PART II - CERTIFICATION

(4) Reopened(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Indianapolis South (152008) for the cost reporting period beginning 09/01/2015 and ending 08/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description		Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	37, 252	0	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	Total	0	37, 252	0	0	0	200. 00

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

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION D	ATA	Provi	der CCN:		Period: From 09/01 To 08/31	/2015 /2016	Worksheet S-2 Part I Date/Time Pre 1/4/2017 9:04	epared:
	1.00	2	2. 00		3. 00			4. 00	1/4/2017 9.04	alli
	Hospital and Hospital Health Care Co									
1.00	Street: 607 S. Greenwood Springs Driv									1.00
2.00	City: Greenwood	State:	IN Zi	p Code	e: 46143	Count	y: Johnson			2. 00
		Component N		CCN	CBSA	Provi der			nt System (P,	
			Nu	umber	Number	Туре	Certi fi ed		0, or N)	
								V	XVIII XIX	
	1	1.00		2. 00	3. 00	4.00	5. 00	6. 00	7. 00 8. 00	
	Hospital and Hospital-Based Componen						1			
3.00	Hospi tal	Kindred Hospital		52008	26900	2	06/01/1994	I N	P 0	3. 00
4 00	Culannavi dan IDE	Indianapolis Sou	utn			-				4 00
4.00	Subprovi der - IPF					-				4.00
5.00	Subprovider - IRF Subprovider - (Other)									5.00
6.00	, ,					-				6.00
7.00	Swing Beds - SNF					-				7.00
8.00	Swing Beds - NF					-				8. 00
9.00	Hospi tal -Based SNF									9.00
10.00	Hospi tal -Based NF									10.00
	Hospi tal -Based OLTC					l				11.00
	Hospi tal -Based HHA					l				12.00
	Separately Certified ASC									13. 00
	Hospi tal -Based Hospi ce									14.00
	Hospital -Based Health Clinic - RHC									15. 00
	Hospital-Based Health Clinic - FQHC									16. 00
17. 00	Hospital-Based (CMHC) I									17. 00
18. 00	Renal Dialysis									18. 00
19. 00	Other						<u> </u>			19. 00
							From		To:	-
							1. 00		2. 00	
	Cost Reporting Period (mm/dd/yyyy)						09/01/2	2015	08/31/2016	20.00
21. 00	Type of Control (see instructions)						4			21. 00
	Inpatient PPS Information									4
22. 00	Does this facility qualify and is it						N		N	22. 00
	share hospital adjustment, in accord									
	for yes or "N" for no. Is this facil	ity subject to 4	2 CFR Secti	on §41:	2. 106(c)	(2) (Pi ckl	9			
	amendment hospital?) In column 2, en									
22. 01	Did this hospital receive interim un						N		N	22. 01
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to									
	for no for the portion of the cost r	eporting period	occurring o	n or a	fter Oct	ober 1.				
	(see instructions)									
22. 02	Is this a newly merged hospital that						N		N	22. 02
	determined at cost report settlement						5			
	or "N" for no, for the portion of th									
	in column 2, "Y" for yes or "N" for	no, for the port	ion of the	cost r	eporting	period o	n			
22 02	or after October 1.	i a maal aaal fi aat	lan from ur	hon +o	nunal a		. N		N	22 02
22. 03	Did this hospital receive a geograph						t N		N	22. 03
	of the OMB standards for delineating									
	in column 1, "Y" for yes or "N" for									
	prior to October 1. Enter in column cost reporting period occurring on o						=			
	hospital contain at least 100 but no									
	42 CFR 412.105)? Enter in column 3,			unteu	i ii accoi	dance with	"			
23. 00	Which method is used to determine Me			/or 25	hel ow?	In column		2	N	23. 00
23.00	1, enter 1 if date of admission, 2 i	,						-	14	25.00
	method of identifying the days in th									
	used in the prior cost reporting per									
	jassa iii tiis piitsi sest i spertiing per	1001 111 001 01111	In-State	In-St		out-of		Medi cai	d Other	
			Medi cai d	Medic		State		HMO day		
			paid days	eligi			Medi cai d		days	
			' = ==,0	unpa			eligible		,-	
				day			unpai d			
			1.00	2.0		3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital	, enter the	0		0	0	0			24. 00
	in-state Medicaid paid days in colum									
	Medicaid eligible unpaid days in col									
	out-of-state Medicaid paid days in c									
	out-of-state Medicaid eligible unpai	d days in column	1							
	4, Medicaid HMO paid and eligible bu									
	column 5, and other Medicaid days in									
25.00	If this provider is an IRF, enter th		0		o	О	o		О	25. 00
	Medicaid paid days in column 1, the					[
	Medicaid eligible unpaid days in col									
	out-of-state Medicaid days in column					[
	Medicaid eligible unpaid days in col									
	HMO paid and eligible but unpaid day									
							'		•	

		ndianapolis Sou		In	Lie	u of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	F	Period: From 09/01/2		Workshe Part I		
				Го 08/31/:		1/4/201	7 9: 04	
				Urban/Rura 1.00	al S	Date of 2.0		
26.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			inning of the		1			26. 00
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ige) sta	atus at the end			1			27. 00
enter the effective date of the geographic reclassifi	cati on	in column 2.						
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	numbe	r of periods SC	H status in		C			35. 00
				Begi nni n 1. 00	ng:	Endi r 2. 0		
36.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number					36. 00
37.00 If this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		C			37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the				N				37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	or yes	or "N" for no.	(see					
38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38. 00
enter subsequent dates.	Po o.			Y/N		Y/N	ı	
				1. 00		2. 0		22.22
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Ente	er in column 1	"Y" for yes	N		N		39. 00
or "N" for no. Does the facility meet the mileage red CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes								
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob				N		N		40. 00
no in column 2, for discharges on or after October 1.					V	XVIII	XI X	
					1. 00		3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymen	nt for (di sproporti onat	e share in ac	cordance	N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce	eption :	for extraordi na	rv circumstan	ces	N	N N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.								
47.00 Is this a new hospital under 42 CFR §412.300 PPS capi 48.00 Is the facility electing full federal capital payment					N N	N N	N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in	approv	ed GME programs	? Enter "Y"	for yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting p	eriod (durina which re	sidents in ap	proved				57. 00
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	yes o	r "N" for no in	column 1. If	column 1				
for yes or "N" for no in column 2. If column 2 is "Y	/", com	plete Worksheet						
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II 58.00 If line 56 is yes, did this facility elect cost reimb	ourseme	nt for physicia	ns' services	as				58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59. 00
60.00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					N			60. 00
	Y/N	I ME	Direct GME	IME		Di rect	GME	
41 00 Did your book to become FTE -1-t- water 404	1.00	2. 00	3. 00	4.00	0.00	5.0		41.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N				0.00	,	0.00	61. 00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care		0.00	0.0	00				61. 01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								
instructions) 61.02 Enter the current year total unweighted primary care		0.00	0. 0	00				61. 02
FTE count (excluding OB/GYN, general surgery FTEs,		0.00	0. 0	.9				01.02
and primary care FTEs added under section 5503 of ACA). (see instructions)								
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0.0	00				61. 03
determining compliance with the 75% test. (see instructions)								
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	od				61. 04
current cost reporting period (see instructions).		0.00	2.2					(1.05
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.0	,0				61. 05
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)								

H0SPI	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMP			dianapolis Sou Provider (CCN: 152008 I	Peri od:	u of Form CMS-2 Worksheet S-2	
						From 09/01/2015 To 08/31/2016	Part I Date/Time Pre 1/4/2017 9:04	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1. 00	2. 00	3. 00	4.00	5.00	
61. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.0	00		61. 0
			Pro	ogram Name	Program Code		Unweighted Direct GME FTE Count	=
	Of the FTEs in line 61.05, speci			1. 00	2. 00	3.00	4.00	
61. 20	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column					0. 00		61.1
		and enter in column						
	ACA Durant at ACC	J. H. D		\\	(HDCA)		1. 00	
62. 00	ACA Provisions Affecting the Heat Enter the number of FTE resident					iod for which	0.00	62.0
62. 01	during in this cost reporting pe	s that rotated from a eriod of HRSA THC prog	a Teachi gram. (s	see instruction		your hospital	0.00	62.0
63. 00	Teaching Hospitals that Claim Re Has your facility trained reside				st reporting	period? Enter	N	63.0
	"Y" for yes or "N" for no in col	umn 1. If yes, comple	ete line	es 64-67. (see	instructions) Unweighted		Ratio (col. 1/	/
					FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
	Section 5504 of the ACA Base Yea	ar FTE Residents in No	onprovi	der SettingsT	1.00 This base year	2.00 is your cost r	eporting	
64. 00	period that begins on or after of Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to resident FTEs that trained in your of (column 1 divided by (column).	s yes, or your facilit aber of unweighted nor otations occurring in a number of unweighted our hospital. Enter in	y trair n-primar all nor d non-pr n columr	ned residents Ty care Inprovider Timary care To 3 the ratio	0.0	0.00	0. 000000	64.0
		Program Name	Pro	ogram Code	Unwei ghted FTEs		Ratio (col. 3/ (col. 3 + col.	1
					Nonprovi der Si te	Hospi tal	4))	
65. 00	Enter in column 1, if line 63	1. 00		2.00	3. 00	4. 00 0 0. 00	5. 00 0. 000000	65.0
	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							

Health Financial Systems		ital Indianapolis Sou			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENIIFICATION DA	IA Provider	F	eriod: from 09/01/2015 o 08/31/2016	Worksheet S-2 Part I Date/Time Pre	pared:
			Unwei ghted	Unwei ghted	1/4/2017 9:04 Ratio (col. 1/	am
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te 1.00	·	,,	
Section 5504 of the ACA Current		n Nonprovider Setting		2.00 or cost reporti	3.00 ng periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of		ry care resident	0.00	0.00	0. 000000	66. 00
FTEs attributable to rotations of Enter in column 2 the number of						
FTEs that trained in your hospit (column 1 divided by (column 1 -	tal. Enter in column 3	the ratio of				
(cordinit i di vi ded by (cordinit i	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	Si te 3.00	4.00	5. 00	
67.00 Enter in column 1, the program	11.00	2.00	0.00		0. 000000	67. 00
name associated with each of your primary care programs in						
which you trained residents. Enter in column 2, the program						
code. Enter in column 3, the number of unweighted primary						
care FTE residents attributable						
to rotations occurring in all non-provider settings. Enter in						
column 4, the number of unweighted primary care						
resident FTEs that trained in						
your hospital. Enter in column 5, the ratio of (column 3						
<pre>divided by (column 3 + column 4)). (see instructions)</pre>						
			'	1.00	2.00 3.00	
Inpatient Psychiatric Facility I					7 2.00 3.00	
70.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or does it conta	ain an IPF sub	provi der? N		70. 00
71.00 If line 70 yes: Column 1: Did the recent cost report filed on or b	ne facility have an ap				0	71. 00
42 CFR 412.424(d)(1)(iii)(c)) Co	olumn 2: Did this faci	lity train residents	in a new teacl	hi ng		
program in accordance with 42 CF Column 3: If column 2 is Y, indi						
(see instructions) Inpatient Rehabilitation Facili	ty PPS					
75.00 Is this facility an Inpatient Re	ehabilitation Facility	(IRF), or does it co	ontain an IRF	N		75. 00
subprovider? Enter "Y" for yes 76.00 If line 75 yes: Column 1: Did th	ne facility have an ap				0	76. 00
recent cost reporting period end no. Column 2: Did this facility						
CFR 412.424 (d)(1)(iii)(D)? Ente	er "Y" for yes or "N"	for no. Column 3: If	column 2 is Y	,		
indicate will on program year bega	an during this cost le	por tring period. (See	111311 4011 0113)		4.00	
Long Term Care Hospital PPS					1.00	
80.00 Is this a long term care hospita 81.00 Is this a LTCH co-located within				period? Enter	Y N	80. 00 81. 00
"Y" for yes and "N" for no.	. 2.10 (1.10)	part of the t		political Enter	.,	31. 50
TEFRA Providers 85.00 Is this a new hospital under 42			-		N	85. 00
86.00 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	ew Other subprovider (or ves and "N" for no	(excluded unit) under	42 CFR Section	n		86. 00
87.00 Is this hospital a "subclause (I for yes or "N" for no.		under section 1886(d)	(1)(B)(iv)(II)	? Enter "Y"	N	87. 00
Tot yes of N Tot Ho.				V	XI X	
Title V and XIX Services				1.00	2.00	
90.00 Does this facility have title V yes or "N" for no in the applica		hospi tal servi ces? En	nter "Y" for	N	Y	90. 00
91.00 Is this hospital reimbursed for	title V and/or XIX th			N	N	91. 00
full or in part? Enter "Y" for y 92.00 Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certificati			N	92. 00
instructions) Enter "Y" for yes 93.00 Does this facility operate an IC			d XIX? Fnter	N	N	93. 00
"Y" for yes or "N" for no in the	e applicable column.					
94.00 Does title V or XIX reduce capitapplicable column.	iai cost <i>i</i> enter i i i i	n yes, and N TOP NO	o ili tile	N	N	94. 00

Health Financial Systems Kindred Hospital In HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 152008 P	eriod: rom 09/01/2		S-2
		1	o 08/31/2	016 Date/Time F 1/4/2017 9:	
			V	XI X	
95.00 If line 94 is "Y", enter the reduction percentage in the app	nlicable column	า	0.00	2.00	95, 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for no	o in the	N	N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable column	า.	0.00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (C/L) 106.00 of this facility qualifies as a CAH, has it elected the all-		nod of payment	N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, column reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see insti	ructions) If			107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respirator 4.00	<u>y</u>
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 Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	OA Demo)for	N	110. 00
				1.00 2.00 3.0	00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on	r "N" for no i	n column 1. If	column 1	N O	115. 00
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 int for long te	is "E", enter i rm care (includ	n column des		
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur	•		'N" for	N Y	116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy i	s	1	118. 00
Crariii-iiiade. Effer 2 11 the portey 13 occurrence.		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		62, 134			236 118. 01
			1.00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.	center other dule listing co	than the ost centers	N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu	n column 1, "Y' ualifies for tl	' for yes or ne Outpatient	N	N	119. 00 120. 00
Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	nts? (see insti	ructions)			
121.00 Did this facility incur and report costs for high cost impla	antable devices	s charged to	N		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the			N		122. 00
where these taxes are included. Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, e		fication date			126. 00
in column 1 and termination date, if applicable, in column 2 127.00 of this is a Medicare certified heart transplant center, en	ter the certifi	cation date			127. 00
in column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, en-	ter the certifi	cation date			128. 00
in column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2		cation date in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas if applicable, in column 1 and termination date if applicable, in column 1 and termination date.		ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in column 131.00 of this is a Medicare certified intestinal transplant center	r, enter the c	erti fi cati on			131. 00
date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column 2	ter the certifi	cation date			132. 00

Health Financial Systems Kindred Ho	ospital Indianapolis S	outh	In Lie	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA Provi de	r CCN: 152008	Peri od: From 09/01/2015		
			To 08/31/2016	Date/Time Pr 1/4/2017 9:0	
			1. 00	2.00	
133.00 If this is a Medicare certified other transplant coin column 1 and termination date, if applicable, in	n column 2.				133. 00
134. 00 If this is an organ procurement organization (0P0), and termination date, if applicable, in column 2.	, enter the OPO number	in column 1			134. 00
All Providers 140.00 Are there any related organization or home office of chapter 10? Enter "Y" for yes or "N" for no in column are claimed, enter in column 2 the home office chai	umn 1. If yes, and hom	ne office costs	Y S	189003	140. 00
1.00 If this facility is part of a chain organization,	2. 00		3.00	of the	
home office and enter the home office contractor na	ame and contractor nur	mber.			
141.00 Name: KINDRED HEALTHCARE OPERATING Contractor's INC.	s Name: WISCONSIN PHYS SERVICES	I CI ANS Contract	tor's Number: 059	01	141. 00
142.00 Street: 680 SOUTH FOURTH AVENUE PO Box: 143.00 Ci ty: LOUISVILLE State:	KY	Zi p Code	e: 402	02	142. 00 143. 00
145. OUDITY. EDUISVILLE State.	N1	ZI p code	;. 402		143.00
144.00 Are provider based physicians' costs included in Wo	orksheet A?			1. 00 Y	144. 00
			1.00	2.00	
145.00 If costs for renal services are claimed on Wkst. A,			1. 00 Y	2.00	145. 00
inpatient services only? Enter "Y" for yes or "N" no, does the dialysis facility include Medicare utiperiod? Enter "Y" for yes or "N" for no in column	ilization for this cos				
146.00 Has the cost allocation methodology changed from the Enter "Y" for yes or "N" for no in column 1. (See (yes, enter the approval date (mm/dd/yyyy) in column	CMS Pub. 15-2, chapter		N F		146. 00
				1.00	
147.00 Was there a change in the statistical basis? Enter				N	147. 0
148.00 Was there a change in the order of allocation? Ento 149.00 Was there a change to the simplified cost finding r			no.	N N	148. 0 149. 0
	Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	
Does this facility contain a provider that qualifi or charges? Enter "Y" for yes or "N" for no for ea	es for an exemption fi	rom the applic	ation of the low	er of costs	
155. 00 Hospi tal	N	N	N	N	155. 0
156.00 Subprovider - IPF 157.00 Subprovider - IRF	N N	N N	N N	N N	156. 0 157. 0
158. OO SUBPROVI DER					158. 0
159.00 SNF 160.00 HOME HEALTH AGENCY	N N	N N	N N	N N	159. 0 160. 0
161. 00 CMHC		N	N	N	161. 0
				1.00	
Multicampus 165.00 Is this hospital part of a Multicampus hospital that Enter "Y" for yes or "N" for no.	at has one or more can	npuses in diffe	erent CBSAs?	N	165. 0
Name	County		p Code CBSA	FTE/Campus	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	1.00	2.00	3.00 4.00	5.00	00 166. 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.0	00166 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 166.01 166.02				0.0	00 166. 0 00 166. 0 00 166. 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 166.01 166.02				0.0	00 166. 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 166.01 166.02 166.03 Health Information Technology (HIT) incentive in the second column in the secon			nt Act	1.00	00 166. 0 00 166. 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 166.01 166.02 166.03 Health Information Technology (HIT) incentive in the column of this provider a meaningful user under \$1886(n)? 168.00 If this provider is a CAH (line 105 is "Y") and is	Enter "Y" for yes or a meaningful user (li	"N" for no.		0. (00 166. 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 166.01 166.02 166.03 Health Information Technology (HIT) incentive in the column of the co	Enter "Y" for yes or a meaningful user (li nstructions) user, does this provic	"N" for no. ne 167 is "Y") der qualify for), enter the	1.00	166. 0 00 166. 0 167. 0

Health Financial Systems	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	Worksheet S-2			
		From 09/01/2015		
		To 08/31/2016	Date/Time Pre	pared:
			1/4/2017 9:04	
	Endi ng			
	2.00			
170.00 Enter in columns 1 and 2 the EHR begingeriod respectively (mm/dd/yyyy)		170. 00		
			1.00	
171.00 If line 167 is "Y", does this provide Medicare cost plans reported on Wkst.	N	171. 00		
(see instructions)				

	Financial Systems Kindred Hospital In	ndi anapolis Sou Provi der		Peri od: From 09/01/2015 To 08/31/2016	1/4/2017 9: 04	2 epared:	
				Y/N	Date		
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente	1.00 rall dates in t	2. 00 the		
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation						
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.00	
	reporting period. IT yes, onter the date of the change in e	701 GIIII 2. (300	Y/N 1.00	Date 2.00	V/I 3. 00		
2. 00	Has the provider terminated participation in the Medicare Pyes, enter in column 2 the date of termination and in columy voluntary or "I" for involuntary.		N	3.00		2. 00	
3.00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	Y			3. 00	
			Y/N 1.00	Type 2. 00	Date 3.00		
	Financial Data and Reports						
4. 005. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ilable in	Y	A	03/31/2017	4. 00	
	those on the filed financial statements? If yes, submit rec					3.00	
				Y/N 1.00	Legal Oper. 2.00		
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is N the legal operator of the program?						
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	· ·	N N		7. 00 8. 00	
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		N		9.00	
10. 0011. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N N		10.00	
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N		
	Bad Debts				1. 00		
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			est reporting	Y N	12. 00 13. 00	
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	structi ons.	N	14. 00	
15. 00	Bed Complement Did total beds available change from the prior cost reporti		yes, see inst	ructions.	N + R	15. 00	
		Y/N	Date	Y/N	Date		
	PS&R Data	1.00	2.00	3. 00	4. 00		
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	Υ	10/31/2016	Y	10/31/2016	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	N		N		17. 00	
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00	
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00	

