIT         6,665           0 CORRNARY CARE UNIT         0           0 Substantial (sum of lines 2 through 8)         0           0 Substant (sum of lines 2 through 8)         0           0 Substant (sum of lines 2 through 19)         0           0 Substant (sum of lines 2 through 19)         0           0 Substant (sum of lines 2 through 19)         0           0 OWER ATHIN ACARE         0           0 OWER ATHIN ACARE         0           0 OWER ATHIN ACARE         0           0 OWER ATHING ACARE         0           0 OWER ATHIN ACARE         0           0 OWER ATHIN ACARE         11 the XIX Dutpatient and Title XIX OUTpatient and Title XIX OUTpatient and Title XIX OUTpatient and Title XIX Parts B           0 OWER ATHING ACARE         11 the XIX Title XIX OUTpatient ACARE           0 OWER ATHING ACARE         0           0 OWER ATHING ACARE         0           0 OWER ATHING ACARE         11 the XIX Tit	Cost Center Description	Part B Only less Part A Coverage but no Part B	Title XIX		(col. 4 x col.	(col. 4 x col.	
Display		6.00	7.00	8.00	9.00	10.00	
00         AULTS & PEDIATINCS         0,000         0           00         INTENSIVE CARE UNIT         0         0         0           00         DORNARY CARE UNIT         0         0         0         0           00         DORNARY CARE UNIT         0         0         0         0         0           00         DIMEST VC CARE UNIT         0         0         0         0         0           00         DIMEST VC CARE UNIT         0         0         0         0         0           00         DIMEST VC CARE UNIT         0         0         0         0         0           00         DIMEST ALL CARE CENTY         0         0         0         0         0         0           00         SUBFORVIORE - IFF         0							1.
00         INTENSIVE CARE UNIT         0							
00         0THER SPECIAL CARE (SPECIFY) 00         <	INTENSIVE CARE UNIT CORONARY CARE UNIT						
LOO SUBPROVIDER - 1PF OS SUBPROVIDER - 1PF DO SUBPROVIDER - 1PF	OTHER SPECIAL CARE (SPECIFY) NURSERY			0	0	0	6. 7. 8. 9.
OO       NURSI NG FACILITY         OO       OTHER LONG TERM CARE         OO       OHWE HEALTH AGENCY         OO       CAHC         OCAHC       CAHC         OMBULATORY SURGICAL CENTER (D. P.)         OD       Subtotal (sum of lines 9 through 19)         Titles V and XIX Outpatient and Title XVIII Part 8 Charges       Titles VI and XIX Outpatient and Title XVIII Part 8 Cost         Cost Center Description       Title XVIII Part 8       Title XVIII Part 8         More HEALTH AGENCY       0       8.00         OB Subtotal Outpatient Services:       6.00       7.00       8.00         OF FEDERALLY OUALIFIED HEALTH CENTER       0       0       0       0         OF EDERALY OUALIFIED HEALTH CENTER       0       0       0       0       0         OF EDERALY OUALIFIED HEALTH CENTER       0       0       0       0       0       0         OF EDERALY OUALIFIED HEALTH CENTER       0	0 SUBPROVI DER – I PF 0 SUBPROVI DER – I RF 0 SUBPROVI DER		0				10. 11. 12.
00       HOSPICE       Ittles V and XIX Outpatient and Title XVIII Part B       Titles V and XIX Outpatient and Title XVIII Part B Charges         Cost Center Description         Title XVIII       Title XVIII       Title V       Title XVIII       Title XVIII         Part B       Cost Center Description         Title XVIII       Title XVIII       Title XVIII       Title XVIII       Part B	0 NURSING FACILITY 0 OTHER LONG TERM CARE 0 HOME HEALTH AGENCY 0 CMHC		U				13. 14. 15. 16. 17. 18.
Titles V and XIX Outpatient and Title XIII Part B         Cost Center Description         Title XVIII Part B         Part B         OCost Center Description         Title XVIII         Title XVIII         Title XVIII         Title XVIII         Part B         OCOST Centre         OCOST Centre Cost Centre         OCOST Centre Description         Title XVIII         Part B         Intervice Cost Centre         OCOST Centre Description         Title XVIII         Part B         Part B         Part B         OCOST Centre Description         Title XVIII         Part B         Part B         Part B         Adjit Controlspan							19.
