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 Northwest Indiana (152012) 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.

(Si gned)				
	Offi cer	or	Admi ni strator	of Provider(s)
				` ,
				
Title				
Date				

			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	33	0	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	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	33	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 152012 Peri od: Worksheet S-2 From 09/01/2015 Part I Date/Time Prepared: 08/31/2016 1/13/2017 9:58 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 5454 Hohman Avenue, 5th Fl. PO Box: 1.00 State: IN 2.00 City: Hammond Zip Code: 46320 County: Lake 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Kindred Hospital 152012 23844 2 08/01/1996 Ν 0 3.00 Northwest Indiana Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 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 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 09/01/2015 08/31/2016 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 | Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 Ν 23 00 2 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

IUSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	I A	Provi der	CCN: 152012	Period: From 09/01, To 08/31,	/2015 /2016	Workshe Part I Date/Ti 1/13/20	me Pre 17 9:5	pared:
					Urban/Ru 1.00	ral S		Geogr	
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ge) sta "2" fo	atus at the end or rural. If ap	of the cost	е	1	2.0	,,,	26. 0 27. 0
5. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. 0
					Begi nni 1. 00		Endi ı 2. C		
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	S.	•		r	0			36. 0 37. 0
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo	e MDH 1	transitional pa	yment in	N				37. C
8. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 0
					Y/N 1. 00		Y/I 2. C		
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.)? Ente ui remer or "N" adj ust er 1. E	er in column 1 nts in accordan for no. (see i tment? Enter "Y Enter "Y" for y	"Y" for yes ce with 42 nstructions) " for yes or	e N		N N		39. 0 40. 0
	1,10 1.1. 30. 4.1. 27 10. 4. 30.14. geo 61. 61. 41. 10. 40.14.	(555 .	110 11 40 11 01107			V 1.00	XVIII	XIX	
	Prospective Payment System (PPS)-Capital							3. 00	
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption 1	for extraordi na	ry circumsta	nces	N N	N N	N N	45. 0
	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N N	N N	47. (48. (
5. 00	Teaching Hospitals Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N	\top		56. (
	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp , if ap	r "N" for no in nis cost report olete Worksheet oplicable.	column 1. I ing period? E-4. If col	f column 1 Enter "Y" umn 2 is				57. (
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	te Wkst. D-5.		as				58.
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health				e	N N			59. (60. (
	provider-operated criteria under §413.85? Enter "Y"				uctions)		Di rect	GME	
. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1. 00 N	2.00	3. 00	4.00	0.00	5. C		61. (
. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.	00				61.
. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.	00				61.
. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.	00				61.
. 04	<pre>instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).</pre>		0.00	0.	oo				61. (
1. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.	oo				61. (