	Financial Systems Kindred Hospital II FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 152008	Peri od: From 09/01/2015	u of Form CMS- Worksheet S-2 Part II		
				To 08/31/2016			
		Descr	i pti on	Y/N	Y/N		
			0	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	report data for other? Describe the other adjustments.	Y/N	Date	Y/N	Date		
		1.00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
	records: 11 yes, see firstructions.	1					
	COURT FTED BY COCT DELINDURGED AND TEEDA HOODI TALC ONLY (EVOL	DT OULL DDENG I	IOCDI TALC)		1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PI CHILDRENS F	HUSPITALS)			+	
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. 0	
23. 00	Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost		23. 0	
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into during	this cost re	porting period?		24. 0	
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	rtina period?	'If ves. see		25. 0	
26. 00	instructions.	•	0.				
	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	•		•		26. 0	
27. 00	Has the provider's capitalization policy changed during the copy. Interest Expense	e cost reportir	ng period? If	yes, submit		27. 0	
28. 00	Were new Loans, mortgage agreements or Letters of credit er	ntered into dum	ing the cost	reporti ng		28. 0	
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		29. 0				
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If ves	. see		30.0	
31. 00	instructions. Has debt been recalled before scheduled maturity without is	,	,			31. 0	
	instructions. Purchased Services						
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual		32. 0	
33. 00			ng to competi	tive bidding? If		33.0	
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provi der-ba	sed physicians?		34.0	
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. 0	
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date		
				1.00	2. 00		
	Home Office Costs						
	Were home office costs claimed on the cost report?			Y		36. 0	
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?	Y		37. 0	
88. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			Y	12/31/2016	38. 0	
39. 00				Ν Ν		39. 0	
10. 00	If line 36 is yes, did the provider render services to the instructions.		40. 0				
		00					
	Cost Report Preparer Contact Information	1.	00				
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JOY		DAVI S		41.0	
1.00	respecti vel y.	KINDRED HEALTHCARE OPERATING					
	Enter the employer/company name of the cost report		ICARE OPERATI	NG		42. 0	
11. 00 12. 00 13. 00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTH INC 5025967581	HCARE OPERATI	NG Jacquel yn. Davi	søkindrod com	42. 0	

Heal th	Financial Systems k	Kindred Hospital	I ndi ar	napolis Sou	th		In Lieu	of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN: 152008		ri od:	Worksheet S-2	2
						To	om 09/01/2015	Date/Time Pro	nared.
						10	08/31/2010	1/4/2017 9:04	1 am
				3. (00				
	Cost Report Preparer Contact Information								
	Enter the first name, last name and the t		REIM	BURSEMENT N	MANAGER				41. 00
	held by the cost report preparer in colum	ins 1, 2, and 3,							
	respecti vel y.								
42. 00	Enter the employer/company name of the co	st report							42. 00
	preparer.								
43. 00	Enter the telephone number and email addr								43. 00
	report preparer in columns 1 and 2, respe	cti vel y.							

| Peri od: | Worksheet S-3 | From 09/01/2015 | Part | To 08/31/2016 | Date/Time Prepared: Health Financial Systems Kindred Hospital Indianapolis South
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN Provider CCN: 152008

						0 08/31/2016	1/4/2017 9: 04	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35p31.0111	Line Number		o. Bous	Avai I abl e	07.11 11041 0		
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		60			0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			60	21, 960	0.00		
	beds) (see instructions)				,			
8.00	INTENSIVE CARE UNIT	31. 00		0	1	0.00	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)			60	21, 960	0.00	0	
15. 00	CAH visits			00	21,700	0.00	0	
16. 00	SUBPROVI DER - I PF						Ĭ	16. 00
17. 00	SUBPROVI DER – I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0		1	0	
20. 00	NURSING FACILITY	11.00		Ü			Ĭ	20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	30.00						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)			60				27. 00
28. 00	Observation Bed Days			00			0	1
29. 00	Ambulance Trips						0	29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days (see l'istruction)							31.00
	Labor & delivery days (see instructions)			0				1
32.00	, , , , , , , , , , , , , , , , , , ,			Ü	C	1		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions) LTCH non-covered days							33. 00
SS. 00	LIGH HOH-COVELED Days				I	1	I	J 33.00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 152008

Peri od: Worksheet S-3 From 09/01/2015 Part I To 08/31/2016 Date/Time Prepared:

1/4/2017 9:04 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 10.00 6.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 7, 115 51 11, 188 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 1, 114 2 00 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 7, 115 51 11, 188 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 0 8.00 CORONARY CARE UNIT 9.00 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) 7, 115 51 11, 188 0.00 105.70 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0 0 0 0.00 0.00 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 24.10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 26.25 27.00 Total (sum of lines 14-26) 0.00 105.70 27.00 28.00 Observation Bed Days 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 32.00 0 Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions)

220

33.00 LTCH non-covered days

| Peri od: | Worksheet S-3 | From 09/01/2015 | Part | To 08/31/2016 | Date/Time Prepared: Health Financial Systems Kindred Hospital Indianapolis South
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN Provi der CCN: 152008

				10	0 08/31/2016	1/4/2017 9:04	
		Full Time	<u>'</u>	Di sch	arges	=	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	268	1	418	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			39	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0.00	0	268	1	418	14. 00
15.00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
		•					

					T	08/31/2016	Date/Time Pre 1/4/2017 9:04	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col. 2 ± col.	Related to Salaries in	Wage (col. 4 ÷	
				Worksheet A-6)	3)	col. 4	col. 5)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							1
1. 00	SALARIES Total salaries (see	200. 00	6, 680, 506	0	6, 680, 506	219, 519. 84	30. 43	1.00
00	instructions)	200.00	0,000,000		0,000,000	217,017.01		
2.00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	2. 00
3.00	A Non-physician anesthetist Part		C	0	0	0. 00	0. 00	3.00
	В		_		_			
4. 00	Physician-Part A -		C	0	0	0. 00	0. 00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		C	0	0	0.00	0.00	4. 01
5.00	Physician-Part B		C	0	0	0. 00	1	
6. 00 7. 00	Non-physician-Part B	21. 00	C	0	0	0. 00 0. 00		
7.00	Interns & residents (in an approved program)	21.00	C	0	0	0.00	0.00	7.00
7. 01	Contracted interns and		C	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office personnel		C	o	0	0. 00	0. 00	8. 00
9. 00	SNF	44. 00	C		0	0. 00		
10. 00	Excluded area salaries (see instructions)		C	71, 497	71, 497	1, 147. 00	62. 33	10.00
	OTHER WAGES & RELATED COSTS			1				1
11. 00	Contract labor: Direct Patient		1, 872, 225	0	1, 872, 225	26, 251. 00	71. 32	11.00
12. 00	Care Contract Labor: Top Level		C	0	0	0.00	0.00	12. 00
	management and other				_			
	management and administrative services							
13. 00	Contract Labor: Physician-Part		473, 743	o	473, 743	4, 732. 00	100. 11	13. 00
	A - Administrative		04/ 440		04/ 440	40.070.00		
14. 00	Home office salaries & wage-related costs		816, 112	0	816, 112	13, 378. 88	61.00	14. 00
15. 00	Home office: Physician Part A		C	0	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		C	0	0	0. 00	0.00	16. 00
	Physicians Part A - Teaching				_			
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		965, 535	0	965, 535		I	17. 00
17.00	instructions)		700, 000		703, 333			17.00
18. 00	Wage-related costs (other) (see instructions)		C	0	0			18. 00
19. 00	Excluded areas		10, 445	0	10, 445			19.00
20. 00	Non-physician anesthetist Part		· C	0	0			20.00
21. 00	A Non-physician anesthetist Part		C	0	0			21. 00
21.00	В							21.00
22. 00	Physician Part A - Administrative		C	0	0			22. 00
22. 01	Physician Part A - Teaching		C	0	0			22. 01
23. 00	Physician Part B		C	_	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	0	0			24. 00 25. 00
23.00	approved program)							25.00
0/ 00	OVERHEAD COSTS - DIRECT SALARIE		50.07		50.040	4 044 07	10.40	0, 00
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	50, 363 938, 025		50, 363 938, 025	·		
28. 00	Administrative & General under	0.00	6, 875	1	6, 875			
20.00	contract (see inst.)					0.00	0.00	20.00
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	99, 413	0	99, 413	0. 00 7, 227. 00		
31. 00	Laundry & Linen Service	8. 00	,,, 116 C	Ö	0	0.00		
32.00	Housekeepi ng	9. 00	154, 574	0	154, 574			
33. 00	Housekeeping under contract (see instructions)		C	0	0	0. 00	0. 00	33. 00
34.00	Di etary	10. 00	42, 055	0	42, 055	1, 566. 00	26. 86	34.00
35. 00	Di etary under contract (see		C	0	0	0. 00	0. 00	35. 00
36. 00	i nstructi ons) Cafeteri a	11. 00	C	0	О	0.00	0. 00	36. 00
37. 00	Maintenance of Personnel	12. 00	C	Ō	0	0. 00	0. 00	37. 00
38. 00 39. 00	Nursing Administration	13. 00	612, 978		612, 978 80, 747			
40. 00	Central Services and Supply Pharmacy	14. 00 15. 00	80, 747 C	1				40.00
	, - '				•			·

Health Financial Systems	Ki ndı	red Hospital I	ndianapolis Sou	ıth	In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION				CCN: 152008	Period: From 09/01/2015 To 08/31/2016		pared:
	Worksheet A	Amount	Recl assi fi cati	Adj usted		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	277, 671	0	277, 67	1 8, 538. 00	32. 52	41. 00
42.00 Social Service	17. 00	246, 247	-71, 497	174, 750	2, 803. 77	62. 33	42.00
43.00 Other General Service	18. 00	C	0		0.00	0. 00	43. 00

instructions)

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 152008 Peri od: From 09/01/2015 To 08/31/2016 1/4/2017 9:04 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 4.00 5.00 6.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 6, 687, 381 6, 687, 381 219, 859. 84 30. 42 1.00 instructions) 2.00 Excluded area salaries (see 0 71, 497 71, 497 1, 147. 00 62. 33 2.00 instructions) 3.00 Subtotal salaries (line 1 6, 687, 381 -71, 497 6, 615, 884 218, 712. 84 30. 25 3.00 minus line 2) 4.00 Subtotal other wages & related 3, 162, 080 3, 162, 080 44, 361. 88 71. 28 4.00 costs (see inst.) Subtotal wage-related costs 5.00 965, 535 Ω 965, 535 0.00 14.59 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 10, 814, 996 -71, 497 10, 743, 499 263, 074. 72 40.84 7.00 Total overhead cost (see 2, 508, 948 -71, 497 2, 437, 451 75, 308. 10 32.37 7.00

Health Financial Systems	Kindred Hospital India	napolis South	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Provi der CCN: 152008		Worksheet S-3
			From 09/01/2015	

	To 08/31/2016	Date/Time Prep 1/4/2017 9:04	
		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Pl an Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	379, 333	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	-4, 006	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	3, 996	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	
13.00	Disability Insurance (If employee is owner or beneficiary)	25, 325	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	77, 241	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	448, 224	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	19. 00
20. 00	State or Federal Unemployment Taxes	18, 298	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))	_	
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	17, 123	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	965, 534	24.00
05.60	Part B - Other than Core Related Cost		05.00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Hearth Financial Systems Kind					U OT FORM CMS	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
				rom 09/01/2015	D-+- /T: D	
				To 08/31/2016	Date/Time Pre	
		0.11	I = 1 1 1 1 1	5	1/4/2017 9: 04	am
Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT		411 004	411, 004	129, 756	F40 7/0	1.00
	1	411, 004			540, 760	
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	1	657, 985			685, 466	2. 00
3.00 00300 OTHER CAP REL COSTS		157, 237			0	3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	50, 363	1, 038, 409	1, 088, 772	2 0	1, 088, 772	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	938, 025	1, 625, 743	2, 563, 768	3 0	2, 563, 768	5. 00
7.00 00700 OPERATION OF PLANT	99, 413	711, 625		sl ol	811, 038	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE) , , , , ,	110, 063			110, 063	8.00
9. 00 00900 HOUSEKEEPI NG	154, 574	46, 226			200, 800	9. 00
	1					1
10. 00 01000 DI ETARY	42, 055	444, 618	486, 673	3 0	486, 673	10.00
11. 00 01100 CAFETERI A	0	0		이	0	11. 00
13.00 O1300 NURSING ADMINISTRATION	612, 978	7, 988	620, 966	6 0	620, 966	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	80, 747	4, 629	85, 376	6 ol	85, 376	14. 00
15. 00 01500 PHARMACY	0	780, 467			780, 467	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	277, 671	19, 106			296, 777	16.00
	1					1
17. 00 01700 SOCI AL SERVI CE	246, 247	26, 409	272, 656	-79, 011	193, 645	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 161, 423	955, 201	4, 116, 624	1 0	4, 116, 624	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	(0	0	31.00
44.00 04400 SKILLED NURSING FACILITY	l ol	0		ol ol	0	44.00
ANCILLARY SERVICE COST CENTERS				-1		
50. 00 05000 OPERATING ROOM	73, 396	292, 588	365, 984	1 0	365, 984	50.00
	94, 035					ł
		187, 824			281, 859	54.00
60. 00 06000 LABORATORY	38, 830	488, 191			527, 021	1
65. 00 06500 RESPIRATORY THERAPY	810, 749	30, 485	841, 234	1 0	841, 234	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 005, 567	1, 005, 567	7 0	1, 005, 567	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	O	0	(ol ol	0	67.00
68. 00 06800 SPEECH PATHOLOGY	ام	0	1	ol ol	0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		647, 776	647, 776		647, 776	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		936, 536			936, 536	73. 00
	-					1
74. 00 07400 RENAL DI ALYSI S	0	328, 478	328, 478	3 0	328, 478	74. 00
OUTPATIENT SERVICE COST CENTERS			T			
90. 00 09000 CLI NI C	0	0		이	0	90. 00
91. 00 09100 EMERGENCY	0	0	(0	0	91. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	0	(ol ol	0	95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			0	98. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	`	,	ŭ	70.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	6, 680, 506	10, 914, 155	17, 594, 661	-79, 011	17, 515, 650	110 00
	0,000,000	10, 914, 133	17, 394, 00	-19,011	17, 313, 630	1110.00
NONREI MBURSABLE COST CENTERS			1	.1 _1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(이		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0		192. 00
194.00 07950 NONALLOWABLE CLINICAL LIAISON	0	0	(79, 011	79, 011	194. 00
194. 01 07951 I DLE SPACE	o	0		ol ol	0	194. 01
194. 02 07952 REGIONAL OFFICE	l ol	0		-		194. 02
	-	0		-		
194. 03 07953 DI STRI CT OFFI CE	0	0				194. 03
194.04 07954 NON MCR CERTIFIED UNIT) O	0		이		194. 04
194. 05 07955 REG NURSG OFFICE	0	0	(이		194. 05
194. 06 07956 CONTACT CENTER	0	0	(ol ol	0	194. 06
194.07 07957 CENTRALIZED ADMISSIONS DEPT		0		ام ار		194. 07
194. 08 07959 HEARTLAND AMBULANCE	ام	0		-		194. 08
		0		(I)		194. 09
194. 09 07958 VI SI TOR MEALS		0]	(I		
194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS	0	0		기 이		194. 10
194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		이		194. 11
200.00 TOTAL (SUM OF LINES 118-199)	6, 680, 506	10, 914, 155	17, 594, 661	이	17, 594, 661	200.00
	•					

Heal th	Financial Systems Kind	red Hospital Li	ndi ana	polis Sou	uth	In Lieu	of Form CMS-	-2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES		Provi der	CCN: 152008	Peri od:	Worksheet A	
						From 09/01/2015 To 08/31/2016	Date/Time Pro	epared:
		1		_		L	1/4/2017 9: 0	
	Cost Center Description	Adjustments		Expenses				
		(See A-8) 6.00		<u>llocation</u> 7.00	<u> </u>			
	GENERAL SERVICE COST CENTERS	0.00		7.00				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-8, 373		532, 387	1			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-74, 725		610, 741				2.00
3.00	00300 OTHER CAP REL COSTS	0		0				3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 331		1, 087, 441				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	66, 369		2, 630, 137	'			5. 00
7.00	00700 OPERATION OF PLANT	-1, 704		809, 334	·			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0		110, 063				8.00
9.00	00900 HOUSEKEEPI NG	0		200, 800				9. 00
10.00	01000 DI ETARY	-25, 166		461, 507	'			10.00
11. 00	01100 CAFETERI A	0		0)			11.00
13.00	01300 NURSING ADMINISTRATION	0		620, 966				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0		85, 376				14.00
15.00	01500 PHARMACY	0	1	780, 467	'			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-991		295, 786				16. 00
17.00	01700 SOCIAL SERVICE	0		193, 645	5			17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	-272, 356		3, 844, 268	1			30.00
31. 00	03100 INTENSIVE CARE UNIT	0		0	1			31.00
44.00	04400 SKILLED NURSING FACILITY	0		0)			44. 00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	-12, 135	1	353, 849	1			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-3, 000	1	278, 859	1			54.00
60.00	06000 LABORATORY	-477	1	526, 544	1			60.00
65. 00	06500 RESPI RATORY THERAPY	0	1	841, 234				65. 00
66. 00	06600 PHYSI CAL THERAPY	-77, 168	1	928, 399	1			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1	0	1			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1	0	•			68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1	647, 776	1			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1	936, 536	1			73.00
74. 00	07400 RENAL DIALYSIS	0	<u> </u>	328, 478	8			74. 00
00 00	OUTPATIENT SERVICE COST CENTERS							1 00 00
90.00	09000 CLINIC	0		0	1			90.00
91. 00	09100 EMERGENCY	0	<u> </u>	0	9			91. 00
05 00	OTHER REIMBURSABLE COST CENTERS							
95. 00	09500 AMBULANCE SERVICES	0		0	•			95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	<u> </u>	0)			98. 00
110 00	SPECIAL PURPOSE COST CENTERS	411 057	1	7 104 502				110 00
118.00		-411, 057	!	7, 104, 593	·L			118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				\			100 00
		0	1	0	1			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1	70.011	1			192. 00
	07950 NONALLOWABLE CLINICAL LIAISON	0	1	79, 011	1			194. 00
	O7951 IDLE SPACE O7952 REGIONAL OFFICE	0		0	1			194. 01 194. 02
	3 07952 REGIONAL OFFICE			0	•			
	107954 NON MCR CERTIFIED UNIT	0		0	•			194. 03 194. 04
	07955 REG NURSG OFFICE	0		0	1			194. 04
	07956 CONTACT CENTER	0		0	1			
	707950 CONTACT CENTER 707957 CENTRALIZED ADMISSIONS DEPT			0	1			194. 06 194. 07
	07957 CENTRALIZED ADMISSIONS DEPT			0	•			194. 07
	0/959 HEARTLAND AMBULANCE			0	•			194. 08
	0/07962 OTHER NONREIMBURSABLE COST CENTERS	0	1	0	1			194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS			0	•			194. 10
174.		-411, 057	1	ں 7, 183, 604	1			200.00
200.00	TOTAL (SUM OF LINES 118-199)							

Heal th	Financial Systems	Ki no	dred Hospital I	ndianapolis So	uth	In Lie	u of Form CMS-	-2552-10
RECLASS	SI FI CATI ONS			Provi der	CCN: 152008	Peri od: From 09/01/2015	Worksheet A-	
						To 08/31/2016	Date/Time Pro 1/4/2017 9:0	
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	A - RECLASS NON ALLOWABLE CAS	SE MANAGER						
1.00	NONALLOWABLE CLINICAL	194. 00	71, 497	7, 514				1. 00
	LI AI SON							
	TOTALS		71, 497	7, 514				
500 00	Grand Total: Increases		71 497	7 514				500 00