Cost Center Description         Title XVIII Part B Charges         XVIII Part B Cost           Hospital Outpatient Services:         Title XVIII Part B         Title XIX         Title V         Title XVIII Part B           0         RURAL HEALTH CLINIC         6.00         7.00         8.00         9.00         10.00           00         RURAL HEALTH CLINIC         0         0         0         9.00         10.00           00         ELERGENCY         0         0         0         0         0         0           00         OBSERVATION BEDS (NON-DISTINCT PART)         0	0 Subtotal (sum of lines 9 through 19)						20.
Part B         Part B         Part B           40spital Outpatient Services:         6.00         7.00         8.00         9.00         10.00           00         RURAL HEALTH CLINIC         0         0.00         0         0.00         9.00         10.00           00         RURAL HEALTH CLINIC         0		and Title X	VIII Part B				
Hospital Outpatient Services:         00       RURAL HEALTH CLINIC         00       FEDERALY QUALIFIED HEALTH CENTER         00       CLINIC       0         00       EMERGENCY       0         00       OTHER OUTPATIENT SERVICE COST CENTER       0       0         00       SUBTORI (sum of lines 20 and 27)       0       0       0         00       Total (sum of lines 20 and 27)       0       0       0       0         00       Total (sum of lines 20 and 27)       0       0       0       0       0         00       Total (sum of lines 20 and 27)       Title XVIII       Expenses       PSA Adj.       Interns &         00       Total (sum of lines 20 and 27)       Title XVIII       Expenses       Psd. Adj.       Interns &         00       Total (sum of lines 20 and 27)       Title XVIII       Expenses       Psd. Adj.       Interns &         100       Total (sum of lines 28)       0       0       10       Interns &         00       O       0       0       0       0       0         00       Swing Bed - SNF       0       0       0       0       0         00       Suing Bed - SNF       0 <t< td=""><td>Cost Center Description</td><td>Part B</td><td></td><td></td><td>Part B</td><td></td><td></td></t<>	Cost Center Description	Part B			Part B		
00       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0         00       CLINIC       0       0       0       0         00       DEMERGNCY       0       0       0       0         00       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0       0         00       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0       0         00       OUTHER OUTPATIENT SERVICE COST CENTER       0       0       0       0         00       Ottotal (sum of lines 20 and 27)       Title XVIII       Expenses       PSA Adj.       Interns & Residents         00       Total (sum of lines 20 and 27)       Title XVIII       Expenses       PSA Adj.       Residents         00       Total (sum of lines 20 and 27)       Title XVIII       Expenses       PSA Adj.       Residents         00       Total (sum of lines 20 and 27)       Title XVIII       PART 11 - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)       Residents         00       ADULTS & PEDIATRICS       0       0       0         00       Swing Bed - SNF       0       0       0         00       Swing Bed - SNF       0       0       0	Hospital Outpatient Services:	0.00	7.00	0.00	9.00	10.00	
00       Subtotal (sum of lines 21 through 26)       0       0       0         00       Total (sum of lines 20 and 27)       Title XVIII       Expenses       PSA Adj.         01       Cost Center Description       Title XVIII       Expenses       PSA Adj.         101       Part B       Applicable to       Interns &         111       Expenses       Applicable to       Interns &         111       Cost Center Description       6.00       7.00       11.00         PART 11 - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)       Hospital Inpatient Routine Services:       0       0         00       ADULTS & PEDIATRICS       0       0       0       0         00       Swing Bed - SNF       0       0       0       0         00       Swing Bed - NF       0       0       0       0         00       SWing Bed - NF       0       0       0       0       0         00       SWIN INTENSIVE CARE UNIT       0       0       0       0       0       0         00       SURGICAL INTENSIVE CARE UNIT       0       0       0       0       0       0       0       0       0       0       0	0 FEDERALLY QUALIFIED HEALTH CENTER 0 CLINIC 0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART)	0	0 0	C	-	-	24. 25.