	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPI			orthwest Indian Provider	CCN: 152012 P	eriod: rom 09/01/2015		pared:
			Y/N	IME	Direct GME	IME	Direct GME	
51. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs		1. 00	2. 00	3. 00	4.00	5. 00	61. 06
	care or general surgery. (see in	structions)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Direct GME FTE	
				1. 00	2. 00	3. 00	Count 4. 00	
51. 10	specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see				0. 00		61. 10
	enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou	and enter in column						
	ACA Provisions Affecting the Hea	Ith Resources and Sei	rvi ces	Admi ni strati on	(HRSA)		1.00	
2. 00	Enter the number of FTE resident	s that your hospital	trai ned			od for which	0.00	62. 00
2. 01	your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	s that rotated from a riod of HRSA THC prog	a Teachi gram. (s	see instruction		your hospital	0.00	62. 01
3. 00	Has your facility trained reside	nts in nonprovider se	ettings	during this co		peri od? Enter	N	63. 00
	"Y" for yes or "N" for no in col	umn 1. If yes, comple	ete line	es 64-67. (see	instructions) Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te			
	Section 5504 of the ACA Base Yea	r FTF Residents in No	onnrovi (der SettingsT	1.00	2.00	3.00	
4. 00	period that begins on or after J Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	uly 1, 2009 and before yes, or your facility ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	re June ty train n-priman all non d non-pn n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0. 00			64. 00
		Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00		2. 00	3. 00	4.00	5. 00	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of				0. 00	0.00	0. 000000	05.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPI	F	In Lie Period: rom 09/01/2015 o 08/31/2016	Date/Time Pre	pared:				
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	1/13/2017 9:55 Ratio (col. 1/ (col. 1 + col. 2))	o dili		
-	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Se	1.00 ttingsEffective f	2.00 or cost report	3.00 ng periods			
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings ry care resident 3 the ratio of		0.00	0. 000000	66. 00		
		Program Name Program Code Unweighted FTEs Nonprovider Site							
	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	3.00	4.00	5.00 0.000000	67. 00		
					1. 0	0 2.00 3.00			
	Inpatient Psychiatric Facility P Is this facility an Inpatient Ps		PE) or does it	contain an IPE sub	provider? N		70. 00		
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	oproved GME teac 004? Enter "Y" lity train resi ((D)? Enter "Y"	hing program in the for yes or "N" for dents in a new teac for yes or "N" for	most no. (see hi ng no.	0	71. 00		
75. 00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or does	it contain an IRF	N		75. 00		
76. 00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 2004? new teaching pr for no. Column	Enter "Y" for yes o ogram in accordance 3: If column 2 is Y	r "N" for with 42	0	76. 00		
						1.00			
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				period? Enter	Y	80. 00 81. 00		
85. 00 86. 00	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (r yes and "N" for no.	(excluded unit)	under 42 CFR Section	n	N	85. 00 86. 00		
	Is this hospital a "subclause (I for yes or "N" for no.	I) LICH CLASSITIED L	unuer Section 18	oo(u)(1)(B)(1V)(II)		N	87. 00		
	V XIX 1.00 2.00								
	Title V and XIX Services Does this facility have title V	and/or XIX inpatient	hospital servic	es? Enter "Y" for	N	Υ	90. 00		
	yes or "N" for no in the applica Is this hospital reimbursed for	ble column.	·		N	N	91. 00		
-	full or in part? Enter "Y" for y	es or "N" for no in t	the applicable c	olumn.	1.4				
ļi	Are title XIX NF patients occupy instructions) Enter "Y" for yes	or"N" for no in the	applicable colu	mn.		N	92. 00		
	Does this facility operate an IC "Y" for yes or "N" for no in the		urposes of title	V and XIX? Enter	N	N	93. 00		
94. 00 I	Does title V or XIX reduce capit applicable column.		or yes, and "N"	for no in the	N	N	94. 00		

Health Financial Systems Kindred Hospital No HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 152012 Pe	eri od:	ieu of Form CMS-	
		To	com 09/01/20 0 08/31/20	16 Date/Time Pr	
			V	1/13/2017 9: XI X	58 am
			1. 00	2. 00	
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appropriate Rural Providers	olicable column	n	0. 00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CA			N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	-inclusive meth	hod of payment			106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see insti 25 and the pi	ructions) If rogram is cost			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.	CRNA fee sched	dul e? See 42	N		108. 00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2. 00 N	3. 00 N	4. 00 N	109. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					107.00
				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	A Demo)for	N	110. 00
			1	. 00 2. 00 3. 00	
Miscellaneous Cost Reporting Information 115.00 st this an all-inclusive rate provider? Enter "Y" for yes or	s "N" for no in	n column 1 lf	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" percer psychiatric, rehabilitation and long term hospitals provider	. If column 2 int for long ter	is "E", enter i rm care (includ	n column es		113.00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y"	for yes or "N'	" for no.		N	116. 00
117.00 s this facility legally-required to carry malpractice insur	rance? Enter "\	Y" for yes or "	N" for	Y	117. 00
118.00 is the mal practice insurance a claims-made or occurrence pol	icy? Enter 1 i	if the policy i	s	1	118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		75, 779			7 118. 01
			1. 00	2. 00	_
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			N N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in			N	N	119. 00 120. 00
"N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	ualifies for th	he Outpatient			
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 th			N		122. 00
where these taxes are included. Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" fo	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, en		fication date			126. 00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, en		ication date			127. 00
in column 1 and termination date, if applicable, in column 2 128.00 of this is a Medicare certified liver transplant center, en	2.				128. 00
in column 1 and termination date, if applicable, in column 2	2.				
129.00 f this is a Medicare certified lung transplant center, ento column 1 and termination date, if applicable, in column 2.					129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		ti fi cati on			130. 00
131.00 If this is a Medicare certified intestinal transplant center	r, enter the ce	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		ication date			132. 00
in column 1 and termination date, if applicable, in column 2				1	1