-2552-10
6
epared:
4 am
1. 00
500.00
4

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 152008 Peri od: Worksheet A-7 From 09/01/2015 Part I Date/Time Prepared: 08/31/2016 1/4/2017 9:04 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 591, 412 0 1.00 0 13, 049 2.00 Land Improvements 0 0 2.00 3. 00 3.00 Buildings and Fixtures 14, 910, 598 0 0 4.00 Building Improvements 555, 703 8,058 8, 058 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 3, 611, 124 79, 064 79, 064 73, 108 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 20, 681, 886 87, 122 87, 122 73, 108 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 87, 122 73, 108 10.00 20, 681, 886 0 87, 122 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 591, 412 0 1.00 2.00 Land Improvements 13, 049 0 2.00 14, 910, 598 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 563, 761 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 3, 617, 080 6.00 7.00 HIT designated Assets 0 7.00

20, 695, 900

20, 695, 900

0

Heal th	n Financial Systems Kind	red Hospital Li	ndianapolis Sou	uth	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS	•	Provi der		Peri od:	Worksheet A-7	
					From 09/01/2015 To 08/31/2016	Part II Date/Time Pre	pared.
						1/4/2017 9:04	
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	408, 896	2, 108		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	169, 189	488, 796	,	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	578, 085	490, 904		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)	45.00	-			
	DART II DECONCILIATION OF AMOUNTS FROM WORK	14.00	15.00				
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	CSHEET A, CULUN	· ·				1 00
1.00	CAP REL COSTS MAD E FOULD	0	411, 004	1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	657, 985				2.00
3. 00	Total (sum of lines 1-2)	1	1, 068, 989	Ί			J 3.00

Heal th	Financial Systems Kind	red Hospital Ir	ndianapolis Sou	ıth	In Lie	u of Form CMS-2	2552-10	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7		
					From 09/01/2015 Fo 08/31/2016		narod:	
					10 00/31/2010	1/4/2017 9:04		
	·	COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance		
			Leases	for Ratio	instructions)			
				(col . 1 - col .				
		1, 00	2.00	2) 3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	CAP REL COSTS-BLDG & FLXT	17, 078, 820	1	17, 078, 820	0. 825227	20, 706	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	3, 617, 080		3, 617, 080				
3.00	Total (sum of lines 1-2)	20, 695, 900		20, 695, 900	1. 000000			
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
			Capi tal -Relate					
		/ 00	d Costs	through 7)	0.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CE	6.00	7. 00	8. 00	9. 00	10. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	109, 050	1	129, 756	409, 305	2, 108	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	23, 096		27, 48		488, 796		
3.00	Total (sum of lines 1-2)	132, 146		157, 237				
				JMMARY OF CAPI				
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
			instructions)	instructions)				
					d Costs (see	through 14)		
		11 00	12.00	12.00	instructions)	15.00		
	DART III DECONCILIATION OF CARLTAL COSTS OF	11. 00	12. 00	13. 00	14. 00	15. 00		

0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

11, 924 4, 385 16, 309

109, 050 23, 096 132, 146

532, 387 1. 00 610, 741 2. 00 1, 143, 128 3. 00

0 0 0

1.00

alth Financial Systems DJUSTMENTS TO EXPENSES	Ki nar	ed Hospital India	Provi der CCN: 152008	Peri od: From 09/01/2015	u of Form CMS-: Worksheet A-8	3
				To 08/31/2016	Date/Time Pre 1/4/2017 9:04	
			xpense Classification of rom Which the Amount is			
Cost Center Descripti	on Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2.00	3. 00	4. 00	5. 00	1.0
00 Investment income - CAP REI COSTS-BLDG & FIXT (chapter	2)		REL COSTS-BLDG & FIXT	1.00	0	
00 Investment income - CAP REI COSTS-MVBLE EQUIP (chapter		OCAP	REL COSTS-MVBLE EQUIP	2. 00	0	2.0
00 Investment income - other (chapter 2)		О		0. 00	0	3.0
00 Trade, quantity, and time	В	-1, 452 ADMI	NI STRATI VE & GENERAL	5. 00	0	4.0
discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.0
expenses (chapter 8) 00 Rental of provider space by	,	0		0.00	0	6.0
suppliers (chapter 8)					_	
Tel ephone services (pay stations excluded) (chapter 21)	- A	-7, 614 ADMI	NISTRATIVE & GENERAL	5. 00	0	7.0
OD Television and radio service (chapter 21)	ce A	-1, 704 OPE	RATION OF PLANT	7. 00	0	8.0
00 Parking Lot (chapter 21)		0		0.00	0	
0.00 Provider-based physician adjustment	A-8-2	-304, 590			0	10.0
.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.0
Related organization transactions (chapter 10)	A-8-1	611, 698			0	12.0
.00 Laundry and linen service		0	-10.4	0.00	0	
2.00 Cafeteria-employees and gue 5.00 Rental of quarters to emplo		-24, 868 DI E ⁻	ARY	10. 00 0. 00	0	
and others .00 Sale of medical and surgical	al	0		0.00	0	16.0
supplies to other than				0.00	O	10.0
patients .00 Sale of drugs to other than	n	o		0.00	0	17. 0
patients 3.00 Sale of medical records and	d B	-991 MFDI	CAL RECORDS & LIBRARY	16. 00	0	18. 0
abstracts			CHE RECORDS & ELEMENT			
.00 Nursing school (tuition, febooks, etc.)	ees,	0		0.00	0	19.0
.00 Vending machines .00 Income from imposition of	В	-298 DI E	TARY	10. 00 0. 00	0	
interest, finance or penal	ty	Ĭ		0.00	O	21.0
charges (chapter 21) . 00 Interest expense on Medicar	re	О		0.00	0	22. 0
overpayments and borrowings repay Medicare overpayments						
8.00 Adjustment for respiratory		ORESI	PIRATORY THERAPY	65.00		23. 0
therapy costs in excess of limitation (chapter 14)						
.00 Adjustment for physical therapy costs in excess of	A-8-3	O PHYS	SI CAL THERAPY	66. 00		24. 0
limitation (chapter 14)						
0.00 Utilization review - physicians' compensation		0 ***	Cost Center Deleted ***	114. 00		25. 0
(chapter 21) 0.00 Depreciation - CAP REL		OCAP	REL COSTS-BLDG & FIXT	1. 00	0	26.0
COSTS-BLDG & FIXT						
COSTS-MVBLE EQUIP		OCAP	REL COSTS-MVBLE EQUIP	2.00	0	27.0
8.00 Non-physician Anesthetist 9.00 Physicians' assistant		0 * * *	Cost Center Deleted ***	19. 00 0. 00	0	28. 0 29. 0
0.00 Adjustment for occupational		ооссі	IPATI ONAL THERAPY	67. 00	O	30.0
therapy costs in excess of limitation (chapter 14)						
Hospice (non-distinct) (see instructions)	9	OADUI	TS & PEDIATRICS	30.00		30. 9
.00 Adjustment for speech	A-8-3	0 SPE	CH PATHOLOGY	68. 00		31.0
pathology costs in excess (limitation (chapter 14)	of					
2.00 CAH HIT Adjustment for Depreciation and Interest		О		0.00	0	32. 0
3. 00		О		0.00		
3. 01 MI SCELLANEOUS I NCOME	В	-241 ADMI	NI STRATI VE & GENERAL	5. 00	0	33.0

Health Financial Systems Kindred Hospital Indianapolis South In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES Provider CCN: 152008 Period: From 09/01/2015 To 08/31/2016 Date/Time Prepared: 1/4/2017 9: 04 am

					08/31/2016	Date/lime Prep 1/4/2017 9:04	
				Expense Classification on To/From Which the Amount is			
					· · · · · · · · · · · · · · · · ·		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
33. 02		1.00	2.00	3.00	4. 00 0. 00	5. 00 0	33. 02
33. 03			0		0. 00	O	33. 03
33. 04 33. 05	OCCUPATIONAL INCENTIVE INCOME	A	12, 730	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	33. 04 33. 05
33. 06 33. 07			0		0. 00 0. 00	0	33. 06 33. 07
33. 08	MEDICARE BAD DEBT - PART A	A	-456, 751	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09 33. 10	OTHER MEDICARE NON ALLOWABLE	A	0 -35, 696	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	33. 09 33. 10
33. 11 33. 12	OTHER OPERATING - PUBLIC	A	0 -234	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	33. 11 33. 12
	RELATI ONS						
33. 13 33. 14	OTHER OPERATING - MARKETING OTHER OPERATING - INTEREST	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 13 33. 14
33. 15 33. 16			0		0. 00 0. 00	0	33. 15 33. 16
33. 17			0		0.00	0	33. 17
33. 18 33. 19			0		0. 00 0. 00	0	33. 18 33. 19
33. 20			0		0.00	0	33. 20
33. 21 33. 22			0		0. 00 0. 00	0	33. 21 33. 22
33. 23 33. 24			0		0. 00 0. 00	0	33. 23 33. 24
33. 25			0		0. 00	0	33. 25
33. 26 33. 27			0		0. 00 0. 00	0	33. 26 33. 27
33. 28	AGGREGATE CAPITAL EROSION	A		ADMINISTRATIVE & GENERAL	5. 00	O	33. 28
33. 29 33. 30	CABLE TV AND SATELLITE	A	-15, 498 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0 0	33. 29 33. 30
33. 31			0		0. 00	0	33. 31
33. 32 33. 33			0		0. 00 0. 00	0 0	33. 32 33. 33
33. 34 33. 35	MALPRACTICE TAIL LIABILITY	A	-10, 818 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	33. 34 33. 35
33. 36			0		0.00	0	33. 36
33. 37	PHYSICIAN BILLING COLLECTION FEES	A	-3	ADMINISTRATIVE & GENERAL	5. 00	0	33. 37
33. 38 33. 39			0		0. 00 0. 00	0	33. 38 33. 39
33. 40			Ö		0. 00	o o	33. 40
33. 41 33. 42			0		0. 00 0. 00	0 0	33. 41 33. 42
	DISTRICT OFFICE SALES AND MARKETING	A	-17, 671	ADMINISTRATIVE & GENERAL	5. 00	o	
33. 44	DISTRICT OFC SALES AND MKT	A	-1, 331	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 44
33. 45	BENEFITS BUSINESS INTERRUPTIONS INS PREMIUM	А	-8, 782	CAP REL COSTS-BLDG & FIXT	1. 00	12	33. 45
34. 00 34. 01	MEDICARE VS BOOK BLDG MEDICARE VS BOOK MOV EQUIP	A A		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	9	34. 00 34. 01
34. 02			0		0.00	0	34. 02
34. 03 34. 04	ASSET ADD-ON BLDG ASSET ADD-ON MOV EQUIP	A A		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	9	34. 03 34. 04
34. 05 34. 06			0		0. 00 0. 00	0	34. 05 34. 06
34. 07			0		0.00	0	34. 07
34. 08 34. 09	NON ALLOWABLE LOBBYING FEES	A	-1, 951 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0 0	34. 08 34. 09
34. 10			0		0.00	O	34. 10
34. 11 34. 12			0		0. 00 0. 00	0	34. 11 34. 12
34. 13	PATIENT PHONE - DEPREC EQUIP	A	-4, 406	CAP REL COSTS-MVBLE EQUIP	2. 00	9	34. 13
34. 14 34. 15			0		0. 00 0. 00	0	34. 14 34. 15
34. 16 34. 17			0		0. 00 0. 00	0	34. 16 34. 17
34. 18			0		0. 00	0	34. 18
34. 19		1	0		0.00	0	34. 19

35. 24

35. 25

50.00

0.00

0.00

ADJUSTMENTS TO EXPENSES Provider CCN: 152008 Peri od: Worksheet A-8 From 09/01/2015 08/31/2016 Date/Time Prepared: 1/4/2017 9:04 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 34. 20 0.00 34. 20 000000 34. 21 0.00 34. 21 34. 22 0.00 34. 22 34. 23 0.00 34. 23 0.00 34 24 34 24 34.25 0.00 34.25 34. 26 0.00 34. 26 0 0.00 34. 27 34 27 O 34.28 0.00 34.28 35.00 0.00 35.00 PHYSICIAN FEE ADJUSTMENT -16, 621 ADMI NI STRATI VE & GENERAL 35. 01 35.01 Α 5.00 35 02 35.02 0 00 35.03 0 0.00 35.03 35.04 0 0 0 0 0.00 35.04 35.05 0.00 35.05 35.06 0.00 35.06 35.07 0.00 35.07 35.08 0.00 35.08 35.09 0 0.00 o 35.09 35.10 35.10 0.00 35. 11 PHYSICIAN FEE ADJUSTMENT -213, 320 ADULTS & PEDIATRICS 30.00 35.11 0.00 35. 12 35.12 35. 13 35, 13 0.00 PHYSICIAN FEE ADJUSTMENT 2, 274 OPERATING ROOM 35.14 Α 50.00 35.14 35. 15 0.00 35. 15 35. 16 35. 16 0.00 PHYSICIAN FEE ADJUSTMENT 227, 668 RESPIRATORY THERAPY 65.00 35.17 0 35.17 Α 35. 18 0.00 35. 18 35. 19 0.00 35. 19 35. 20 0 0.00 35. 20 35, 21 0.00 35, 21 35. 22 0.00 35. 22 0 35. 23 35. 23 0.00

0

-411, 057

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

35. 24

35. 25

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

* 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.

Liability Insurance

HOSPITAL RELATED SERVICES

Therapy Services

117, 594

926, 389

24, 753

2, 415, 522

117, 594

24, 753

1, 003, 557

1, 803, 824

4.00

4.01

4 02

5.00

 as not seen peeted to not reneed by contains a many of 27 the amount at enable chedral see that each of the part.								
			Related Organization(s) and/	or Home Office				
			norated organization(s) and	or nome orrice				
Symbol (1)	Name	Percentage of	Name	Percentage of				
Symbol (1)	Name		Ivallic					
		Ownershi p		Ownershi p				
1 00	2.00	2.00	4.00	· · · · · · · · · · · · · · · · · · ·				
1. 00	2. 00	3. 00	4. 00	5. 00				
R INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:						
 D. THILKKELATIONSHIT TO KELAT	ED ONGAINT EATT ON (3) AND FOR THO	WL OITIGE.						

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	100.00	Cornerstone	100. 00	7.00
8. 00	В	KHOI	100.00	Cornerstone	100. 00	8.00
9. 00	В	KHOI	100.00	RehabCare	100. 00	9.00
10.00	В	KHOI	100.00	KH-I NDI ANAPOLI S	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:

5. 00 ADMINISTRATIVE & GENERAL

66. 00 PHYSI CAL THERAPY

54. 00 RADI OLOGY-DI AGNOSTI C

- 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.
- $\hbox{E. Individual is director, of ficer, administrator, or key person of provider and related organization.}\\$
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

4.00

4.01

4 02

Heal th	Financial Syste	ems	Kiı	ndred Hospital Indi	anapolis South	In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	N RELATED ORGAN	IZATIONS AND HOME	Provi der CCN: 152008	Peri od:	Worksheet A-8	3-1
OFFI CE	COSTS					From 09/01/2015 To 08/31/2016	Date/Time Pre 1/4/2017 9:04	
	Net	Wkst. A-7 Ref						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED	AS A RESULT OF TRA	ANSACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:						
1.00	688, 866		0					1.00
2.00	0		0					2.00
3.00	0		0					3.00
4.00	0		o					4. 00
4. 01	-77, 168		ol					4. 01

* 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.

4 02

5.00

nas no	been posted to norksheet A,	cordinate transfer 2, the amount arrowable should be mareated in cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	HomeOffice Cost	6.00
7.00	Worker Comp Ins	7.00
8.00	Liability Insur	8.00
9.00	Therapy Svcs	9.00
10.00	CT SERVICES	10.00
100.00		100.00

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

0

0

611, 698

4 02

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 152008 | Peri od: From 09/01

Peri od: Worksheet A-8-2 From 09/01/2015 To 08/31/2016 Date/Time Prepared:

						'	00/31/2010	1/4/2017 9: 04	
	Wkst. A Line #	Cost	Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
			Identi fi er	Remuneration	Component	Component		ider Component	
								Hours	
	1. 00		2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	30. 00 D			440, 975	C	1.107,770		4, 546	1
2.00	50. 00 D	R. B		14, 409		0	208, 000	0	
3.00	0. 00			0	_	0	0	0	0.00
4.00	65. 00 D			227, 668	227, 668		177, 200	0	
5.00	30. 00 D			675	C	675	177, 200	5	5. 00
6.00	30. 00 D			1, 800		1, 800		10	
7. 00	30. 00 D	R. G		9, 600	C	9, 600	177, 200	64	1
8. 00	0.00			0	C	0	0	0	8. 00
9.00	54.00 D			3, 000	3, 000	0	225, 300	0	9. 00
10.00	60. 00 D	R. J		1, 203	C	1, 203	215, 700	7	10.00
200.00				699, 330	245, 077			4, 632	
	Wkst. A Line #	Cost		Unadjusted RCE		Cost of		Physician Cost	
			l denti fi er	Li mi t		Memberships &		of Malpractice	
					Limit	Conti nui ng	Share of col.	Insurance	
	1.00					Educati on	12	44.00	
1.00	1. 00 30. 00 D	D 4	2. 00	8.00	9. 00	12.00	13. 00	14. 00	4.00
1.00	50. 00 D			387, 284	· ·		0	0	
2.00		IK. B		0			0	0	
3. 00 4. 00	0. 00 65. 00 D	ח ח		0			0	0	3. 00 4. 00
4. 00 5. 00	30. 00 D			426	21	0	0	0	1
6. 00	30. 00 D			852			0	0	6. 00
7. 00	30. 00 D			5, 452			0	0	1
8. 00	0.00	rk. G		J, 452	2/3		0	0	8. 00
9. 00	54. 00 D	D I		0		_	0	0	9. 00
10. 00	60. 00 D			726	_	1	0	0	1
200.00	00.000	rk. J		394, 740			0		200.00
	Wkst. A Line #	Cost	Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	MRSt. A LINE "	0031	I denti fi er	Component	Limit	Di sal I owance	riaj astilierre		
			racitifici	Share of col.	21 (Di Sai i Gwariec			
				14					
	1. 00		2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	30. 00 D	R. A		0	387, 284	53, 691	53, 691		1. 00
2.00	50. 00 D	R. B		0	C	0	14, 409		2. 00
3.00	0.00			0	l c	0	0		3. 00
4.00	65. 00 D	R. D		0	C	0	227, 668		4. 00
5.00	30. 00 D	R. E		0	426	249	249		5. 00
6.00	30. 00 D	R. F		0	852	948	948		6. 00
7.00	30. 00 D	R. G		0	5, 452	4, 148	4, 148		7. 00
8. 00	0.00			0	C	0	0		8. 00
9. 00	54.00 D	R. I		0	C	0	3, 000		9. 00
10.00	60. 00 D	R. J		0	726	477	477		10. 00
200.00				0	394, 740	59, 513	304, 590		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 152008 Peri od: Worksheet B From 09/01/2015 Part I Date/Time Prepared: 08/31/2016 1/4/2017 9:04 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 532 387 1 00 00100 CAP REL COSTS-BLDG & FLXT 532, 387 2.00 00200 CAP REL COSTS-MVBLE EQUIP 610, 741 610, 741 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,087,441 1,881 2, 161 1, 091, 483 4.00 00500 ADMINISTRATIVE & GENERAL 2, 958, 246 5 00 80, 826 92, 862 154 421 5 00 2, 630, 137 7.00 00700 OPERATION OF PLANT 809, 334 29, 394 33, 771 16, 366 888, 865 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 110,063 4, 332 4, 978 119, 373 8.00 9.00 00900 HOUSEKEEPI NG 200,800 12, 217 14,037 25, 447 252, 501 9.00 01000 DI ETARY 10.00 461, 507 70, 551 10 00 61, 406 6,923 600, 387 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 620, 966 5, 753 100, 911 734, 240 13.00 6,610 13.00 01400 CENTRAL SERVICES & SUPPLY 18, 263 20, 983 13, 293 137, 915 14.00 85.376 14.00 8, 995 01500 PHARMACY 780, 467 7, 829 15.00 797, 291 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 295, 786 5, 642 6, 482 45, 711 353, 621 16.00 01700 SOCIAL SERVICE 17.00 193, 645 4,918 5,650 28, 768 232, 981 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 844, 268 257, 048 295, 325 520, 449 4, 917, 090 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 353, 849 7, 091 8.147 12, 083 381, 170 50.00 7, 968 05400 RADI OLOGY-DI AGNOSTI C 278, 859 9, 155 15, 480 311, 462 54.00 54.00 60.00 06000 LABORATORY 526, 544 2, 605 2, 993 6, 392 538, 534 60.00 5, 474 65.00 06500 RESPIRATORY THERAPY 841, 234 4, 764 133, 469 984, 941 65.00 66.00 06600 PHYSI CAL THERAPY 928, 399 11, 437 13, 140 0 952, 976 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 647, 776 C 0 0 647, 776 71.00 07300 DRUGS CHARGED TO PATIENTS 936, 536 0 73.00 936, 536 73.00 07400 RENAL DIALYSIS 74.00 328, 478 8, 205 9, 427 346, 110 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 0 09100 EMERGENCY 0 0 91.00 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVI CES 95.00 0 0 0 Λ 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 17, 104, 593 531, 579 610, 741 1, 079, 713 17, 092, 015 118. 00 118 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 90, 781 194. 00 194. 00 07950 NONALLOWABLE CLINICAL LIAISON 11, 770 79, 011 0 0 194. 01 07951 I DLE SPACE 0 0 0 0 0 194. 01 194. 02 07952 REGIONAL OFFICE 0 0 0 0 0 194. 02 0 194. 03 07953 DISTRICT OFFICE 0 0 0 0 0 0 194. 03 0 0 194, 04 194.04 07954 NON MCR CERTIFIED UNIT Ω 194. 05 07955 REG NURSG OFFICE 0 0 o 0 194. 05 194.06 07956 CONTACT CENTER 0 194. 06 0 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 0 0 0 0 194. 07 194. 08 07959 HEARTLAND AMBULANCE 0 808 194. 08 808 0 194.09 07958 VISITOR MEALS 0 0 194. 09 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 10 C 194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 0 194 11 C 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 17, 183, 604 610, 741 1, 091, 483 17, 183, 604 202. 00 202.00 TOTAL (sum lines 118-201) 532, 387