Part B Inpati ent Days     Applicable to Title XVIII (col. 5 x col. 6)     Interns & Residents       PART 11 - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)     6.00     7.00     11.00       Hospital Inpati ent Routine Services:     0     0     0       ADULTS & PEDIATRICS     0     0     0       00     Swing Bed - SNF     0     0       00     Swing Bed - NF     0     0       00     INTENSIVE CARE UNIT     0     0       00     Swing Ided - NF     0     0       00     INTENSIVE CARE UNIT     0     0     0       00     SUBGI CAL INTENSIVE CARE UNIT     0     0     0       00     Subtotal (sum of lines 28, and 29 through 36)     0     0     0       00     SUBPROVI DER - I PF     0     0     0       00     SUBPROVI DER - I RF     0     0     0	0 Subtotal (sum of lines 21 through 26) 0 Total (sum of lines 20 and 27)	<b>T</b>	-		0 0	0	26. 27. 28.
6.00     7.00     11.00       PART 11 - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)       Hospital Inpatient Routine Services:       00       ADULTS & PEDIATRICS       00       0       ADULTS & PEDIATRICS       0       0       00       0    <		Part B Inpatient Days	Applicable to Title XVIII (col. 5 x col.	Interns &			
Hospi tal Inpati ent Routi ne Services:         .00       ADULTS & PEDI ATRI CS         .00       Swing Bed - SNF         .00       Swing Bed - SNF         .00       Swing Bed - NF         .00       INTENSI VE CARE UNI T         .00       DURN INTENSI VE CARE UNI T         .00       BURN INTENSI VE CARE UNI T         .00       SURGI CAL INTENSI VE CARE UNI T         .00       SUBGI CAL INTENSI VE CARE UNI T         .00       SUBTOVI DER - I PF         .00       SUBPROVI DER - I RF         .00       SUBPROVI DER			7.00				
00ADULTS & PEDIATRICS00000Swing Bed - SNF00000Swing Bed - NF00000INTENSIVE CARE UNIT00000CORONARY CARE UNIT00000CORONARY CARE UNIT00000SURGI CAL INTENSIVE CARE UNIT00000SUBCAL INTENSIVE CARE UNIT00000Subtotal (sum of lines 28, and 29 through 36)00000SUBPROVI DER - I PF0SUBPROVI DER - I RF000SUBPROVI DER000		TLE XVIII, PAR	I B INPAILENT	ROUTINE COSTS	UNLY)		-
00INTENSIVE CARE UNIT00000CORONARY CARE UNIT00000BURN INTENSIVE CARE UNIT00000SURGICAL INTENSIVE CARE UNIT00000OTHER SPECIAL CARE (SPECIFY)00000Subtotal (sum of lines 28, and 29 through 36)00000SUBPROVIDER - IPF00000SUBPROVIDER - IRF000	0 ADULTS & PEDLATRICS 0 Swing Bed - SNF				)		29. 30. 31.
00       Subtotal (sum of lines 28, and 29 through 36)       0       0         00       SUBPROVI DER - I PF       0       0         00       SUBPROVI DER - I RF       0       0         00       SUBPROVI DER - I RF       0       0	0 INTENSIVE CARE UNIT 0 CORONARY CARE UNIT 0 BURN INTENSIVE CARE UNIT 0 SURGICAL INTENSIVE CARE UNIT	O	0	(			31. 32. 33. 34. 35. 36.
00     SUBPROVI DER - I RF       00     SUBPROVI DER			0	C	ס		37.
. 00   SKILLED NURSING FACILITY 0 0 0	36)						

Health Financial Systems Kin	ndred Hospital N	Northern Indiana	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	RNS AND RESIDENT	TS Provider CCN: 152018	Peri od:	Worksheet D-2	
			From 09/01/2014 To 08/31/2015	Date/Time Pre 1/21/2016 11:	
	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 CO	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 2.00	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 2.00	0		49.00

Health Financial Systems Kindred Hospit	al Northern Indiar	na	In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Period:	Worksheet D-3	
			From 09/01/2014 To 08/31/2015	Date/Time Pre	narod
			10 00/31/2015	1/21/2016 11:	
	Titl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			10.075.450		30.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			18, 075, 650		30.00
ANCI LLARY SERVICE COST CENTERS			0		31.00
50. 00 05000 OPERATI NG ROOM		0, 99485	0 259, 283	257, 948	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20503			
60. 00 06000 LABORATORY		0. 11597			
65. 00 06500 RESPI RATORY THERAPY		0. 08250	6, 260, 614	516, 544	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 32298	7 1, 989, 284	642, 513	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 00000	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 16969			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27996			•
74.00 07400 RENAL DIALYSIS		0. 59865	2 601, 428	360, 046	74.00
OUTPATIENT SERVICE COST CENTERS			-	-	
90. 00 09000 CLINIC		0.00000		0	90.00
91. 00 09100 EMERGENCY		0.00000	0 0	0	91.00
0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES					95.00
98. 00 09850 OTHER REIMBURSABLE CC'S		0.00000	0	0	
200.00 Total (sum of lines 50-94 and 96-98)		0.00000	21, 740, 553	-	
201.00 Less PBP Clinic Laboratory Services-Program only c	hardes (line 61)		21,740,000		200.00
202.00 Net Charges (line 200 minus line 201)	and ges (The OT)		21, 740, 553		202.00
		1	2., 110,000		1-0-1.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT       Provider CCN: 152018       Period: From 09/01/2014 To 08/31/2015       Worksheet D-3 Date/Time Prepared: 1/21/2016 11: 13 am         Cost Center Description       Title XIX       Hospital       Cost         Cost Center Description       Ratio of Cost To Charges       Inpatient Program Charges       Inpatient Program Charges       Inpatient Program Charges       Inpatient Program Charges
To     08/31/2015     Date/Time Prepared: 1/21/2016       Cost Center Description     Title XIX     Hospital     Cost       Ratio of Cost To Charges     Inpatient Program Charges     Inpatient Program Charges     Inpatient Program Charges     Inpatient Program Charges       1.00     2.00     3.00
Title XIX     Hospital     Cost       Cost Center Description     Ratio of Cost To Charges     Inpatient Program Charges     Inpatient Program Charges     Inpatient Program Charges     Inpatient Program Cost       1.00     2.00     3.00
Cost Center Description       Ratio of Cost To Charges       Inpatient Program Costs (col. 1 x col. 2)         1.00       2.00       3.00
To Charges Program Object Program Costs (col. 1 x col. 2) 1.00 2.00 3.00
Charges         (col. 1 x col. 2)           1.00         2.00         3.00
<u> </u>
1.00 2.00 3.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS         5, 896         30. 00
31. 00 03100 I NTENSI VE CARE UNI T 0 31. 00
ANCI LLARY SERVICE COST CENTERS
50. 00 05000/0PERATI NG ROOM 0.994850 1,822 1,813 50. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 205030 0 54. 0
60. 00 06000 LABORATORY 0. 115979 0 0 60. 0
65. 00 06500 RESPI RATORY THERAPY 0. 082366 11, 440 942 65. 0
66. 00         06600         PHYSI CAL         THERAPY         0         0         66. 00
67.00 06700 OCCUPATIONAL THERAPY 0.00000 0 0 67.0
68. 00 06800 SPEECH PATHOLOGY 0. 00000 0 68. 0
71.00         07100         MEDI CAL         SUPPLI ES         CHARGED         TO         PATI ENTS         0.169697         3, 174         539         71.00
73. 00         07300         DRUGS         CHARGED_TO         PATI ENTS         0. 279960         1, 182         331         73. 0
74. 00 07400 RENAL DI ALYSI S 0. 598234 0 0 74. 0
OUTPATI ENT SERVI CE COST CENTERS
90.00         09000         CLINIC         0.00000         0         0         90.00         91.00         0.000000         0         0         91.00         91.00         0.000000         0         0         91.00         91.00         0         0         91.00         0         0         91.00 </td
91. 00 09100 EMERGENCY 0. 000000 0 0 0 91. 0 OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES 95. 0
98. 00 09850 OTHER REI MBURSABLE CC' S 0. 000000 0 0 98. 0
200.00 Total (sum of Lines 50-94 and 96-98) 17, 618 3, 625 200.0
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00
202.00 Net Charges (1 ne 200 minus 1 ne 201) 17,618 202.0

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 152018	Period: From 09/01/2014 To 08/31/2015		
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)	、 、		0	1.0
00 00	Medical and other services reimbursed under OPPS (see instructi PPS payments	ons)		4, 912 2, 060	2.0 3.0
00	Outlier payment (see instructions)			2,000	4.0
00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	
00	Line 2 times line 5			0	6.0
00 00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	9.0
. 00	Organ acqui si ti ons	, cor. 13, true 200		0	10.0
	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
00	Reasonable charges			0	1.1.2.1
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	0. 60)		0	12. ( 13. (
. 00	Total reasonable charges (sum of lines 12 and 13)			0	
	Customary charges			0	1
	Aggregate amount actually collected from patients liable for pa	5	U U	0	
00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.