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152008

						1/4/2017 9:04	am
	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			T			
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 958, 246					5. 00
7. 00	00700 OPERATION OF PLANT	184, 845	1, 073, 710				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	24, 824	11, 068	155, 265	l .		8. 00
9.00	00900 HOUSEKEEPI NG	52, 509	31, 211	0	336, 221		9. 00
10.00	01000 DI ETARY	124, 854	156, 875	0	51, 137	933, 253	10. 00
11. 00	01100 CAFETERI A	0	0	0	0	304, 077	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	152, 690	14, 698	0	4, 791	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	28, 680	46, 657	0	15, 209	0	14. 00
15.00	01500 PHARMACY	165, 801	20, 001	0	6, 520	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	73, 538	14, 413	0	4, 698	0	16. 00
17.00	01700 SOCIAL SERVICE	48, 450	12, 563	0	4, 095	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 022, 537	656, 682	155, 265	214, 063	570, 223	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	79, 267	18, 115	0	5, 905	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	64, 770	20, 357	0	6, 636	0	54. 00
60.00	06000 LABORATORY	111, 991	6, 655	0	2, 169	0	60.00
65.00	06500 RESPI RATORY THERAPY	204, 824	12, 171	0	3, 968	0	65. 00
66.00	06600 PHYSI CAL THERAPY	198, 177	29, 218	0	9, 524	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	134, 709	0	0	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	194, 758	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	71, 976	20, 962	0	6, 833	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	1	l .	0	
91. 00	09100 EMERGENCY	0	0	0	0	0	91. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0	1	l .	0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00		2, 939, 200	1, 071, 646	155, 265	335, 548	874, 300	118. 00
400.00	NONREI MBURSABLE COST CENTERS	1 0					100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	07950 NONALLOWABLE CLINICAL LIAISON	18, 878	0	0	0		194. 00
	07951 I DLE SPACE	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	0	0	0	0		194. 04
	07955 REG NURSG OFFICE	0	0	0	0		194. 05
	07956 CONTACT CENTER	0	0	0	0		194. 06
	07957 CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194. 07
	07959 HEARTLAND AMBULANCE	168	2, 064	0	673		194. 08
	07958 VISITOR MEALS	0	0	0	0		194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	_	0		194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	۱	이	0	194. 11
200.00	, ,	_	=	_	_	=	200. 00
201.00		0 050 011	1 070 710	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	2, 958, 246	1, 073, 710	155, 265	336, 221	933, 253	J2U2. UU

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152008

				_		1/4/2017 9:04	am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	'		ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14.00	15. 00	16. 00	
	CENEDAL CEDVICE COCT CENTEDS	11.00	13.00	14.00	13.00	10.00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
	1						•
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	304, 077					11. 00
13. 00	01300 NURSING ADMINISTRATION	25, 340	931, 759				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1		235, 701			14. 00
	1	7, 240	1		004.044		1
	01500 PHARMACY	0	0	5, 203	994, 816		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	14, 480	0	250	0	461, 000	16. 00
17.00	01700 SOCIAL SERVICE	7, 240	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						Ī
30.00	03000 ADULTS & PEDIATRICS	195, 477	914, 818	5, 641	17, 096	162, 041	30.00
31. 00	03100 INTENSIVE CARE UNIT	173,477	0	0	17,070	02,041	31.00
				- 1	- 1		1
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 620	16, 941	0	0	8, 182	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 620	0	262	ol	10, 717	54.00
60.00	06000 LABORATORY	3, 620		9, 772	أ	45, 044	60.00
					0		•
65. 00	06500 RESPI RATORY THERAPY	43, 440	0	860	U	75, 278	1
66. 00	06600 PHYSI CAL THERAPY	0	0	490	O	24, 626	1
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	213, 121	ol	27, 322	71. 00
	07300 DRUGS CHARGED TO PATIENTS		0	0	977, 720	97, 610	•
	1		1	-			•
74.00	07400 RENAL DI ALYSI S	0	0	102	0	10, 180	74. 00
	OUTPATIENT SERVICE COST CENTERS						
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				•		
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
98. 00				0	0		98. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		l U	U	U	0	98.00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1-117)	304, 077	931, 759	235, 701	994, 816	461, 000]118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	o	0	n		192, 00
	07950 NONALLOWABLE CLINICAL LIAISON		٥	0	٥		194. 00
		0	0	0	0		1
	07951 I DLE SPACE	0	0	0	Q		194. 01
194. 02	07952 REGIONAL OFFICE	0	0	0	0	0	194. 02
194.03	07953 DISTRICT OFFICE	0	0	0	0	0	194. 03
194.04	07954 NON MCR CERTIFIED UNIT	0	l o	0	ol	0	194. 04
	07955 REG NURSG OFFICE	0	0	0	n	0	194. 05
	07956 CONTACT CENTER		٥	0	٥		194. 06
			0	0	0		
	07957 CENTRALIZED ADMISSIONS DEPT	0		0	0		194. 07
	07959 HEARTLAND AMBULANCE	0	0	0	0		194. 08
194. 09	07958 VISITOR MEALS	0	0	0	0	0	194. 09
194. 10	07962 OTHER NONREIMBURSABLE COST CENTERS	0	l ol	0	ol	0	194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	1	ا	n	n		194. 11
200.00			l ~		٩	O	200.00
	1	_				_	
201.00		1	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	304, 077	931, 759	235, 701	994, 816	461, 000	J202. 00

Kindred Hospital Indianapolis South In Lieu of Form CMS-2552-10

Provider CCN: 152008 | Period: From 09/01/2015 | Part I

					From 09/01/2015 To 08/31/2016	
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	
		17. 00	24. 00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS					
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION					1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	305, 329				16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	303, 327				17.00
30. 00	03000 ADULTS & PEDIATRICS	305, 329	9, 136, 262	(9, 136, 262	30.00
31.00	03100 INTENSIVE CARE UNIT	O	0	(0	31.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	(0	44. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	513, 200	(0.0,200	50.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	417, 824 717, 785	,	0 417, 824 0 717, 785	54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY		1, 325, 482			65. 00
66. 00	06600 PHYSI CAL THERAPY		1, 215, 011	ì	1, 215, 011	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	l ol	0		0 0	67. 00
68. 00	06800 SPEECH PATHOLOGY	O	0	(o o	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	1, 022, 928	(1, 022, 928	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 206, 624		2, 206, 624	73. 00
74. 00		0	456, 163	(456, 163	74. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0	Γ ,	lo lo	90.00
91.00	1	0	0			91. 00
71.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	O		<u> </u>	71.00
95. 00	09500 AMBULANCE SERVICES	0	0	(0	95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	O	0	(98. 00
	SPECIAL PURPOSE COST CENTERS					
118. 00		305, 329	17, 011, 279	(17, 011, 279	118. 00
100.00	NONREI MBURSABLE COST CENTERS		0			100,00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1920 PHYSICIANS' PRIVATE OFFICES	0	0			190. 00 192. 00
	07950 NONALLOWABLE CLINICAL LIAISON		109, 659		109, 659	194. 00
	07951 I DLE SPACE		107, 037	ì	0 107, 037	194. 01
	07952 REGIONAL OFFICE	l ol	0			194. 02
	07953 DISTRICT OFFICE	O	0	(194. 03
	O7954 NON MCR CERTIFIED UNIT	0	0	(0 0	194. 04
	07955 REG NURSG OFFICE	0	0	(0	194. 05
	07956 CONTACT CENTER	0	0	9	0	194. 06
	7 07957 CENTRALIZED ADMISSIONS DEPT 8 07959 HEARTLAND AMBULANCE	0	0 3, 713		3, 713	194. 07 194. 08
	07959 REARTLAND AMBULANCE		58, 953		58, 953	194. 08
	07962 OTHER NONREIMBURSABLE COST CENTERS		35, 733		0 30, 733	194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION		Ö			194. 11
200.00	Cross Foot Adjustments		0			200. 00
201.00		0	0	(이	201. 00
202.00	TOTAL (sum lines 118-201)	305, 329	17, 183, 604		17, 183, 604	202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 152008 Peri od: Worksheet B From 09/01/2015 Part II 08/31/2016 Date/Time Prepared: 1/4/2017 9:04 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** Capi tal DEPARTMENT Related Costs 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 881 2, 161 4, 042 4,042 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 115, 887 80, 826 92, 862 289, 575 572 5.00 00700 OPERATION OF PLANT 29, 394 33.771 7 00 63, 165 7 00 61 4, 978 00800 LAUNDRY & LINEN SERVICE 8.00 0 4, 332 9, 310 0 8.00 9.00 00900 HOUSEKEEPI NG 0 12, 217 14, 037 26, 254 94 9.00 61, 406 01000 DI ETARY 0 0 70.551 131, 957 26 10.00 10 00 01100 CAFETERI A 11.00 0 11.00 13.00 01300 NURSING ADMINISTRATION 5, 753 6, 610 12, 363 374 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 0 18, 263 20, 983 39, 246 49 14.00 01500 PHARMACY 8, 995 7, 829 16, 824 15 00 15 00 Ω 01600 MEDICAL RECORDS & LIBRARY 16.00 5,642 6, 482 12, 124 169 16.00 01700 SOCIAL SERVICE 4, 918 5, 650 10, 568 107 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 295, 325 30 00 03000 ADULTS & PEDIATRICS 0 257, 048 552, 373 1.925 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 04400 SKILLED NURSING FACILITY 44.00 44.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 7.091 15, 238 50.00 8, 147 45 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 7, 968 9, 155 17, 123 57 54.00 06000 LABORATORY 00000 2, 993 5, 598 24 60.00 2,605 60.00 06500 RESPIRATORY THERAPY 5, 474 10, 238 65.00 4.764 495 65.00 06600 PHYSI CAL THERAPY 13, 140 66.00 11, 437 24.577 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 0 0 06800 SPEECH PATHOLOGY 68.00 0 0 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 8, 205 9.427 17,632 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 0 0 0 09100 EMERGENCY 91.00 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 0 09850 OTHER REIMBURSABLE COST CENTERS O 98.00 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 115, 887 531, 579 610, 741 1, 258, 207 3, 998 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 000000000000 0 0 0 0 0 192.00 0 194.00 07950 NONALLOWABLE CLINICAL LIAISON 0 44 194. 00 194. 01 07951 I DLE SPACE 0 0 194, 01 0 194. 02 07952 REGIONAL OFFICE 0 0 0 194. 02 194. 03 07953 DISTRICT OFFICE 0 0 194. 03 0 0 194. 04 07954 NON MCR CERTIFIED UNIT Ω 0 0 194.04 0 194. 05 194.05 07955 REG NURSG OFFICE 0 0 194.06 07956 CONTACT CENTER 0 0 0 194. 06 194. 07 07957 CENTRALIZED ADMISSIONS DEPT ol 0 194. 07 0 808 194. 08 07959 HEARTLAND AMBULANCE 0 0 194. 08 808 194. 09 07958 VISITOR MEALS 0 C 0 0 194, 09 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 10

0

115.887

C

532.387

0

0

1, 259, 015

0 194. 11

0 201.00

4, 042 202. 00

200 00

0

610, 741

200 00

201.00

202.00

194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION

TOTAL (sum lines 118-201)

Cross Foot Adjustments

Negative Cost Centers

1/4/2017 9:04 am

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 152008

Peri od: Worksheet B From 09/01/2015 Part II To 08/31/2016 Date/Time Prepared:

33, 863

12, 584

161, 264 202. 00

Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE & GENERAL PLANT 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5 00 00500 ADMINISTRATIVE & GENERAL 290, 147 5 00 7.00 00700 OPERATION OF PLANT 18, 129 81, 355 7.00 00800 LAUNDRY & LINEN SERVICE 2, 435 839 12, 584 8.00 8.00 9.00 00900 HOUSEKEEPI NG 5, 150 2, 365 0 33, 863 9.00 01000 DI ETARY 0 161, 264 10.00 10.00 12, 245 11,886 5.150 11.00 01100 CAFETERI A 0 52, 544 11.00 13.00 01300 NURSING ADMINISTRATION 14, 976 1, 114 0 483 Ω 13.00 01400 CENTRAL SERVICES & SUPPLY 2,813 14 00 3, 535 0 14.00 1,532 0 0 15.00 01500 PHARMACY 16, 262 1, 515 657 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 7.212 1,092 0 473 0 16.00 01700 SOCIAL SERVICE 17.00 4, 752 952 0 17.00 412 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 100, 295 49, 758 12, 584 21, 560 98, 533 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7,774 1, 373 50.00 595 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 6, 353 1, 542 668 0 54.00 0 06000 LABORATORY 10.984 60.00 60.00 504 218 0 65.00 06500 RESPIRATORY THERAPY 20,089 922 400 0 65.00 66, 00 06600 PHYSI CAL THERAPY 19, 437 2, 214 0 959 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 0 0 0 06800 SPEECH PATHOLOGY 0 0 68.00 0 C Λ 68.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 13, 212 C 0 0 71.00 07300 DRUGS CHARGED TO PATIENTS 19, 102 0 73.00 0 0 73.00 74.00 07400 RENAL DIALYSIS 7.059 1,588 0 688 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09100 EMERGENCY 0 0 91.00 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 Λ 0 0 Λ 95.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 81, 199 151, 077 118. 00 118.00 288, 279 12, 584 33, 795 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 Ω 0 0 0 192.00 194.00 07950 NONALLOWABLE CLINICAL LIAISON 0 194.00 0 0 1,852 0 194. 01 07951 I DLE SPACE 0 0 0 0 194. 01 194. 02 07952 REGIONAL OFFICE 0 0 0 194. 02 0 194. 03 07953 DISTRICT OFFICE 0 0 194. 03 Ω 194.04 07954 NON MCR CERTIFIED UNIT 0 0 194. 04 194.05 07955 REG NURSG OFFICE 0 0 0 0 0 194. 05 194.06 07956 CONTACT CENTER 0 0 0 194.06 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 0 0 194 07 C 194. 08 07959 HEARTLAND AMBULANCE 16 156 0 68 0 194. 08 194. 09 07958 VISITOR MEALS 0 0 0 10, 187 194. 09 0 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 10 0 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 0 194 11 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00

290.147

81, 355

202.00

TOTAL (sum lines 118-201)

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 152008

Peri od: Worksheet B From 09/01/2015 Part II To 08/31/2016 Date/Time Prepared:

1/4/2017 9:04 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16, 00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 52, 544 11.00 01300 NURSING ADMINISTRATION 4, 379 33, 689 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1, 251 r 48 426 14 00 15.00 01500 PHARMACY 0 1,069 36, 327 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,502 Ω 51 23, 623 16.00 01700 SOCIAL SERVICE 17.00 251 0 0 17.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 303 30.00 33.777 33.0761, 159 624 03100 INTENSIVE CARE UNIT 31.00 31.00 0 0 0 0 04400 SKILLED NURSING FACILITY 0 44.00 44.00 0 0 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 626 613 С 419 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 549 54.00 626 54 54.00 C 06000 LABORATORY 2, 308 60.00 626 0 2,008 60.00 65.00 06500 RESPIRATORY THERAPY 7,506 0 177 0 3,858 65.00 0 06600 PHYSI CAL THERAPY 66.00 0 0 101 1, 262 66.00 0 67 00 06700 OCCUPATIONAL THERAPY 0 67.00 0 Ω 06800 SPEECH PATHOLOGY 0 68.00 C 0 0 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 43, 786 0 1, 400 71.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 35, 703 5,002 73.00 07400 RENAL DIALYSIS 74.00 0 21 522 74.00 OUTPATIENT SERVICE COST CENTERS 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 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 52, 544 33, 689 118.00 48, 426 36, 327 23, 623 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 190. 00 000000000000 0 0 0 192.00 Ω 194.00 07950 NONALLOWABLE CLINICAL LIAISON 0 0 194.00 194. 01 07951 I DLE SPACE 0 0 0 0 0 0 0 0 0 0 0 194. 01 194. 02 07952 REGIONAL OFFICE 0 0 194. 02 0 194. 03 07953 DISTRICT OFFICE 0 0 194. 03 0 194.04 07954 NON MCR CERTIFIED UNIT 0 0 0 194. 04 194. 05 07955 REG NURSG OFFICE 0 194. 05 194.06 07956 CONTACT CENTER 0 0 194.06 0 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 0 0 194. 07 0 194. 08 07959 HEARTLAND AMBULANCE 0 194. 08 194. 09 07958 VISITOR MEALS 0 194. 09 0 0 194. 10 07962 OTHER NONRELMBURSABLE COST CENTERS 0 194, 10 C 0 0 194. 11 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201, 00 0 0 202.00 TOTAL (sum lines 118-201) 52, 544 33, 689 48. 426 36.327 23, 623 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 152008 Peri od: Worksheet B From 09/01/2015 Part II Date/Time Prepared: 08/31/2016 1/4/2017 9:04 am Cost Center Description SOCIAL SERVICE Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 18,042 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 932, 009 30.00 18,042 932,009 0 0 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 0 50.00 05000 OPERATING ROOM 0 26, 683 26, 683 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0000000 26, 972 26, 972 54.00 60.00 06000 LABORATORY 22, 270 0 22, 270 60.00 06500 RESPIRATORY THERAPY 0 65.00 43, 685 43, 685 65.00 06600 PHYSI CAL THERAPY 0 48, 550 66.00 66.00 48, 550 06700 OCCUPATIONAL THERAPY 0 67.00 C 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 58, 398 0 58, 398 71.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 59, 807 59, 807 73.00 74.00 07400 RENAL DIALYSIS 27, 510 0 27, 510 74.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 0 90.00 0 09100 EMERGENCY 0 91.00 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 0 0 95.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 0 98.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 118.00 18, 042 1, 245, 884 0 1, 245, 884 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 \cap 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 194. 00 07950 NONALLOWABLE CLINICAL LIAISON 00000000000 1,896 0 1, 896 194.00 194. 01 07951 | I DLE SPACE 194. 02 07952 | REGIONAL OFFICE 194. 01 0 C 0 C 0 194. 02 194. 03 07953 DISTRICT OFFICE 0 194.03 194. 04 07954 NON MCR CERTIFIED UNIT 0 0 0 194. 04 0 194. 05 07955 REG NURSG OFFICE 0 194 05 C 194.06 07956 CONTACT CENTER C 0 194.06 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 194. 07 0 194. 08 07959 HEARTLAND AMBULANCE 1.048 1.048 194. 08 194. 09 194. 09 07958 VISITOR MEALS 10, 187 10, 187 194. 10 07962 OTHER NONREI MBURSABLE COST CENTERS C 0 194. 10 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 194. 11 0 200.00 Cross Foot Adjustments 0 ol 200. 00 C 0 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 18,042 1, 259, 015 1, 259, 015 202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 152008 Peri od: Worksheet B-1 From 09/01/2015 08/31/2016 Date/Time Prepared: 1/4/2017 9:04 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SOUARE FEET (SQUARE FEET BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT #1) #2) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 38 217 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 38, 159 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 135 6, 630, 143 4.00 135 00500 ADMINISTRATIVE & GENERAL 14, 225, 358 5 00 5 802 5 802 938 025 -2, 958, 246 5 00 7.00 00700 OPERATION OF PLANT 2, 110 2, 110 99, 413 888, 865 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 311 311 119, 373 8.00 9.00 00900 HOUSEKEEPI NG 877 877 154, 574 0 252, 501 9.00 0 01000 DI ETARY 10 00 10 00 4.408 4, 408 42, 055 600, 387 11.00 01100 CAFETERI A 0 11.00 01300 NURSING ADMINISTRATION 612, 978 0 734, 240 13.00 413 413 13.00 0 01400 CENTRAL SERVICES & SUPPLY 137, 915 14.00 1.311 1.311 80, 747 14.00 15.00 01500 PHARMACY 562 562 C 797, 291 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 405 405 277, 671 0 353, 621 16.00 01700 SOCIAL SERVICE ol 17.00 353 353 174, 750 232, 981 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18.452 18, 452 3, 161, 423 0 4, 917, 090 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 509 509 73, 396 381, 170 50 00 05400 RADI OLOGY-DI AGNOSTI C 94, 035 0 311, 462 54.00 572 572 54.00 0 60.00 06000 LABORATORY 187 187 38, 830 538, 534 60.00 65.00 06500 RESPIRATORY THERAPY 342 810, 749 984, 941 65.00 342 0 66.00 06600 PHYSI CAL THERAPY 821 821 0 952, 976 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 647, 776 71.00 0 C 0 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 936, 536 73.00 07400 RENAL DIALYSIS 74.00 589 589 0 346, 110 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 91.00 0 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 95 00 95 00 0 0 0 Λ 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 C 0 0 98.00 SPECIAL PURPOSE COST CENTERS 38, 159 38, 159 -2, 958, 246 14, 133, 769 118. 00 118 00 SUBTOTALS (SUM OF LINES 1-117) 6, 558, 646 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 0 194. 00 07950 NONALLOWABLE CLINICAL LIAISON 90, 781 194. 00 0 71, 497 194. 01 07951 I DLE SPACE 0 0 194, 01 194. 02 07952 REGIONAL OFFICE 0000 0 0 194. 02 0 0 0 0 0 0 194. 03 07953 DISTRICT OFFICE 0 0 194. 03 0 194, 04 194.04 07954 NON MCR CERTIFIED UNIT 0 Ω 194. 05 07955 REG NURSG OFFICE 0 0 0 194. 05 194.06 07956 CONTACT CENTER 0 194. 06 0 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 0 194. 07 0 0 194. 08 07959 HEARTLAND AMBULANCE 58 0 808 194, 08 Ω 194.09 07958 VISITOR MEALS 0 0 0 194. 09 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 10 0 194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 194 11 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 532, 387 610.741 1, 091, 483 2, 958, 246 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 0. 207956 203. 00 203.00 13. 930633 16.005163 0.164624 204.00 Cost to be allocated (per Wkst. B, 290, 147 204. 00 4.042 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000610 0. 020396 205. 00 II)

Health Financial Systems Kindred Hospital Indianapolis South In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 152008 Period: Worksheet B-1
From 09/01/2015
To 08/31/2016 Date/Time Prepared:

				F	rom 09/01/2015 o 08/31/2016	Date/Time Pre 1/4/2017 9:04	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)		DIETARY (MEALS SERVED)	CAFETERI A (CAFETERI A FTES)	
		7. 00	8.00	9. 00	10.00	11. 00	
4 00	GENERAL SERVICE COST CENTERS		1				4 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						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	30, 170					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	311					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	877 4, 408		28, 982 4, 408			9. 00 10. 00
11. 00	01100 CAFETERI A	4, 400	0	4, 406		84	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	413	o	413		7	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 311	0	1, 311	O	2	14. 00
15. 00	01500 PHARMACY	562		562		0	15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	405 353		405 353		4	16. 00 17. 00
17.00	I NPATIENT ROUTINE SERVICE COST CENTERS	303	0	353	l U		17.00
30. 00	03000 ADULTS & PEDIATRICS	18, 452	11, 188	18, 452	26, 203	54	30. 00
31.00	03100 INTENSIVE CARE UNIT	0				0	31. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	509	0	509	O	1	FO 00
50. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	572	l .			1 1	50. 00 54. 00
60.00	06000 LABORATORY	187		187	o	1	60.00
65.00	06500 RESPI RATORY THERAPY	342	l .	342	O	12	65. 00
66. 00	06600 PHYSI CAL THERAPY	821	0	821	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0		0	67.00
68. 00 71. 00	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	=	0	68. 00 71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	0		0	73.00
74.00	+ +	589	0	589	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS		1				
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0			_	0	90. 00 91. 00
91.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	<u> </u>	0] 91.00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
110 00	SPECIAL PURPOSE COST CENTERS	30, 112	11 100	20.024	40 17/	0.4	110 00
118. 00	D SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	30, 112	11, 188	28, 924	40, 176	84	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	0 07950 NONALLOWABLE CLINICAL LIAISON	0	0	0	0		194. 00
	1 07951 1 DLE SPACE 2 07952 REGI ONAL OFFI CE	0	0	0	0		194. 01 194. 02
	3 07953 DI STRI CT OFFI CE		Ö	Ö	Ö		194. 03
	4 07954 NON MCR CERTIFIED UNIT	0	0	0	O		194. 04
	07955 REG NURSG OFFICE	0	0	0	0		194. 05
	6 07956 CONTACT CENTER	0	0	0	_		194. 06
	7 07957 CENTRALIZED ADMISSIONS DEPT B 07959 HEARTLAND AMBULANCE	58	0	0 58	_		194. 07 194. 08
	9 07958 VISITOR MEALS	0	0	0			194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 10
	1 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194. 11
200.00							200.00
201. 00 202. 00		1, 073, 710	155, 265	336, 221	933, 253	304, 077	201.00
202.00	Part I)	1,0/3,710	155, 265	330, 221	733, 233	304, 077	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	35. 588664				3, 619. 964286	1
204.00		81, 355	12, 584	33, 863	161, 264	52, 544	204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	2. 696553	1. 124777	1. 168415	3. 760382	625. 523810	205 00
	II)				1.755502	020010	

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 152008 Peri od: Worksheet B-1 From 09/01/2015 08/31/2016 Date/Time Prepared: 1/4/2017 9:04 am Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE (COSTED RECORDS & ADMI NI STRATI ON SERVICES & **SUPPLY** REQUIS.) LI BRARY (PATIENT DAYS) (NURSING FTES) (COSTED (GROSS REQUIS.) REVENUE) 17.00 13.00 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 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 55 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 716, 409 14.00 0 15.00 01500 PHARMACY 15, 815 952, 912 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 59, 661, 585 16 00 761 C 17.00 01700 SOCIAL SERVICE 0 11, 188 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 11, 188 30.00 03000 ADULTS & PEDIATRICS 17, 145 20, 971, 423 30.00 54 16, 376 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM n O 1 058 873 n 50 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 795 1, 386, 935 0 54.00 06000 LABORATORY 29, 701 5, 829, 449 60.00 60.00 0 65.00 06500 RESPIRATORY THERAPY 0 0 2, 615 0 9, 742, 220 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 1, 490 3, 187, 000 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 67.00 C 06800 SPEECH PATHOLOGY 0 0 68.00 0 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 535, 888 71.00 647, 776 0 0 71.00 936, 536 07300 DRUGS CHARGED TO PATIENTS 12, 632, 350 73.00 73.00 0 07400 RENAL DIALYSIS 311 1, 317, 447 0 74.00 74.00 C OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 90.00 0 0 0 0 09100 EMERGENCY 0 91.00 0 Ω 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 0 0 n 95.00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 0 98.00 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 118.00 55 716, 409 952, 912 59, 661, 585 11, 188 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 \cap 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 194. 00 07950 NONALLOWABLE CLINICAL LIAISON 0 0 0 0 0 0 194.00 194. 01 07951 I DLE SPACE 00000 0 194, 01 0 0 194. 02 07952 REGIONAL OFFICE 0 0 0 194, 02 194. 03 07953 DISTRICT OFFICE 0 194. 03 0 0 0 194.04 07954 NON MCR CERTIFIED UNIT 0 0 0 194. 04 194. 05 07955 REG NURSG OFFICE 0 194 05 0 194.06 07956 CONTACT CENTER 0 194.06 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 0 0 194. 07 0 0 194. 08 07959 HEARTLAND AMBULANCE 0 194.08 0 194. 09 07958 VISITOR MEALS 0 194. 09 C 0 194. 10 07962 OTHER NONREI MBURSABLE COST CENTERS 0 C 0 0 0 194. 10 0 194. 11 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 200 00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 931, 759 235, 701 994, 816 461, 000 305, 329 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 16, 941. 072727 0.329003 1.043975 0.007727 27. 290758 203. 00 204.00 Cost to be allocated (per Wkst. B, 33.689 48, 426 36, 327 23.623 18. 042 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 612. 527273 0.067595 0.038122 0.000396 1. 612621 205. 00 II)

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	F	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Pre 1/4/2017 9:04	
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 136, 262		9, 136, 262	59, 036	9, 195, 298	
31.00 03100 INTENSIVE CARE UNIT	0		[C	0	0	31. 00
44. 00 04400 SKILLED NURSING FACILITY	0		<u> </u>)	0	44. 00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	513, 200		513, 200	1	513, 200	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	417, 824		417, 824	1	417, 824	54.00
60. 00 06000 LABORATORY	717, 785	_	717, 785	1	718, 262	
65. 00 06500 RESPI RATORY THERAPY	1, 325, 482	0	1, 325, 482		1, 325, 482	
66. 00 06600 PHYSI CAL THERAPY	1, 215, 011	0	1, 215, 011	0	1, 215, 011	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 022, 928		1, 022, 928		1, 022, 928	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 206, 624		2, 206, 624	I	2, 206, 624	
74. 00 O7400 RENAL DIALYSIS	456, 163		456, 163	8 0	456, 163	74. 00
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLI NI C	0		C		0	90.00
91. 00 09100 EMERGENCY	0		<u> </u>)	0	91. 00
OTHER REI MBURSABLE COST CENTERS				ام		05.00
95. 00 09500 AMBULANCE SERVICES	0				0	, , , , , ,
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0			0	0	98. 00
200.00 Subtotal (see instructions)	17, 011, 279	0	17, 011, 279	59, 513		
201.00 Less Observation Beds	0		47.044.076	50.540		201. 00
202.00 Total (see instructions)	17, 011, 279	0	17, 011, 279	59, 513	17, 070, 792	J202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 152008 Peri od: Worksheet C From 09/01/2015 Part I 08/31/2016 Date/Time Prepared: 1/4/2017 9:04 am Title XVIII Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRI CS 20, 971, 423 20, 971, 423 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 1, 058, 873 0.000000 50.00 1, 058, 873 0.484666 50.00 05000 OPERATING ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 386, 935 1, 386, 935 0.301257 0.000000 54.00 60.00 06000 LABORATORY 5, 829, 449 0 5, 829, 449 0.123131 0.000000 60.00 06500 RESPIRATORY THERAPY 9, 742, 220 65.00 9, 742, 220 0 0.136055 0.000000 65.00 06600 PHYSI CAL THERAPY 3, 187, 000 0 3, 187, 000 0.381240 0.000000 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0.000000 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 535, 888 0 3, 535, 888 0. 289299 0.000000 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 12, 632, 350 0 12, 632, 350 0.174680 0.000000 73.00 07400 RENAL DIALYSIS 1, 317, 447 1, 317, 447 0.346248 0.000000 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0.000000 0.000000 90.00 0 91.00 09100 EMERGENCY 0 0 0.000000 0.00000091.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0.000000 0.000000 95.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 \cap 0.000000 0.000000 98.00 200.00 Subtotal (see instructions) 59, 661, 585 0 59, 661, 585 200.00 Less Observation Beds 201.00 201.00 202.00 202. 00 Total (see instructions) 59 661 585 0 59, 661, 585

				1/4/2017 9:04 a	am
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
31.00 03100 INTENSIVE CARE UNIT					31. 00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 484666			I	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 301257				54.00
60. 00 06000 LABORATORY	0. 123213			I .	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 136055				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 381240			1	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 289299				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 174680			'	73.00
74. 00 07400 RENAL DIALYSIS	0. 346248				74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000			I	90.00
91. 00 09100 EMERGENCY	0. 000000				91. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	0. 000000				95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			•	98. 00
200.00 Subtotal (see instructions)					00.00
201.00 Less Observation Beds				•	01.00
202.00 Total (see instructions)				20	02.00

near th	Triancial Systems Kind	ar cu nospi tar Ti	idi dilapori 3 30	utii	TIT LIC	u or rorm cws .	2002 10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 152008	Peri od: From 09/01/2015		
					To 08/31/2016	Date/Time Pre 1/4/2017 9:04	
			Ti :	tle XIX	Hospi tal	Cost	aiii
				I	Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	0001 00mtor 200011 pt 10m	(from Wkst. B,	Adj.	1014. 00010	Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9, 136, 262		9, 136, 26	59, 036	9, 195, 298	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	513, 200		513, 20	0 0	513, 200	50.00
	05400 RADI OLOGY-DI AGNOSTI C	417, 824		417, 82	24 0	417, 824	54.00
	06000 LABORATORY	717, 785		717, 78	35 477	718, 262	60.00
	06500 RESPI RATORY THERAPY	1, 325, 482	(1, 325, 48	32 0	1, 325, 482	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 215, 011	(1, 215, 01	1 0	1, 215, 011	66. 00
	06700 OCCUPATI ONAL THERAPY	0	(0	0	67. 00
	06800 SPEECH PATHOLOGY	0	(0	0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 022, 928		1, 022, 92		1, 022, 928	
	07300 DRUGS CHARGED TO PATIENTS	2, 206, 624		2, 206, 62		2, 206, 624	
74.00	07400 RENAL DIALYSIS	456, 163		456, 16	0	456, 163	74. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0			0	0	90.00
91. 00	09100 EMERGENCY	0			0 0	0	91.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0			0		95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0			0	0	70.00
200.00	,	17, 011, 279	(17, 011, 27	79 59, 513		
201.00		0			0		201. 00
202.00	Total (see instructions)	17, 011, 279	(17, 011, 27	79 59, 513	17, 070, 792	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 152008 Peri od: Worksheet C From 09/01/2015 Part I 08/31/2016 Date/Time Prepared: 1/4/2017 9:04 am Title XIX Hospi tal Cost Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRI CS 20, 971, 423 20, 971, 423 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 1, 058, 873 0.000000 50.00 1, 058, 873 0.484666 50.00 05000 OPERATING ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 386, 935 1, 386, 935 0.301257 0.000000 54.00 60.00 06000 LABORATORY 5, 829, 449 0 5, 829, 449 0.123131 0.000000 60.00 06500 RESPIRATORY THERAPY 9, 742, 220 65.00 9, 742, 220 0 0.136055 0.000000 65.00 06600 PHYSI CAL THERAPY 3, 187, 000 0 3, 187, 000 0. 381240 0.000000 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0.000000 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 535, 888 0 3, 535, 888 0. 289299 0.000000 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 12, 632, 350 0 12, 632, 350 0.174680 0.000000 73.00 07400 RENAL DIALYSIS 1, 317, 447 1, 317, 447 0. 346248 0.000000 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0.000000 0.000000 90.00 0 91.00 09100 EMERGENCY 0 0 0.000000 0.00000091.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0.000000 0.000000 95.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 \cap 0.000000 0.000000 98.00 200.00 Subtotal (see instructions) 59, 661, 585 0 59, 661, 585 200.00 Less Observation Beds 201.00 201.00 202.00 202. 00 Total (see instructions) 59 661 585 0 59, 661, 585

			10 00/31/2010	1/4/2017 9:04 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 00
31.00 03100 INTENSIVE CARE UNIT				31. 00
44.00 O4400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE 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 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90. 00
91. 00 09100 EMERGENCY	0. 000000			91. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	Kindred Hospital I	ndianapolis Sou	uth	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provi der		Period: From 09/01/2015		
				To 08/31/2016	Date/Time Pre 1/4/2017 9:04	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	932, 009	0	932, 00	9 11, 188	83. 30	30.00
31.00 INTENSIVE CARE UNIT	0			0	0.00	31.00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44.00
200.00 Total (lines 30-199)	932, 009		932, 00	9 11, 188		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	7, 115	592, 680)			30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
44.00 SKILLED NURSING FACILITY	0	0)			44.00
200.00 Total (lines 30-199)	7, 115	592, 680)			200. 00

Provider CN: 152008	Heal th	Health Financial Systems Kindred Hospital Indianapolis South In Lieu of Form CMS-2552-10						
Cost Center Description	APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 152008			
Cost Center Description								
Title XVIII Hospital PPS Capital Related Cost (from Wkst. B, Part II, col. 26) Loo						10 08/31/2016		
Capital Related Cost (from Wkst. C, (from Wkst. C, (from Wkst. C) (from Wkst. C) (col. 1 + col. 2)				Ti +I	Δ Y// I I	Hospi tal		alli
Related Cost (from Wkst. B, Part I, col. 26) Part I, col. 26) Rate I, col. 1 ÷ col. 26) Rate I, col. 27) Rate II, col. 26) Rate III, col. 27) Rate III, col. 27) Rate III, col. 26) Rate III, col. 27) Rate III, col. 26, 672 Rate III, col. 27) Rate III, c		Cost Center Description	Cani tal					
Charges Column 4 Part 1, col. Col. 1 + col. Charges Column 4 Part 1, col. Col. 2 Part 1, col. Col. Col. 2 Part 1, col. Col. 2 Part 2 Par		oost center bescription						
Part II, col. 26 1.00 2.00 3.00 4.00 5.00								
26						onal goo	001 4	
1.00 2.00 3.00 4.00 5.00			·]				
50. 00				2.00	3.00	4. 00	5. 00	
54. 00		ANCILLARY SERVICE COST CENTERS		•				
60. 00	50.00	05000 OPERATING ROOM	26, 683	1, 058, 873	0. 02519	99 909, 410	22, 916	50.00
65. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	26, 972	1, 386, 935	0. 01944	17 804, 865	15, 652	54.00
66. 00 06600 PHYSI CAL THERAPY 48,550 3,187,000 0.015234 2,050,253 31,234 66.00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0.000000 0 0 67.00 68. 00 06800 SPEECH PATHOLOGY 0 0 0.000000 0 0 68.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 58,398 3,535,888 0.016516 2,416,419 39,910 71.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 59,807 12,632,350 0.004734 8,109,791 38,392 73.00 74. 00 07400 RENAL DI ALYSI S 27,510 1,317,447 0.02081 912,397 19,052 90. 00 09000 CLI NI C 0 0 0.000000 0 0 91.00 91. 00 09100 EMERGENCY 0 0 0.000000 0 0 91.00 95. 00 09500 AMBULANCE SERVI CES 95.00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0 0 98.00 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0 0 98.00 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0 0 98.00 99. 00 0 0.000000 0 0 0 0.000000 0	60.00	06000 LABORATORY	22, 270	5, 829, 449	0. 00382	3, 817, 692	14, 584	60.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 000000 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0000000 0 0 68. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 58, 398 3, 535, 888 0. 016516 2, 416, 419 39, 910 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 59, 807 12, 632, 350 0. 004734 8, 109, 791 38, 392 73. 00 74. 00 07400 RENAL DI ALYSI S 27, 510 1, 317, 447 0. 020881 912, 397 19, 052 74. 00 000000 000000 000000 0000000	65.00	06500 RESPI RATORY THERAPY	43, 685	9, 742, 220	0. 00448	5, 864, 995	26, 299	65.00
68. 00	66.00	06600 PHYSI CAL THERAPY	48, 550	3, 187, 000	0. 01523	2, 050, 253	31, 234	66. 00
71. 00	67.00	06700 OCCUPATI ONAL THERAPY	0	C	0. 00000	00	0	67. 00
73. 00	68.00	06800 SPEECH PATHOLOGY	0	C	0. 00000	00	0	68. 00
74. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	58, 398	3, 535, 888	0. 01651	16 2, 416, 419	39, 910	71. 00
OUTPATIENT SERVICE COST CENTERS O	73.00	07300 DRUGS CHARGED TO PATIENTS	59, 807	12, 632, 350	0.00473	8, 109, 791	38, 392	73. 00
90. 00	74.00	07400 RENAL DIALYSIS	27, 510	1, 317, 447	0. 02088	912, 397	19, 052	74. 00
91. 00 09100 EMERGENCY 0 0 0.000000 0 0 0 0								
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 95.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0.000000 0 0.98.00			0	(0	
95. 00	91. 00	09100 EMERGENCY	0	C	0.00000	00	0	91. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0 98.00								
	95.00	09500 AMBULANCE SERVI CES						95. 00
200. 00 Total (lines 50-199) 313, 875 38, 690, 162 24, 885, 822 208, 039 200. 00			0	(0.00000	00	Ĭ	
	200.00	Total (lines 50-199)	313, 875	38, 690, 162	2	24, 885, 822	208, 039	200. 00