00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	17.
00	Excess of customary charges over reasonable cost (complete only	ifline 18 exceeds li	ne 11) (see	0	
	instructions)		(	_	
00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.
~~	instructions)	:			21
	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	Instructions)		0	21. 22.
	Cost of physicians' services in a teaching hospital (see instru	ictions)		0	23.
	Total prospective payment (sum of lines 3, 4, 8 and 9)			2,060	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions)			0	
	Deductibles and Coinsurance relating to amount on line 24 (for Subtatal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			488 1, 572	
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl instructions)	us the sum of times 22	and 23] (See	1, 572	27.
00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		0	28.
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.
	Subtotal (sum of lines 27 through 29)			1, 572	
	Primary payer payments			0	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)		1, 572	32.
	Composite rate ESRD (from Wkst. 1-5, line 11)	3)		0	33.
	Allowable bad debts (see instructions)			0	34.
	Adjusted reimbursable bad debts (see instructions)			0	35.
	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		0	36.
	Subtotal (see instructions)			1, 572	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 39.
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.
	Partial or full credits received from manufacturers for replace		tions)	0	39.
99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.
	Subtotal (see instructions)			1, 572	
	Sequestration adjustment (see instructions)			31	
00	Interim payments Tentative settlement (for contractors use only)			1, 540 0	41. 42.
	Balance due provider/program (see instructions)			1	42.
	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	chapter 1,	0	
-	§115. 2				
00	TO BE COMPLETED BY CONTRACTOR			2	
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet E-1 Part I Date/Time Prep 1/21/2016 11:	pared
		Ti tl	e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 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		9, 145, 0	40 0	1, 540 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	09/16/2014	173, 4		0	
. 02		05/22/2015	1, 134, 5		0	-
. 03 . 04				0	0	3. 3.
. 04				0	0	
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM	12/02/2015	1, 125, 4		0	
51				0	0	
52 53				0	0	
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		182, 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)		9, 327, 5	40	1, 540	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER	[		0	0	5.
01				0	0	
03				0	0	
	Provider to Program					
50 E 1	TENTATI VE TO PROGRAM			0	0	5. 5.
51 52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		29, 1		1	6.
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		9, 356, 6	0	0 1, 541	
00			9, 356, 6	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

LCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 152018	Period: From 09/01/2014 To 08/31/2015	1/21/2016 11:	pared
	Title XVIII	Hospi tal	PPS	
			1 00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS			1.00	
00 Net Federal PPS Payments (see instructions)			9, 258, 885	1.
00 Outlier Payments			546, 851	2.
00 Total PPS Payments (sum of lines 1 and 2)			9, 805, 736	
00 Nursing and Allied Health Managed Care paymen	ts (see instructions)		000,700	4.
00 Organ acquisition (DO NOT USE THIS LINE)			0	5.
00 Cost of physicians' services in a teaching ho	spital (see instructions)		0	6.
00 Subtotal (see instructions)			9, 805, 736	
00 Primary payer payments			0	8.
00 Subtotal (line 7 less line 8).			9, 805, 736	
. 00 Deducti bl es			13, 640	
.00 Subtotal (line 9 minus line 10)			9, 792, 096	
. 00 Coi nsurance			454, 014	
.00 Subtotal (line 11 minus line 12)			9, 338, 082	
.00 Allowable bad debts (exclude bad debts for pr	ofessional services) (see instructions)		322, 390	
.00 Adjusted reimbursable bad debts (see instruct			209, 554	
.00 Allowable bad debts for dual eligible benefic			177, 066	
.00 Subtotal (sum of lines 13 and 15)			9, 547, 636	
.00 Direct graduate medical education payments (f	rom Wkst. E-4. line 49)		0	18.
. 00 Other pass through costs (see instructions)			0	19
. 00 Outlier payments reconciliation			0	20.
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY	)		0	21
. 50 Pioneer ACO demonstration payment adjustment	·		0	21
. 99 Recovery of Accel erated Depreciation			0	21
.00 Total amount payable to the provider (see ins	tructions)		9, 547, 636	
. 01 Sequestration adjustment (see instructions)			190, 953	
. 00 Interim payments			9, 327, 540	
.00 Tentative settlement (for contractor use only	)		0 0	
. 00 Balance due provider/program (line 22 minus l	·		29, 143	
.00 Protested amounts (nonallowable cost report i		chapter 1,	0	26
§115.2 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			0	
. 00 The rate used to calculate the Time Value of			0.00	
.00 Time Value of Money (see instructions)	money (see this true truths)		0.00	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 152018	Period: From 09/01/2014 To 08/31/2015	Worksheet E-3 Part VII Date/Time Pre 1/21/2016 11:	pared:
		Title XIX	Hospital	Cost Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR X		2100	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		5, 172		1.00
00	Medical and other services			0	2.00
00	Organ acquisition (certified transplant centers only)		0		3.00
00	Subtotal (sum of lines 1, 2 and 3)		5, 172	0	
00	Inpatient primary payer payments		0	0	5.0
00	Outpatient primary payer payments		E 170	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		5, 172	0	7.0
	Reasonable Charges				-
00	Routi ne servi ce charges		5, 896		8.00
00	Ancillary service charges		17, 618	0	9.00
D. 00	Organ acquisition charges, net of revenue		0	-	10.0
1.00	Incentive from target amount computation		0		11.0
2.00	Total reasonable charges (sum of lines 8 through 11)		23, 514	0	12.0
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.0
	basi s				
4.00	Amounts that would have been realized from patients liable for		n 0	0	14.0
- 00	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)	0,000000	0,00000	15 0
5.00 5.00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)	0. 000000 23, 514	0.000000	15.0 16.0	
7.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	18, 342	0	
1.00	line 4) (see instructions)	IT THE TO EXCEEds	10, 342	0	17.0
3. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0	18.0
9.00	Interns and Residents (see instructions)		0	0	19.00
0. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	20.0
1.00	Cost of covered services (enter the lesser of line 4 or line 16		5, 172	0	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provi		-	
2.00	Other than outlier payments		0	0	22.0
3.00	Outlier payments		0	0	
4.00 5.00	Program capital payments Capital exception payments (see instructions)		0		24.0
5.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	27.0
3.00	Customary charges (title V or XIX PPS covered services only)			0	28.0
7.00	Titles V or XIX (sum of lines 21 and 27)		5, 172	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
0. 00	Excess of reasonable cost (from line 18)		0	0	30.0
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5, 172	0	31.0
2.00	Deducti bl es		0	0	
	Coinsurance		0	0	
4.00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0 5, 172	_	35.0
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	
7.00	OTHER ADJUSTMENTS			0	37.0
7.01	OTHER ADJUSTMENTS Subtotal (line 36 ± line 37)			0	
B. 00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)			0	
9.00			U E 170	0	39.0 40.0
D. 00 1. 00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		5, 172 412	0	
2.00	Balance due provider/program (line 40 minus line 41)		4,760	0	
2.00 3.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15_2	4,700	0	42.0
	chapter 1, §115.2		0	0	'0.0

ALANC	Financial Systems Kindred Hospital N E SHEET (If you are nonproprietary and not maintain was accounting pagarda complete the Canada Summa and	Provi der	CCN: 152018	Period: From 09/01/2014	u of Form CMS- Worksheet G	
und-t	ype accounting records, complete the General Fund column onl	y)		To 08/31/2015	Date/Time Pre 1/21/2016 11:	
		General Fund	Specific	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS		1	-	_	
. 00	Cash on hand in banks	-253		0 0	0	
. 00 . 00	Temporary investments Notes receivable	0		0 0	0	
. 00	Accounts receivable	1, 983, 008		0 0	0	
. 00	Other recei vabl e	328		0 0	0	
. 00	Allowances for uncollectible notes and accounts receivable	-277, 030		0 0	0	6.