Health Financial Systems Kind	red Hospital I	ndianapolis Sou	uth	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Period: From 09/01/2015 To 08/31/2016		narodi
				10 00/31/2010	1/4/2017 9:04	
		Ti tl	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		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
44.00 04400 SKILLED NURSING FACILITY	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.	Inpatient	I npati ent		
	Days	5 ÷ col . 6)	Program Days	Program		
	,			Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	11, 188	0.00	7, 11	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		0 0		44. 00
200.00 Total (lines 30-199)	11, 188		7, 11	5 0		200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 152008 Period: From 09/01/2015 Part IV Date/Time 1/4/2017 From 09/01/2015 Part IV Date/Time 1/4/2017 Part IV Date	Prepared: 9:04 am PS st
To 08/31/2016 Date/Time 1/4/2017 Title XVIII Hospital P	es st I 1
Cost Center Description Non Physician Nursing School Allied Health All Other Total Co Anesthetist Mursing School Allied Health Medical Sum of co	es st I 1
Cost Center Description Non Physician Nursing School Allied Health All Other Anesthetist Title XVIII Hospital P Anesthetist School Allied Health Medical (sum of co	es st I 1
Cost Center Description Non Physician Nursing School Allied Health All Other Total Co Anesthetist Medical (sum of co	st I 1
Anesthetist Medical (sum of co	1 1
) .
$\frac{3}{4}$	
1.00 2.00 3.00 4.00 5.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM O O O O	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 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 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O O O O	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
OUTPATLENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 0 0 0	0 90.00
91.00 O9100 EMERGENCY O O O O	0 91.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 O9500 AMBULANCE SERVICES	95. 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0	0 98.00
200.00 Total (lines 50-199) 0 0 0	0 200. 00

APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 152008 Peri od: From 09/01/2015 Prom 09/01/2015	Health Financial Systems Kindred Hospital Indianapolis South In Lieu of Form CMS-2552-10							2552-10
To 08/31/2016 Date/Time Prepared: 1/4/2017 9; 04 am PPS Title XVIII Hospital PPS Cost Center Description Total Outpatient (Cost (sum of col. 2, 3 and 4) PPS Cost	APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provi der				
Title XVIII Hospital PPS	THROUG	H COSTS						
Title XVIII Hospital PPS						10 08/31/2016	Date/IIme Pre	pared:
Total Outpati (From Wkst. C, cost (sum of				Ti +I	ο X//111	Hosni tal		alli
Outpatient Cost (sum of Cost (sum of Col. 2, 3 and 4)		Cost Center Description	Total					
Cost (sum of col 2, 3 and al 3, 2 and al 3, 3 and al		oost center bescription						
COI								
ANCILLARY SERVICE COST CENTERS							l onar ges	
ANCILLARY SERVICE COST CENTERS S. 0.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000					//			
ANCI LLARY SERVI CE COST CENTERS Service Services Se			- '/	7 00	8 00	• • • • • • • • • • • • • • • • • • • •	10.00	
50.00 05000 0PERATING ROOM 0 1,058,873 0.000000 0.000000 909,410 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 1,386,935 0.000000 0.000000 804,865 54.00 60.00 06000 LABORATORY 0 5,829,449 0.000000 0.000000 3,817,692 60.00 6500 RESPI RATORY THERAPY 0 9,742,220 0.000000 0.000000 5,864,995 65.00 66.00 06600 PHYSI CAL THERAPY 0 0,3187,000 0.000000 0.000000 2,050,253 66.00 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0.000000 0.000000 0.000000 0.6800 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0		ANCILLARY SERVICE COST CENTERS	1 2. 2.		1	1		
54. 00	50.00		0	1, 058, 873	0. 00000	0. 000000	909, 410	50.00
65. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0. 000000	804, 865	54.00
65. 00	60.00	06000 LABORATORY	0	5, 829, 449	0. 00000	0. 000000	3, 817, 692	60.00
66. 00 06600 PHYSI CAL THERAPY 0 3, 187, 000 0.000000 0.000000 2, 050, 253 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0.000000 0.000000 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0.000000 0.000000 0 68. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3, 535, 888 0.000000 0.000000 2, 416, 419 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 12, 632, 350 0.000000 0.000000 8, 109, 791 73. 00 74. 00 07400 RENAL DI ALYSI S 0 1, 317, 447 0.000000 0.000000 912, 397 74. 00 00TPATI ENT SERVI CE COST CENTERS 0 0.000000 0.000000 0.000000 0.000000 74. 00 09100 EMERGENCY 0 0 0.000000 0.000000 0.000000 0.000000 75. 00 09500 AMBULANCE SERVI CES 95. 00 76. 00 09850 0THER REI MBURSABLE COST CENTERS 0 0.000000 0.000000 0.000000 0.000000 0.000000 77. 00 0.000000 0.000000 0.000000 0.000000 0.000000 78. 00 09850 0THER REI MBURSABLE COST CENTERS 0 0.000000 0.000000 0.000000 0.000000 78. 00 09850 0THER REI MBURSABLE COST CENTERS 0 0.000000 0.000000 0.000000 0.000000 0.000000 79. 00 0.000000 0.000000 0.000000 0.000000 0.000000 79. 00 0.000000 0.000000 0.000000 0.000000 0.000000 79. 00 09850 0THER REI MBURSABLE COST CENTERS 0 0.0000000 0.000000 0.000000 0.000000 0.000000 79. 00 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000	65.00	06500 RESPIRATORY THERAPY	0	9, 742, 220	0. 00000	0. 000000		
68. 00	66.00	06600 PHYSI CAL THERAPY	0			0. 000000	2, 050, 253	66.00
71. 00	67.00	06700 OCCUPATI ONAL THERAPY	0	(0. 00000	0. 000000		67.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 12, 632, 350 0.000000 0.000000 8, 109, 791 73. 00 74. 00 07400 RENAL DI ALYSIS 0 1, 317, 447 0.000000 0.000000 912, 397 74. 00 000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	68.00	06800 SPEECH PATHOLOGY	0		0. 00000	0. 000000	0	68. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 12, 632, 350 0.000000 0.000000 8, 109, 791 73. 00 74. 00 07400 RENAL DI ALYSIS 0 1, 317, 447 0.000000 0.000000 912, 397 74. 00 000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 535, 888	0. 00000	0. 000000	2, 416, 419	71.00
OUTPATIENT SERVICE COST CENTERS OUTP	73.00	07300 DRUGS CHARGED TO PATIENTS	0			0. 000000	8, 109, 791	73. 00
OUTPATI ENT SERVI CE COST CENTERS O O O O 0 O O O O	74.00	07400 RENAL DIALYSIS	0	1, 317, 447	0. 00000	0. 000000	912, 397	74. 00
91. 00 09100 EMERGENCY 0 0 0.000000 0.000000 0 91. 00		OUTPATIENT SERVICE COST CENTERS						
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0. 0000000 0. 0000000 0 98. 00	90.00	09000 CLI NI C	0	(0.00000	0.000000	0	90.00
95. 00 09500 AMBULANCE SERVICES 95. 00 98. 00 0 0 0 0 0 0 0 0 0	91.00	09100 EMERGENCY	0	(0.00000	0. 000000	0	91.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0.000000 0 98. 00		OTHER REIMBURSABLE COST CENTERS				<u> </u>		
	95.00	09500 AMBULANCE SERVICES						95. 00
200 00 Total (Lines 50-199)	98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	(0.00000	0. 000000	0	98. 00
200.00 10tal (11103 30 177) 0	200.00	Total (lines 50-199)	0	38, 690, 162	2		24, 885, 822	200.00

Health Financial Systems	Kindred Hospital Indian	apolis South	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 152008	Peri od: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/4/2017 9:04 am

					1/4/201/ 9:04	alli
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C	0			50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	14, 893	0			54.00
60. 00 06000 LABORATORY	0	2, 140	0			60.00
65. 00 06500 RESPIRATORY THERAPY	0	67, 675	5 0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	0			67.00
68. 00 06800 SPEECH PATHOLOGY	0	C	0			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 008	B 0			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0			73. 00
74. 00 07400 RENAL DI ALYSI S	0	111, 414	. 0			74. 00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLI NI C	0	C	0			90.00
91. 00 09100 EMERGENCY	0	C	0			91.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>		•			
95. 00 09500 AMBULANCE SERVICES						95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	ol o			98. 00
200.00 Total (lines 50-199)	0	198, 130	0			200. 00

Hearth Financial Systems Kind	ired Hospital i	nuranaporis soc	1111	III LIE	u or Form CMS	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 09/01/2015		
				To 08/31/2016		
		T' 11	2071.1.1		1/4/2017 9: 04	am
			e XVIII	Hospi tal	PPS	
		550 5 1 1	Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 484666			0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 301257	14, 893		0 0	4, 487	54.00
60. 00 06000 LABORATORY	0. 123131	2, 140		0 0	264	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 136055	67, 675		0 0	9, 208	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 381240	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. 289299	2, 008		0 0	581	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 174680	0		0 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 346248	111, 414		0 0	38, 577	74. 00
OUTPATIENT SERVICE COST CENTERS	•			<u>'</u>		
90. 00 09000 CLI NI C	0.000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 000000)		0		95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	98. 00
200.00 Subtotal (see instructions)		198, 130		0 0	53, 117	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		198, 130		0 0	53, 117	202. 00
	•	•	•		•	•

Title XVIII Hospital PPS	
Costs	
Cost Center Description Cost Cost	
Reimbursed Reimbursed	
Servi ces Servi ces Not	
Subj ect To Subj ect To	
Ded. & Coi ns. Ded. & Coi ns.	
(see inst.)	
6.00 7.00	
ANCILLARY SERVICE COST CENTERS	FO 00
50. 00 05000 0PERATING ROOM	50.00
54. 00 05400 RADI 0LOGY - DI AGNOSTI C	54.00
60. 00 06000 LABORATORY	60.00
65. 00 06500 RESPI RATORY THERAPY 0 0	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0	73.00
74. 00 07400 RENAL DI ALYSI S 0 0 0	74. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0	00 00
	90.00
91. 00 09100 EMERGENCY 0 0 O O O O O O O O	91. 00
95. 00 09500 AMBULANCE SERVICES 0	95. 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0	98. 00
	200.00
	200.00
Only Charges	201.00
	202. 00

Health Financial Systems	Kindred Hospital	Indianapolis South	In Lie	eu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 152008	Peri od: From 09/01/2015	Worksheet D-1			
			To 08/31/2016	Date/Time Prep 1/4/2017 9:04			
		Title XVIII	Hospi tal	PPS			
Cost Center Description							
·				1. 00			
PART I - ALL PROVIDER COMPONENTS							
I NPATI ENT DAYS							
1.00 Inpatient days (including private room	m days and swing-bed	days, excluding newborn)		11, 188	1.00		

	Cost Center Description		
	DADT I ALL DROW DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11, 188	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11, 188	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11, 188	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	o	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	7 445	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7, 115	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
47.00	SWING BED ADJUSTMENT		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period	0.00	
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20. 00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	9, 195, 298	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)	Ĭ	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	In line 20)	٥	23.00
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 195, 298	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges)	0	29. 00 30. 00
31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 195, 298	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	821. 89	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	5, 847, 747	39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5, 847, 747	41.00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 152008	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Pre	
				\0.41.1		1/4/2017 9:04	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bessirption	Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
12.00	NUDCEDY (+: +1 - V 0 VIV1.)	1.00	2. 00	3.00	4. 00	5. 00	12.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT	C	C	0.	00 0	0	43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description	L.					
48. 00	Program inpatient ancillary service cost (Wks	st D 2 col 1	2 line 200)			1. 00 5, 164, 822	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		11, 012, 569	
	PASS THROUGH COST ADJUSTMENTS		•	,			
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sui	m of Parts I and	592, 680	50.00
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancilla	ry services (fr	rom Wkst. D,	sum of Parts II	208, 039	51.00
52.00	Total Program excludable cost (sum of lines!	,				800, 719	
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line !	10, 211, 850	53. 00				
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						- A 00
55. 00	Target amount per discharge		0.00	54. 00 55. 00			
56. 00	Target amount (line 54 x line 55)					0	1
57. 00	Difference between adjusted inpatient operati	ng cost and to	arget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	ending 1996 ı	indated and co	amnounded by the	0.00	
07.00	market basket	0.	9		simpounded by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	1
61.00	which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see i		•		3		
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	ont (eoo inetri	ictions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstr	actions)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of the	cost report	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ner 31 of the d	rost reporting	neriod (See	0	65. 00
03.00	instructions)(title XVIII only)	ts arter become	oci or the t	cost reporting	g perrou (see		05.00
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 d	of the cost r	eporting period	0	67. 00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after I	December 31 of	the cost rep	orting period	0	68. 00
69. 00	[`	routine costs	(line 67 + line	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU		•			Г	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	,		•)		70.00
72. 00	Program routine service cost (line 9 x line		7110 70 . 11110	2)			72. 00
73.00	Medically necessary private room cost applica						73. 00
74. 00 75. 00	Total Program general inpatient routine servi	•	,		Dart II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient (26, line 45)	outine Service	E CUSIS (II UIII V	NOI VOITEEL D,	art II, COTUIIII		/ 3.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		orovi der record	15)			78. 00 79. 00
	, and the second of the second						

Health Financial Systems Kind	dred Hospital	I ndi ana	apolis Sou	ıth	In Lie	u of Form CMS-2	2552-10			
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od: From 09/01/2015	Worksheet D-1				
					To 08/31/2016	Date/Time Pre 1/4/2017 9:04				
			Ti tl	e XVIII	Hospi tal	PPS	pared:			
Cost Center Description	Cost	Rout	ine Cost	column 1 ÷	Total	Observation				
		(from	line 21)	column 2	Observati on	Bed Pass				
					Bed Cost (from	Through Cost				
					line 89)	(col. 3 x col.				
						4) (see				
						instructions)				
	1.00		2. 00	3. 00	4. 00	5. 00				
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST									
90.00 Capital -related cost	932, 00	19	9, 195, 298	0. 10135	57 0	0	90. 00			
91.00 Nursing School cost		0	9, 195, 298	0.00000	0 0	0	91. 00			
92.00 Allied health cost		0	9, 195, 298	0.00000	0 0	0	92. 00			
93.00 All other Medical Education		0	9, 195, 298	0.00000	00	0	93. 00			

Heal th	Financial Systems Kindred Hospital Indian	napolis South	In Lie	u of Form CMS-2	2552-10		
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 152008	Peri od:	Worksheet D-1			
			From 09/01/2015 To 08/31/2016	Date/Time Pre 1/4/2017 9:04			
-		Title XIX	Hospi tal	Cost			
	Cost Center Description						
				1. 00			
	PART I - ALL PROVIDER COMPONENTS						
	I NPATI ENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days,			11, 188			
2.00	Inpatient days (including private room days, excluding swing-be			11, 188			
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00		
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		11, 188	4.00		
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5.00		
3.00	reporting period	days) thi odgir beceinbe	i 31 of the cost		3.00		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost						
0.00	reporting period (if calendar year, enter 0 on this line)	0	6. 00				
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00		
	reporting period						
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00		
	reporting period (if calendar year, enter 0 on this line)						
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	51	9. 00		
40.00	newborn days)				10.00		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction)		oom days)	0	10.00		
11. 00			nom days) after	_	11.00		
11.00	December 31 of the cost reporting period (if calendar year, ent		oolii days) ai tei	0	11.00		
12. 00			e room days)	0	12. 00		
	through December 31 of the cost reporting period	y (p p					
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00		
	after December 31 of the cost reporting period (if calendar yea	r, enter O on this lin	e)				
	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0			
	Total nursery days (title V or XIX only)			0	1		
16. 00	Nursery days (title V or XIX only)			0	16. 00		
	SWING BED ADJUSTMENT						
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00		
10.00	reporting period	-ft D 31	414		10.00		
18.00	Medicare rate for swing-bed SNF services applicable to services reporting period	arter December 31 of	the cost	0.00	18. 00		
10 00	Medicaid rate for swing-bed NF services applicable to services	through December 21 of	the cost	0.00	19.00		
17.00	Imedical dirace for swilly-bed in services applicable to services	tin ough becember 31 01	THE COST	0.00	J 17. UU		

		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1 00	I NPATI ENT DAYS	11 100	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	11, 188 11, 188	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	11, 188	3.00
3.00	do not complete this line.	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11, 188	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
0.00	reporting period	· ·	0.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	51	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	· ·	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	9, 136, 262	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22 00	5 x line 17)	0	23. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x line 19)	· ·	21.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 136, 262	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0 000000	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	32.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 136, 262	37. 00
	27 minus line 36)		
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	816. 61	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	41, 647	39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 152008	Peri od: From 09/01/2015		
			T. 1	II. WIW		Date/Time Pre 1/4/2017 9:04	
	Cost Center Description	Total	Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
	0000 000000 20000 1 pt. 011	Inpatient Cost				(col . 3 x col . 4)	
10.00	AND SERVICE AND	1.00	2. 00	3.00	4. 00	5. 00	10.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT	0	C	0.0	00 0	0	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk:	st D-3 col 3	R line 200)			1.00	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		41, 647	
50. 00	Pass through costs applicable to Program inp.	atient routine	services (from	m Wkst. D, sur	n of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	ry services (fi	rom Wkst. D, s	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	,				0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-phy	ysician anesth	netist, and	0	53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55. 00
56. 00	Target amount (line 54 x line 55)				==>	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (I	ine 56 minus	Tine 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996, เ	updated and co	ompounded by the	-	1
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		is (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	,				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	na period (See	0	64. 00
	instructions)(title XVIII only)	Ü		·			
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reportino	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 d	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31 of	the cost repo	orting period	0	68. 00
60.00	(line 13 x line 20) Total title V or XLX swing-bed NF inpatient	routino costs (lino 67 . lino	. 60)		0	69. 00
69.00	PART III - SKILLED NURSING FACILITY, OTHER NU] 0	09.00
70.00	Skilled nursing facility/other nursing facil	,		•	1		70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications		n (line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine serv	ice costs (line	2 72 + line 73))			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	Worksheet B, F	Part II, column		75. 00
76. 00		ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minuse) Aggregate charges to beneficiaries for excess		rovi den rocer	4e)			78. 00 79. 00
1 1.00	magnegate charges to belieffer all tes for the colors	J JUJEJ (TIUH L	,,	a /		i .	. , ,