. 00	Inventory	131, 880		0 0	0	
. 00	Prepai d expenses	50, 762		0 0	0	
. 00 0. 00	Other current assets	0		0 0	0	
1.00	Due from other funds Total current assets (sum of lines 1-10)	1, 888, 695		0 0	0	
1.00	FIXED ASSETS	1,000,075	1	0 0	0	1
2.00	Land	0		0 0	0	12.
3.00	Land improvements	126, 200		0 0	0	13.
4.00	Accumulated depreciation	-50, 717		0 0	0	14.
5.00	Bui I di ngs	0		0 0	0	
6.00	Accumulated depreciation			0 0	0	
7.00	Leasehold improvements	685, 540		0 0	0	
8.00 9.00	Accumulated depreciation Fixed equipment	-399, 427		0 0	0	
0.00	Accumulated depreciation			0 0	0	
1.00	Automobiles and trucks	0		0 0	0	
2.00	Accumulated depreciation	0		0 0	0	
3.00	Major movable equipment	1, 892, 601		0 0	0	23
4.00	Accumulated depreciation	-1, 008, 926		0 0	0	24
5.00	Minor equipment depreciable	0		0 0	0	
5.00	Accumulated depreciation	0		0 0	0	
7.00	HIT designated Assets	0		0 0	0	
3.00 9.00	Accumulated depreciation Minor equipment-nondepreciable			0 0	0	
9.00 D.00	Total fixed assets (sum of lines 12-29)	1, 245, 271		0 0	0	
0.00	OTHER ASSETS	1,210,2,1	1	0 0		
1. 00	Investments	0		0 0	0	31
2.00	Deposits on leases	0		0 0	0	
3.00	Due from owners/officers	0		0 0	0	
4.00	Other assets	3, 162, 500		0 0	0	
5.00	Total other assets (sum of lines 31-34)	3, 162, 500		0 0	0	
5.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	6, 296, 466		0 0	0	36
7.00	Accounts payable	384, 991	1	0 0	0	37
3.00	Salaries, wages, and fees payable	352, 496		0 0	0	
9.00	Payroll taxes payable	8, 158		0 0	0	
0. 00	Notes and Loans payable (short term)	0		0 0	0	40
1. 00	Deferred income	0		0 0	0	
2.00	Accelerated payments	0			_	42
3.00	Due to other funds	0		0 0	0	
4.00 5.00	Other current liabilities	64, 801 810, 446		0 0	0	
5.00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	010, 440		0 0	0	45
6.00	Mortgage payable	0		0 0	0	46
7.00	Notes payable	0		0 0	0	
8.00	Unsecured Loans	0		0 0	0	
9.00	Other long term liabilities	-6, 945, 771		0 0	0	
0.00	Total long term liabilities (sum of lines 46 thru 49	-6, 945, 771		0 0	0	
. 00	Total liabilites (sum of lines 45 and 50)	-6, 135, 325		0 0	0	51
. 00	CAPI TAL ACCOUNTS General fund balance	12, 431, 791				52
. 00	Specific purpose fund	12,431,791		0		52
. 00	Donor created - endowment fund balance - restricted			~ 		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
5.00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
3. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
9.00	Total fund balances (sum of lines 52 thru 58)	12, 431, 791		0 0	0	
0. OO	Total liabilities and fund balances (sum of lines 51 and	6, 296, 466		U 0	0	60

	Financial Systems Kin ENT OF CHANGES IN FUND BALANCES	dred Hospital N		na CCN: 152018	Do	riod:	In Lieu of Form CMS Worksheet G-		
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider	CCN: 152018		om 09/01/2014		epared:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Func		
		1.00	2.00	3,00		4,00	5.00		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	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	0 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 035, 792 2, 395, 995 12, 431, 787 4 12, 431, 791			0 0 0 0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 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 12, 431, 791			0 0		18.00 19.00	
		Endowment Fund	PI ant	Fund				-	
	T	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		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	00	0 0 0 0 0 0		0			10.00 11.00 12.00 13.00 14.00 15.00 16.00	
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	

00 00 00 00 00 00 00 00 00 00	Cost Center Description PART I - PATIENT REVENUES General Inpatient Routine Services			1	08/31/2015	Date/Time Pre 1/21/2016 11:	
00 00 00 00 00 00 00 00 00 00			I npati ent	0	utpati ent	Total	
00 00 00 00 00 00 00 00 00 00			1.00		2.00	3.00	
00 00 00 00 00 00 00 00 00	General Innatient Routine Services						
00 00 00 00 00 00 00 00					1		4
00 00 00 00 00 00	Hospi tal		24, 508, 0	61		24, 508, 061	
00 00 00 00 00 00	SUBPROVIDER - IPF					l	2.0
00 00 00 00 00	SUBPROVIDER - IRF					l	3.
00 00 00 00	SUBPROVIDER					l	4.0
00 00 00	Swing bed - SNF			0		0	
00 00	Swing bed - NF			0		0	
00	SKILLED NURSING FACILITY			0		0	
	NURSING FACILITY					1	8.
0.00	OTHER LONG TERM CARE						9.1
	Total general inpatient care services (sum of lines 1-9)		24, 508, 0	61		24, 508, 061	1 10.
1 00	Intensive Care Type Inpatient Hospital Services		[	0			
	INTENSIVE CARE UNIT			0		0	
	CORONARY CARE UNIT					1	12.
	BURN INTENSIVE CARE UNIT					1	13.
	SURGICAL INTENSIVE CARE UNIT					1	14.
	OTHER SPECIAL CARE (SPECIFY)			~		c.	15.
5.00	Total intensive care type inpatient hospital services (sum of	ines		0		0	) 16.
7.00	11-15) Total inpatient routine care services (sum of lines 10 and 16)		24, 508, 0	41		24, 508, 061	1 17.
	Ancillary services		29, 714, 4		0	29, 714, 481	
	Outpatient services		27, /14, 4	0	0	27, 714, 481	
	RURAL HEALTH CLINIC			0	0	0	
	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
	HOME HEALTH AGENCY			0	0		22.
	AMBULANCE SERVICES			0	0	o	
	CMHC			U	0	l	24.
	AMBULATORY SURGICAL CENTER (D. P. )						25.
	HOSPICE						26.
	OTHER (SPECIFY)			0	0	o	
	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	54, 222, 5	42	0	54, 222, 542	
	G-3, line 1)				-		
	PART II - OPERATING EXPENSES						
9.00	Operating expenses (per Wkst. A, column 3, line 200)				14, 672, 881		29.
0. 00	ADD (SPECIFY)			0		l	30.
1.00				0		l	31.
2.00				0		l	32.
3.00				0		l	33.
4.00				0		l	34.
5.00				0		l	35.
	Total additions (sum of lines 30-35)				0	l	36.
	DEDUCT (SPECIFY)			0		l	37.
3.00				0			38.
9.00				0			39.
0. 00				0			40.
1.00				0			41.
	Total deductions (sum of lines 37-41)				0		42.
	Total operating expenses (sum of lines 29 and 36 minus line 42) to Wkst. G-3, line 4)	(transfer			14, 672, 881		43.

Heal th	Health Financial Systems Kindred Hospital Northern Indiana In Lieu						
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 152018 Period:						
	From 09/01/2014 To 08/31/2015						
	10 00/31/2013						
				1.00			
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			54, 222, 542	1.00		
2.00	Less contractual allowances and discounts on patients' accounts	5		37, 450, 086	2.00		
3.00	Net patient revenues (line 1 minus line 2)			16, 772, 456	3.00		
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		14, 672, 881	4.00		
5.00	Net income from service to patients (line 3 minus line 4)			2, 099, 575	5.00		
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc			0	6.00		
7.00	Income from investments			0	7.00		
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8.00		
9.00	Revenue from television and radio service			0	9.00		
10.00	Purchase di scounts			1, 038			
11.00	Rebates and refunds of expenses			0	11.00		
12.00	Parking lot receipts			0	12.00		
13.00	Revenue from Laundry and Linen service			0	13.00		
14.00	Revenue from meals sold to employees and guests			0	14.00		
15.00				0	15.00		
16.00		in patrents		0	16.00		
17.00				0 197	17.00 18.00		
18.00	Revenue from sale of medical records and abstracts			197	18.00 19.00		
19.00 20.00	Tuition (fees, sale of textbooks, uniforms, etc.) Revenue from gifts, flowers, coffee shops, and canteen			0	20.00		
20.00	Rental of vending machines			0	20.00		
21.00	Rental of hospital space			0	21.00		
22.00	Governmental appropriations			0	22.00		
23.00	MISCELLANEOUS INCOME			295, 185			
24.00	Total other income (sum of lines 6-24)			295, 185			
25.00	Total (line 5 plus line 25)			2, 395, 995			
28.00	OTHER EXPENSES			2, 395, 995	28.00		
27.00	Total other expenses (sum of line 27 and subscripts)			0	27.00		
	Net income (or loss) for the period (line 26 minus line 28)			2, 395, 995			
27.00	met medine (or ross) for the period (rme zo inmus rme zo)		I	2, 373, 773	27.00		