Health Financial Systems Kin	dred Hospital I	ndianapolis S	outh	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi de	r CCN: 152008	Peri od: From 09/01/2015	Worksheet D-1	
				To 08/31/2016	Date/Time Pre 1/4/2017 9:04	pared: am
		Ti	tle XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 2) 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	932, 009	9, 136, 20	0. 1020	12 0	0	90.00
91.00 Nursing School cost		9, 136, 26	0. 00000	00	0	91.00
92.00 Allied health cost	(9, 136, 26	0. 00000	00	0	92.00
93.00 All other Medical Education		9, 136, 20	0. 0000	00 0	0	93. 00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS Provi der CCN: 152008 Peri od: Worksheet D-2 From 09/01/2015 08/31/2016 Date/Time Prepared: 1/4/2017 9:04 am Heal th Care Program Inpati<u>ent Days</u> Cost Center Description Percent of Expense Total Average Cost Title V Inpatient Day Assigned Time All ocation Per Day All Patients 1.00 2.00 4.00 5.00 3.00 PART I - NOT IN APPROVED TEACHING PROGRAM Total cost of services rendered 0.00 0 1.00 1.00 Hospital Inpatient Routine Services: 2.00 ADULTS & PEDIATRICS 0. 00 0 11, 188 0.00 0 2.00 3.00 INTENSIVE CARE UNIT 0.00 0.00 3.00 CORONARY CARE UNIT 4 00 4 00 5.00 BURN INTENSIVE CARE UNIT 5.00 6.00 SURGICAL INTENSIVE CARE UNIT 6.00 OTHER SPECIAL CARE (SPECIFY) 7.00 7 00 8.00 NURSERY 8.00 9.00 Subtotal (sum of lines 2 through 8) 0.00 0 9.00 SUBPROVI DER - I PF SUBPROVI DER - I RF 10.00 10.00 11 00 11 00 12.00 SUBPROVI DER 12.00 SKILLED NURSING FACILITY 0.00 0.00 0 13.00 13.00 0 NURSING FACILITY 14.00 14.00 15.00 OTHER LONG TERM CARE 15.00 16.00 HOME HEALTH AGENCY 16.00 17.00 CMHC 17.00 18.00 AMBULATORY SURGICAL CENTER (D. P.) 18.00 HOSPI CE 19.00 19.00 20.00 Subtotal (sum of lines 9 through 19) 0.00 20.00 Titles V and XIX Outpatient and Title XVIII Part B Charges Cost Center Description Total Charges Ratio of Cost Title V (from to Charges Worksheet C. (col. 2 ÷ col 3 Part I, column 8, lines 88 through 93) 1.00 2.00 3.00 4.00 5.00 Hospital Outpatient Services: 21.00 RURAL HEALTH CLINIC 21.00 22.00 FEDERALLY QUALIFIED HEALTH CENTER 22.00 23.00 CLI NI C 0.000000 23.00 0.00 24. 00 EMERGENCY 0.00 0.000000 24.00 OBSERVATION BEDS (NON-DISTINCT PART) 25.00 25.00 OTHER OUTPATIENT SERVICE COST CENTER 26.00 26.00 Subtotal (sum of lines 21 through 26) 27.00 0.00 27.00 28. 00 28.00 Total (sum of lines 20 and 27) 0.00 Expenses Cost Center Description Swing bed Net cost Total Average Cost Allocated To (column 1 plus|Inpatient Days|Per Day (col. Amount cost centers - All Patients column 2) 3 ÷ col . 4) on Worksheet B. Part I columns 21 and 22 1.00 2.00 3.00 4.00 5.00 PART B INPATIENT ROUTINE COSTS ONLY) PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, Hospital Inpatient Routine Services: 0 00 29. 00 ADULTS & PEDIATRICS 11, 188 29 00 30.00 Swing Bed - SNF 0 0 0.00 30.00 Swing Bed - NF 31.00 31.00 INTENSIVE CARE UNIT 0 0.00 0 0 32.00 32 00 33.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 34.00 35.00 SURGICAL INTENSIVE CARE UNIT 35.00 OTHER SPECIAL CARE (SPECIFY) 36.00 36.00 37.00 Subtotal (sum of lines 29, and 32 through 0 37.00 SUBPROVIDER - IPF 38.00 38.00 SUBPROVIDER - IRF 39.00 39.00 SUBPROVI DER 40.00 40.00 41.00 SKILLED NURSING FACILITY 0 0.00 41.00 42.00 Total (sum of lines 37 through 41) 42.00

Health Financial Systems	Ki ndı	red H	ospi	tal Inc	di ana	apolis So	uth			In Li∈	u of Form	CMS-2	2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED B	Y INTERI	NS AN	D RE	SI DENTS	3	Provi der	CCN:	152008		eri od:	Workshee	et D-2	
									Fr	om 09/01/2015 08/31/2016	Date/Tin	na Drai	narod:
									'	00/31/2010	1/4/2017		
			Not	In App	rove	d Teachii	ng Pr	ogram		In Approved Te	achi ng Pr	ogram	
Cost Center Description			(f	from Pa	rt I	.)		Amount	-	(from Part II	col 7	-)	
cost conton bood (pt. c.)			(.			. ,		7 11110 01110		(,	,	
				1. 0	0			2.00		3.	00		
PART III - SUMMARY FOR TITLE XVIII (TO	BE COM	IPLETE	ED ON	NLY IF	BOTH	I PARTS I	AND	II ARE U	SED))			
Hospi tal													
43.00 Inpati ent				ine 9.0					0	line 37.00			43. 00
44.00 Outpati ent		col .	9, I	ine 27.	. 00				0				44. 00
45.00 Total Hospital (sum of lines 43 and 44	1)								0				45. 00
46. 00 SUBPROVI DER - I PF													46. 00
47. 00 SUBPROVI DER - I RF													47.00
48. 00 SUBPROVI DER													48. 00
49.00 SKILLED NURSING FACILITY		col.	9, I	ine 13.	. 00				0	col. 9, line 4	1. 00		49. 00

	Financial Systems Kind ONMENT OF COST OF SERVICES RENDERED BY INTER	red Hospital II		CCN: 152008	Period: From 09/01/2015 To 08/31/2016		epared:
		Health Car Inpatie					
	Cost Center Description	Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Title XIX	Title V (col 4 x col. 5)		Title XIX (col. 4 x col. 7)	
		6. 00	7.00	8. 00	9. 00	10.00	
	PART I - NOT IN APPROVED TEACHING PROGRAM	I		T	1	T	1 00
-	Total cost of services rendered Hospital Inpatient Routine Services:						1. 00
2. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	7, 115 0	51 C	1	0 0	_	3. 00 4. 00 5. 00 6. 00 7. 00
9. 00 S 10. 00 S 11. 00 S 12. 00 S	NURSERY Subtotal (sum of lines 2 through 8) SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY	0	C		0 0		10. 00 11. 00 12. 00
15. 00 0 16. 00 H 17. 00 0 18. 00 H	NURSING FACILITY DTHER LONG TERM CARE HOME HEALTH AGENCY CMHC AMBULATORY SURGICAL CENTER (D.P.) HOSPICE SUBTOTAL (Sum of lines 9 through 19)	Till V		Title		1.77.11	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
		Titles V and XIX Outpatient and Title XVIII Part B XVIII Part B Cost Charges					
	Cost Center Description	Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX	
Н	lospital Outpatient Services:	6. 00	7.00	8. 00	9. 00	10.00	+
21. 00 F 22. 00 F 23. 00 C 24. 00 E 25. 00 C 26. 00 C 27. 00 S	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0 0	0	24. 00 25. 00 26. 00
	Cost Center Description	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents			23. 00
	AADT III IN AN ADDOUGD TEACHING	6.00	7.00	11.00	ONLYO		
	PART II - IN AN APPROVED TEACHING PROGRAM (TI Hospital Inpatient Routine Services:	ILE XVIII, PAR	T B INPATIENT	ROUTINE COSTS	UNLY)		4
29. 00 A	ADULTS & PEDLATRICS Swing Bed - SNF	0	l	1	0		29. 00 30. 00

			0)			4
		6. 00	7. 00	11. 00		
	PART II - IN AN APPROVED TEACHING PROGRAM (TI	TLE XVIII, PAR	T B INPATIENT	ROUTINE COSTS (ONLY)	
	Hospital Inpatient Routine Services:					l
29. 00	ADULTS & PEDIATRICS	0	0	0	<u> </u>	29. 00
30.00	Swing Bed - SNF	0	0			30. 00
31.00	Swing Bed - NF					31. 00
32.00	INTENSIVE CARE UNIT	0	0	0		32. 00
33.00	CORONARY CARE UNIT					33. 00
34.00	BURN INTENSIVE CARE UNIT					34. 00
35.00	SURGICAL INTENSIVE CARE UNIT					35. 00
36.00	OTHER SPECIAL CARE (SPECIFY)					36. 00
37.00	Subtotal (sum of lines 29, and 32 through		0	0	<u> </u>	37. 00
	36)					
38. 00	SUBPROVIDER - IPF					38. 00
39. 00	SUBPROVI DER - I RF					39. 00
40.00	SUBPROVI DER					40. 00
41.00	SKILLED NURSING FACILITY	0	0	0		41. 00
42.00	Total (sum of lines 37 through 41)		0	0	ı	42. 00

Health Financial Systems Kind	red Hospital II	ndianapolis South	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	NS AND RESIDEN	TS Provi der CCN: 152008	Peri od:	Worksheet D-2	
			From 09/01/2015 To 08/31/2016	Date/Time Prep 1/4/2017 9:04	oared: am
	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 Outpati ent					44.00
45.00 Total Hospital (sum of lines 43 and 44)	0	line 22	0		45.00
46. 00 SUBPROVI DER - I PF					46.00
47. 00 SUBPROVI DER - I RF					47.00
48. 00 SUBPROVI DER					48.00
49.00 SKILLED NURSING FACILITY	0	line 22	0		49. 00

		ospital Indianapolis Son			u of Form CMS-1	
INPAILE	NT ANCILLARY SERVICE COST APPORTIONMENT	Provider	CCN: 152008	Peri od: From 09/01/2015	Worksheet D-3	
				To 08/31/2016	Date/Time Pre 1/4/2017 9:04	
		Ti +I	e XVIII	Hospi tal	PPS	alli
	Cost Center Description		Ratio of Cos		Inpati ent	
	odst denter beserretten		To Charges	Program	Program Costs	
					(col. 1 x col.	
				ŭ .	2)	
			1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			12, 972, 849		30. 00
	03100 INTENSIVE CARE UNIT			0		31. 00
	ANCILLARY SERVICE COST CENTERS					
	D5000 OPERATING ROOM		0. 48466		· ·	
	D5400 RADI OLOGY - DI AGNOSTI C		0. 30125			54.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY		0. 12321 0. 13605			
	06600 PHYSI CAL THERAPY		0. 13603		· ·	
	06700 OCCUPATIONAL THERAPY		0. 00000		761,036	67.00
	06800 SPEECH PATHOLOGY		0.00000		0	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 28929			
	07300 DRUGS CHARGED TO PATIENTS		0. 17468		1, 416, 618	
	07400 RENAL DI ALYSI S		0. 34624		315, 916	
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0.00000	00 0	0	90.00
91.00	09100 EMERGENCY		0.00000	00	0	91.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95. 00
	09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	
200.00	Total (sum of lines 50-94 and 96-98)			24, 885, 822	5, 164, 822	
201.00	Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201. 00
202. 00	Net Charges (line 200 minus line 201)		I	24, 885, 822		202. 00

Health Financial Systems	Kindred Hospital India	napolis South	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152008		Worksheet E
			From 09/01/2015	Part B
			To 08/31/2016	Date/Time Prenared

			10 08/31/2016	1/4/2017 9:04	
	Title XVIII Hospital			PPS	aiii
			•		
	1.00				
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1.00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			53, 117	2.00
3.00	PPS payments			57, 297	3.00
4. 00					4.00
5. 00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	5. 00
6.00	Line 2 times line 5				6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges				1 12 00
12. 00 13. 00	Ancillary service charges	0. 40)		0	12. 00 13. 00
14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin Total reasonable charges (sum of lines 12 and 13)	le 09)		0	14.00
14.00	Customary charges				14.00
15. 00	Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		Ü		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
20.00	instructions)	. : & ! 11	10) (20.00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	TI TIME IT exceeds IT	ne 18) (See	0	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21. 00
22. 00	Interns and residents (see instructions)	111311 4011 0113)		Ö	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ıctions)		Ō	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	•		57, 297	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			11, 481	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	45, 816	27. 00
28. 00	instructions) Direct graduate modical education payments (from Wkst. E. 4. Lin	10 EO)		0	28. 00
29. 00	Direct graduate medical education payments (from Wkst. E-4, lin ESRD direct medical education costs (from Wkst. E-4, line 36)	le 50)			29.00
30. 00	Subtotal (sum of lines 27 through 29)			45, 816	30.00
31. 00	Primary payer payments			0	31.00
32. 00	Subtotal (line 30 minus line 31)			45, 816	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	icti ons)		0	36.00
37. 00	, ,			45, 816	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 00 39. 50
39. 98	Partial or full credits received from manufacturers for replace		tions)		39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see institue	(1013)	Ö	39. 99
40. 00	Subtotal (see instructions)			45, 816	•
40. 01				916	1
41.00				44, 900	•
42.00	1.9			0	42.00
43.00	Balance due provider/program (see instructions)			0	43.00
44.00				0	44.00
	§115. 2			·	ļ
00.00	TO BE COMPLETED BY CONTRACTOR				00.00
90.00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	91. 00 92. 00
	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
00	1 (,

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 09/01/2015 | Part | Date/Time Prepared: | 1/4/2017 9:04 am | Heal th FinancialSystemsKindred HospitalIndianapolisSouthANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICESRENDEREDProvider CCN: 152008

		Ti +I	e XVIII	Hospi tal	PPS	<u> </u>
			t Part A		t B	
		Tripatren	t fall A	Pai	t D	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider	1.00	11, 197, 706	3. 00	44, 900	1. 00
2.00	Interim payments payable on individual bills, either		11, 197, 700		44, 700	2. 00
2.00	submitted or to be submitted to the contractor for		U		١	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	1				
3. 01	ADJUSTMENTS TO PROVIDER	05/19/2016	159, 900		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	03/ 19/ 2010	137, 700			3. 02
3. 02			0			3. 02
			0			3. 03
3.04			0		- 1	
3.05			0		0	3. 05
0 50	Provi der to Program	44 (00 (004 (705 000			0.50
3.50	ADJUSTMENTS TO PROGRAM	11/22/2016	705, 000		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		-545, 100		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		10, 652, 606		44, 900	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider					F 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program		_			
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)					,
6. 01	SETTLEMENT TO PROVI DER		37, 252		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		10, 689, 858		44, 900	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Health Financial Systems	Kindred Hospital Indian	napolis South	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152008	From 09/01/2015	Worksheet E-3 Part IV Date/Time Prepared: 1/4/2017 9:04 am

2.00					1/4/2017 9: 04	am
PART I IV - MEDICARE PART A SERVICES - LTGH PPS Net Federal PPS Payments (see instructions) 10,751,108 1.00 2.00 Outlier Payments 690,563 2.00 3.00 Total PPS Payments (sum of lines 1 and 2) 11,441,671 3.00 3.00 Organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (See instructions) 11,441,671 7.00 11,441,			Title XVIII	Hospi tal	PPS	
PART I IV - MEDICARE PART A SERVICES - LTGH PPS Net Federal PPS Payments (see instructions) 10,751,108 1.00 2.00 Outlier Payments 690,563 2.00 3.00 Total PPS Payments (sum of lines 1 and 2) 11,441,671 3.00 3.00 Organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (D0 NOT USE THIS LINE) 5.00 0 organ acquisition (See instructions) 11,441,671 7.00 11,441,						
1.0					1.00	
2.00						
Total PPS Payments (sum of lines 1 and 2)	1.00	Net Federal PPS Payments (see instructions)			10, 751, 108	1.00
4. 00 Nursing and Ållied Health Managed Care payments (see instructions) 0 4. 00 0 0 0 0 0 0 0 0 0	2.00				690, 563	2. 00
5.00 Organ acquisition (DO NOT USE THIS LINE) 5.00 Cost of physicians' services in a teaching hospital (see instructions) 0.6.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 Cost of physicians' services in a teaching hospital (see instructions) 11, 441, 671 7.00 20, 410 20, 410 20, 410 20, 410 20, 411 20, 4					11, 441, 671	3. 00
6. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 6. 00 11, 441, 671 7. 00 8. 00 Primary payer payments 0 8. 00 9. 00 Subtotal (line 7 less line 8). 11, 441, 671 9. 00 9. 00 Subtotal (line 9 minus line 10) 11, 441, 671 9. 00 11, 441, 671 9. 00 11. 00 Subtotal (line 9 minus line 10) 11, 421, 231 11. 00 11. 00 11, 421, 231 11. 00 11. 00 11, 421, 231 11. 00 11. 00 11, 421, 231 11. 00 11. 00 11. 00 11, 421, 231 11. 00 11. 00 11, 421, 231 11. 00 11. 00 11, 421, 231 11. 00 11. 00 11. 00 11, 421, 231 11. 00 11. 00 11, 421, 231 11. 00 </td <td>4.00</td> <td></td> <td>ns)</td> <td></td> <td>0</td> <td>4. 00</td>	4.00		ns)		0	4. 00
7. 00 Subtotal (see instructions) 11, 441, 671 7. 00 8. 00 Primary payer payments 0 8. 00 9. 00 Subtotal (line 7 less line 8). 11, 441, 671 9. 00 10. 00 Deductibles 20, 440 10. 00 11. 02 Subtotal (line 9 minus line 10) 11, 421, 231 11. 00 12. 00 Coinsurance 11, 401, 231 11. 00 13. 00 Subtotal (line 11 minus line 12) 10, 601, 727 13. 00 14. 00 All lowable bad debts (exclude bad debts for professional services) (see instructions) 30, 291 15. 00 16. 00 Adj usted reimbursable bad debts (see instructions) 30, 291 15. 00 16. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 344, 505 16. 00 17. 00 Subtotal (sum of lines 13 and 15) 10, 908, 018 17. 00 18. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 18. 00 19. 908, 018 17. 00 20. 00 Outlier payments reconciliation 0 20. 00 20. 00 21. 00 21. 00 21. 00 22. 00 21. 00 22. 00 22. 00 <td>5.00</td> <td>Organ acquisition (DO NOT USE THIS LINE)</td> <td></td> <td></td> <td></td> <td>5. 00</td>	5.00	Organ acquisition (DO NOT USE THIS LINE)				5. 00
8. 00 Primary payer payments 0 8. 00 9. 00 Subtotal (line 7 less line 8). 11, 441, 671 9. 00 11, 00 00 00 00 00 00	6.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	6. 00
9.00 Subtotal (line 7 less line 8). 11, 441, 671 9.00	7.00	Subtotal (see instructions)			11, 441, 671	7. 00
10.00 Deductibles 20,440 10.00	8.00	Pri mary payer payments			0	8. 00
11. 00 Subtotal (line 9 minus line 10) 11. 421, 231 11. 00 12. 00 Coinsurance 819, 504 12. 00 13. 00 Subtotal (line 11 minus line 12) 10. 601, 727 13. 00 14. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 471, 217 14. 00 Allowable bad debts (see instructions) 306, 291 15. 00 304, 505 16. 00 17. 00 Subtotal (sum of lines 13 and 15) 10. 908, 018 17. 00 19. 00		Subtotal (line 7 less line 8).			11, 441, 671	9. 00
12.00 Coinsurance 819,504 12.00 13.00 Subtotal (line 11 minus line 12) 10,601,727 13.00 10,601,727 13.00 14.00 All lowable bad debts (exclude bad debts for professional services) (see instructions) 306,291 15.00 Adjusted reimbursable bad debts (see instructions) 306,291 15.00 344,505 16.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 344,505 16.00 10,908,018 17.00 Subtotal (sum of lines 13 and 15) 10,908,018 17.00 10,908,018 17.00 10,908,018 17.00 10,908,018 17.00 10,908,018 17.00 10,908,018 17.00 10,908,018 17.00 10,908,018 17.00 10,908,018 10,908	10.00				20, 440	10.00
13.00 Subtotal (line 11 minus line 12) 10, 601, 727 13.00 14.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 471, 217 14.00 15.00 Adjusted reimbursable bad debts (see instructions) 306, 291 15.00 16.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 344, 505 16.00 17.00 Subtotal (sum of lines 13 and 15) 10, 908,018 17.00 18.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 18.00 19.00 Other pass through costs (see instructions) 0 19.00 20.00 Outlier payments reconciliation 0 20.00 21.50 Outlier payments reconciliation 0 21.00 21.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 21.50 21.99 Recovery of Accelerated Depreciation 0 21.90 22.01 Total amount payable to the provider (see instructions) 10, 908,018 22.00 23.00 Interim payments 10, 652,606 23.00 24.00 Tentative settlement (for contractor use only) 37,252 25.00 25.00 Balance due provider/program (line 22 minus	11. 00	Subtotal (line 9 minus line 10)			11, 421, 231	11. 00
14.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 471, 217 14.00 15.00 Adjusted reimbursable bad debts (see instructions) 306, 291 15.00 16.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 344,505 16.00 17.00 Subtotal (sum of lines 13 and 15) 10,908,018 17.00 18.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 18.00 19.00 Other pass through costs (see instructions) 0 19.00 20.00 Outlier payments reconciliation 0 20.00 21.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 21.00 21.90 Recovery of Accelerated Depreciation 0 21.90 22.01 Total amount payable to the provider (see instructions) 10,908,018 22.00 22.01 Sequestration adjustment (see instructions) 10,908,018 22.00 23.00 Tentative settlement (for contractor use only) 218,160 22.01 25.00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 37,252 25.00 26.00 Descompleted amounts (nonal lowable cost r	12.00	Coinsurance			819, 504	12. 00
15.00 Adjusted reimbursable bad debts (see instructions) 306, 291 15.00 16.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 344, 505 16.00 17.00 Subtotal (sum of lines 13 and 15) 10, 908, 018 17.00 18.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 18.00 19.00 Other pass through costs (see instructions) 0 19.00 20.00 Outlier payments reconciliation 0 20.00 21.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 21.50 21.99 Pioneer ACO demonstration payment adjustment (see instructions) 0 21.50 21.99 Recovery of Accelerated Depreciation 0 21.95 22.01 Sequestration adjustment (see instructions) 10,908,018 22.01 23.00 Interim payments 218,160 22.01 25.00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 37,252 25.00 26.00 Sil15.2 70 BE COMPLETED BY CONTRACTOR 26.00 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 0 50.00<	13.00	Subtotal (line 11 minus line 12)			10, 601, 727	13. 00
16.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 344,505 16.00 17.00 Subtotal (sum of lines 13 and 15) 10,908,018 17.00 18.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 18.00 19.00 Other pass through costs (see instructions) 0 19.00 20.00 Outlier payments reconciliation 0 20.00 21.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 21.00 21.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 21.50 22.01 Recovery of Accelerated Depreciation 0 21.90 22.01 Sequestration adjustment (see instructions) 10,908,018 22.00 22.01 Sequestration adjustment (see instructions) 218,160 22.01 23.00 Interim payments 0 24.00 24.00 Tentative settlement (for contractor use only) 37,252 25.00 25.00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 37,252 25.00 20.00 To BE COMPLETED BY CONTRACTOR 26.00 50.00 Original outlier amou	14.00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		471, 217	14. 00
17. 00 Subtotal (sum of lines 13 and 15) 10,908,018 17. 00 18. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 18. 00 19. 00 Other pass through costs (see instructions) 0 19. 00 19. 00 Outlier payments reconciliation 0 20. 00 0. 00 Outlier payments reconciliation 0 21. 00 0.	15. 00	Adjusted reimbursable bad debts (see instructions)			306, 291	15. 00
18.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 18.00 19.00 1	16.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		344, 505	16. 00
19.00 Other pass through costs (see instructions) 20.00 Outlier payments reconciliation 21.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 21.50 Pioneer ACO demonstration payment adjustment (see instructions) 21.99 Recovery of Accelerated Depreciation 22.00 Total amount payable to the provider (see instructions) 30.00 Interim payments 31.00 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Interim payments 32.00 Tentative settlement (for contractor use only) 32.00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 37.252 25.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 30.00 Outlier reconciliation adjustment amount (see instructions) 31.00 Outlier reconciliation adjustment amount (see instructions) 32.00 The rate used to calculate the Time Value of Money (see instructions) 32.00 Outlier reconciliation adjustment amount (see instructions) 33.00 Outlier reconciliation adjustment amount (see instructions) 34.00 Outlier reconciliation adjustment amount (see instructions) 35.00 Outlier reconciliation adjustment amount (see instructions) 35.00 Outlier reconciliation adjustment amount (see instructions) 36.00 Outlier reconciliation adjustment amount (see instructions) 37.00 Outlier reconciliation adjustment amount (see instructions) 38.00 Outlier reconciliation adjustment amount (see instructions) 39.00 Outlier reconciliation adjustment amount (see instructions)	17. 00	Subtotal (sum of lines 13 and 15)			10, 908, 018	17. 00
20. 00 Outlier payments reconciliation 0 20. 00 21. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 21. 00 21. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 21. 50 21. 99 Recovery of Accelerated Depreciation 0 21. 99 22. 00 Total amount payable to the provider (see instructions) 10, 908, 018 22. 00 23. 00 Interim payments 218, 160 22. 01 23. 00 Interim payments 10, 652, 606 23. 00 24. 00 Tentative settlement (for contractor use only) 0 24. 00 25. 00 Balance due provider/program (line 22 minus lines 22. 01, 23 and 24) 37, 252 25. 00 26. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26. 00 27. 00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 0 51. 00 28. 00 The rate used to calculate the Time Value of Money (see instructions) 0. 0. 00 52. 00	18. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 49)		0	18. 00
21. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 21. 50 Pioneer ACO demonstration payment adjustment (see instructions) 21. 99 Recovery of Accelerated Depreciation Total amount payable to the provider (see instructions) 22. 01 Sequestration adjustment (see instructions) 10, 908, 018 22. 00 22. 01 Interim payments 23. 00 Interim payments 10, 652, 606 23. 00 24. 00 Tentative settlement (for contractor use only) 25. 00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 26. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 50. 00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money (see instructions) 0 21. 00 21. 00 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 21. 90 22. 01 23. 00 24. 00 25. 00 37, 252 25. 00 37, 252 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20. 00 20. 00 21. 90 20. 00 21. 90 22. 01 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00	19. 00				0	19. 00
21. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 21. 99 Recovery of Accelerated Depreciation Total amount payable to the provider (see instructions) 22. 01 Sequestration adjustment (see instructions) 33. 00 Interim payments Tentative settlement (for contractor use only) 25. 00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 26. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 50. 00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 51. 00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money (see instructions) 0 21. 50 21. 50 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 21. 99 22. 00 22. 00 23. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 21. 99 21. 99 22. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29 29 20. 00 20. 0	20.00	Outlier payments reconciliation			0	20. 00
21. 99 Recovery of Accelerated Depreciation 22. 00 Total amount payable to the provider (see instructions) 22. 01 Sequestration adjustment (see instructions) 23. 00 Interim payments 24. 00 Tentative settlement (for contractor use only) 25. 00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 26. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15. 2 To BE COMPLETED BY CONTRACTOR 50. 00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 51. 00 Outlier reconciliation adjustment amount (see instructions) 52. 00 The rate used to calculate the Time Value of Money (see instructions) 53. 00 The rate used to calculate the Time Value of Money (see instructions) 54. 00 Sequestration adjustment amount (see instructions) 55. 00 The rate used to calculate the Time Value of Money (see instructions) 56. 00 The rate used to calculate the Time Value of Money (see instructions) 57. 00 The rate used to calculate the Time Value of Money (see instructions)	21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	21. 00
22. 00 Total amount payable to the provider (see instructions) 22. 01 Sequestration adjustment (see instructions) 23. 00 Interim payments Tentative settlement (for contractor use only) 25. 00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15. 2 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money (see instructions) 10, 908, 018 22. 00 22. 01 10, 652, 606 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20.	21.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	21. 50
22. 01 Sequestration adjustment (see instructions) 218, 160 22. 01 23. 00 Interim payments Tentative settlement (for contractor use only) 25. 00 Balance due provider/program (line 22 minus lines 22. 01, 23 and 24) 26. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{515.2}}{\text{10 BE COMPLETED BY CONTRACTOR}} 50. 00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 51. 00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money (see instructions) 218, 160 22. 01 10, 652, 606 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 01 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 0	21. 99	Recovery of Accelerated Depreciation			0	21. 99
23.00 Interim payments 24.00 Tentative settlement (for contractor use only) 25.00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 50.00 The rate used to calculate the Time Value of Money (see instructions) 10,652,606 23.00 24.00 25.00 24.00 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Protested amounts	22.00	Total amount payable to the provider (see instructions)			10, 908, 018	22. 00
24.00 Tentative settlement (for contractor use only) 25.00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 Si15.2 To BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 53.00 The rate used to calculate the Time Value of Money (see instructions) 54.00 The rate used to calculate the Time Value of Money (see instructions) 55.00 The rate used to calculate the Time Value of Money (see instructions)	22. 01	Sequestration adjustment (see instructions)			218, 160	22. 01
25.00 Balance due provider/program (line 22 minus lines 22.01, 23 and 24) 26.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 26.00 St. 15.2 To BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 52.00 Occurrence of the contraction of	23.00	Interim payments			10, 652, 606	23. 00
26.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 53.00 The rate used to calculate the Time Value of Money (see instructions)	24.00	Tentative settlement (for contractor use only)			0	24. 00
\$115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 53.00 Outlier reconciliation adjustment amount (see instructions) 54.00 The rate used to calculate the Time Value of Money (see instructions) 55.00 Outlier reconciliation adjustment amount (see instructions) 56.00 The rate used to calculate the Time Value of Money (see instructions)	25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and	24)		37, 252	25. 00
TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 52.00 Outlier reconciliation adjustment amount (see instructions) 53.00 Outlier reconciliation adjustment amount (see instructions) 54.00 Outlier reconciliation adjustment amount (see instructions) 55.00 Outlier reconciliation adjustment amount (see instructions) 56.00 Outlier reconciliation adjustment amount (see instructions) 57.00 Outlier reconciliation adjustment amount (see instructions)	26.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	26. 00
50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money (see instructions) 52.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 53.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 54.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 55.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 56.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 57.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 58.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 59.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 59.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions) 50.00 Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)		§115. 2		·		
51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money (see instructions) 0 0.00 52.00		TO BE COMPLETED BY CONTRACTOR				
52.00 The rate used to calculate the Time Value of Money (see instructions) 0.00 52.00	50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see inst	ructions)		0	50. 00
	51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52 00 Time Velore of Manage (and instructions)	52.00	The rate used to calculate the Time Value of Money (see instruc	ti ons)		0.00	52.00
53.00 Time value or money (see instructions)	53.00	Time Value of Money (see instructions)			0	53.00

Health Financial Systems	Kindred Hospital Indianapolis South	In Lieu of Form CMS-2552-10
CALCULATION OF DELMDLIDSEMENT SETTLEMENT	Provider CCN: 152009 Period	Workshoot E 2

near th	Financial Systems Kindred Hospital Indian	iaporis south	III LI e	U OF FORM CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 152008	Peri od: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part VII Date/Time Pre 1/4/2017 9:04	pared:
		Title XIX	Hospi tal	Cost	alli
		I tie xix	Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR VI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	TOES FOR TITLES VOR XI	X SERVICES		1
1.00	Inpatient hospital/SNF/NF services		41, 647		1.00
2.00	Medical and other services		41,047	0	1
3.00	Organ acquisition (certified transplant centers only)		0	0	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		41, 647	0	1
5. 00	Inpatient primary payer payments		11,047	0	5. 00
6.00	Outpatient primary payer payments		J	0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		41, 647	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		11,017		7.00
	Reasonable Charges				1
8.00	Routi ne servi ce charges		0		8.00
9. 00	Ancillary service charges		0	0	1
10.00	Organ acquisition charges, net of revenue		0	_	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	1
	CUSTOMARY CHARGES			-	
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for	payment for services or	n 0	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15. 00
16.00	Total customary charges (see instructions)		0	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	e 41, 647	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	ompleted for PPS provid			
22. 00	Other than outlier payments		0		1
23. 00	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		41 / 47	0	20.00
30.00	Excess of reasonable cost (from line 18)		41, 647	0	1
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
32.00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	1 .
35.00	Utilization review	22)	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
37. 00	OTHER ADJUSTMENTS		0	0	
37. 01	OTHER ADJUSTMENTS		0	0	
38. 00	Subtotal (line 36 ± line 37)		0	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		-	_	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	1
41. 00	Interim payments		0	0	1
42.00	Balance due provider/program (line 40 minus line 41)	o with CMC Dub 15 0	0	0	1
43. 00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	e with two Pub 15-2,		0	43. 00
	Griaptor 1, 3110.2		l l	l	1

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

Provi der CCN: 152008

| Period: | Worksheet G | From 09/01/2015 | To 08/31/2016 | Date/Time Prepared: 1/4/2017 9:04 am |

					1/4/2017 9:04	am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	CHRRENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	76			0	1.00
2.00	Temporary investments	/6			0	
3. 00	Notes recei vabl e			-	0	
4. 00	Accounts receivable	3, 028, 286	Ί `	,	0	
5. 00	Other recei vable	3, 674			0	
6. 00	Allowances for uncollectible notes and accounts receivable	-295, 719	1		0	
7. 00	Inventory	195, 481			0	
8. 00	Prepaid expenses	0		o o	0	
9. 00	Other current assets			0	0	
10. 00	Due from other funds			0	0	
11. 00	Total current assets (sum of lines 1-10)	2, 931, 798	3	0	0	11. 00
	FIXED ASSETS					1
12.00	Land	1, 591, 412	2 (0	0	12. 00
13.00	Land improvements	13, 049		0	0	13.00
14.00	Accumulated depreciation	-11, 309		0	0	14. 00
15. 00	Bui I di ngs	15, 474, 360) (0	0	
16. 00	Accumulated depreciation	-3, 449, 551		0	0	1
17. 00	Leasehold improvements	0) (0	0	
18. 00	Accumul ated depreciation	0) (0	0	
19. 00	Fi xed equipment	0) (0	0	
20. 00	Accumulated depreciation	0)	0	0	
21. 00	Automobiles and trucks	0		1	0	
22. 00	Accumulated depreciation	0 (17 000		1	0	
23. 00	Maj or movable equipment	3, 617, 080	1	1	0	1
24. 00 25. 00	Accumulated depreciation	-3, 045, 027		1	0	
26. 00	Minor equipment depreciable				0	
27. 00	Accumulated depreciation HIT designated Assets				0	
28. 00	Accumulated depreciation				0	
29. 00	Mi nor equi pment-nondepreci abl e			,	0	1
30. 00	Total fixed assets (sum of lines 12-29)	14, 190, 014		1	-	
30.00	OTHER ASSETS	14, 170, 014		,,		30.00
31. 00	Investments			0	0	31.00
32. 00	Deposits on Leases			-	0	1
33. 00	Due from owners/officers			0	0	1
34. 00	Other assets			0	0	1
35.00	Total other assets (sum of lines 31-34)	0		0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	17, 121, 812	2	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	749, 018	3	0	0	37. 00
38. 00	Salaries, wages, and fees payable	488, 715	i (0	0	38. 00
39. 00	Payroll taxes payable	5, 596		0	0	
40.00	Notes and Loans payable (short term)	0) (0	0	
41. 00	Deferred income	0) (0	0	
42. 00	Accel erated payments	0				42. 00
43. 00	Due to other funds	0		0	0	
44. 00	Other current liabilities	331, 841		-	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	1, 575, 170	Д (0	0	45. 00
44 00	LONG TERM LIABILITIES		\		0	14 00
46. 00 47. 00	Mortgage payable Notes payable			,	-	
48. 00	1			-	0	
49. 00	Unsecured Loans Other Long term Liabilities	-12, 176, 147		-	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	-12, 176, 147		1		1
51. 00	Total liabilities (sum of lines 45 and 50)	-10, 600, 977				
31.00	CAPITAL ACCOUNTS	-10,000,777		<u>, </u>	0	31.00
52. 00	General fund balance	27, 722, 789	ol			52. 00
53. 00	Specific purpose fund	27,722,707				53.00
54. 00	Donor created - endowment fund balance - restricted		1	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				Ö	
	repl acement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	27, 722, 789		0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	17, 121, 812	2 0	0	0	60.00
	[59]	I	I		l	I

Fund balance at end of period per balance

sheet (line 11 minus line 18)

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 152008 Peri od: Worksheet G-1 From 09/01/2015 Date/Time Prepared: 1/4/2017 9:04 am 08/31/2016 General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 26, 275, 246 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 1, 447, 542 2.00 Total (sum of line 1 and line 2) 3.00 27, 722, 788 0 3.00 4.00 Additions (credit adjustments) 0 4.00 0 5.00 INTERCOMPANY TRANSFERS\ROUNDING 0 5.00 1 0 0 0 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 27, 722, 789 11 00 11.00 0 12.00 Deductions (debit adjustments) 0 12.00 00000 13.00 INTERCOMPANY TRANSFERS\ROUNDING 13.00 14.00 14.00 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 27, 722, 789 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 Additions (credit adjustments) 4.00 4.00 5.00 INTERCOMPANY TRANSFERS\ROUNDING 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 Deductions (debit adjustments) 12.00 INTERCOMPANY TRANSFERS\ROUNDING 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0

0

0

19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 152008 Peri od: Worksheet G-2 From 09/01/2015 Parts I & II Date/Time Prepared: 08/31/2016 1/4/2017 9:04 am Cost Center Description Outpati ent Inpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 20, 971, 423 20, 971, 423 1.00 SUBPROVIDER - IPF 2.00 2.00 3.00 SUBPROVIDER - IRF 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 0 6.00 SKILLED NURSING FACILITY 0 7.00 Λ 7.00 8.00 NURSING FACILITY 8.00 9.00 OTHER LONG TERM CARE 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 20, 971, 423 20, 971, 423 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 0 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13.00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 0 0 16, 00 11 - 15) 20, 971, 423 17.00 Total inpatient routine care services (sum of lines 10 and 16) 20, 971, 423 17.00 18.00 Ancillary services 38, 690, 162 38, 690, 162 18.00 Outpatient services 19.00 0 0 19.00 RURAL HEALTH CLINIC 20.00 0 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 22. 00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 0 0 23.00 CMHC 24.00 24.00 25.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 26.00 HOSPI CE 26.00 27.00 OTHER (SPECIFY) 27.00 0 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 59, 661, 585 28.00 59, 661, 585 28.00 G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 29.00 17, 594, 661 29.00 0 30.00 ADD (SPECIFY) 30.00 31.00 0 31.00 32.00 32.00 0 33.00 33.00 0 34.00 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 0 37.00 DEDUCT (SPECIFY) 37.00 0 38.00 38.00 39.00 0 39.00 40.00 0 40.00 0 41.00 41.00 Total deductions (sum of lines 37-41) 42.00 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 17, 594, 661 43.00

to Wkst. G-3, line 4)

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	Financial Systems Kindred Hospital Indian			u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provi der CCN: 152008	Peri od:	Worksheet G-3	
			From 09/01/2015 To 08/31/2016	Date/Time Pre	narod:
			10 00/31/2010	1/4/2017 9: 04	
				., .,	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		59, 661, 585	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	i		40, 644, 100	2. 00
3.00	Net patient revenues (line 1 minus line 2)			19, 017, 485	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43			17, 594, 661	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			1, 422, 824	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			1, 452	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			24, 868	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients	•		0	17. 00
18.00	Revenue from sale of medical records and abstracts			991	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			298	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
0.4.00	MI COELL ANEQUE LA COME			0.004	04.00

-2, 891 24.00

1, 447, 542 29. 00

25. 00 26. 00

28. 00

0 27.00

24, 718 1, 447, 542

24. 00 MI SCELLANEOUS I NCOME

27. 00 OTHER EXPENSES

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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