Health Financial Systems	Kindred Hospital			1	In Lie	u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II	DENTIFICATION DATA	Provi der	CCN: 152012	Period: From 09/ To 08/	′01/2015 ′31/2016	Worksheet S- Part I Date/Time Pr 1/13/2017 9:	epared:
					00		Jo dill
133.00 If this is a Medicare certified other	transplant center, e	nter the certifi	cation date	1	. 00	2.00	133. 00
in column 1 and termination date, if 134.00 If this is an organ procurement organ and termination date, if applicable,	ization (OPO), enter		n column 1				134. 00
All Providers 140.00 Are there any related organization or chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the ho	for no in column 1. I [.] m <u>e office chain numbe</u>	f yes, and home r. (see instruct	office costs		Υ	189003	140. 00
1.00 If this facility is part of a chain o		00 Lines 141 throu	 ah 143 the	name and	3.00	of the	
home office and enter the home office	contractor name and	contractor numbe	er.				141 00
141.00 Name: KINDRED HEALTHCARE OPERATING INC.	Contractor's Name: W	ERVICES	ANSCONTRACT	or s numi	ber: 0590)	141. 00
142.00 Street: 680 SOUTH FOURTH AVENUE 143.00 City: LOUISVILLE	PO Box: State: K	Υ	Zi p Code	۸٠.	4020	12	142. 00 143. 00
143. 00 ci ty. E0013VI EEE	State. K	s I	Zi p code		4020)Z	143.00
144.00 Are provider based physicians' costs	included in Worksheet	Λ2				1. 00 Y	144. 00
144. OUNT e provider based physicians costs	The dued the worksheet	A:				I	144.00
145 00 f agata for renal garviago are alaim	ad an Wkat A Lina 7	4 are the costs	for		. 00 Y	2. 00	145.0
145.00 If costs for renal services are claim inpatient services only? Enter "Y" fo no, does the dialysis facility includ period? Enter "Y" for yes or "N" for	r yes or "N" for no in e Medicare utilization no in column 2.	n column 1. If c n for this cost	column 1 is reporting		Υ		145. 00
146.00Has the cost allocation methodology c Enter "Y" for yes or "N" for no in co yes, enter the approval date (mm/dd/y	lumn 1. (See CMS Pub.				N		146. 00
						1.00	
147.00 Was there a change in the statistical 148.00 Was there a change in the order of al 149.00 Was there a change to the simplified	location? Enter "Y" fo	or yes or "N" fo	or no.	no.		N N N	147. 0 148. 0 149. 0
·		Part A	Part B		tle V	Title XIX	
Does this facility contain a provider or charges? Enter "Y" for yes or "N"				ation of			
155.00 Hospi tal 156.00 Subprovi der - TPF		N N	N N		N N	N N	155. 00 156. 00
156.00 Subprovider - TPF 157.00 Subprovider - TRF		N N	N N		N	N N	157. 0
158. 00 SUBPROVI DER		N.	N		N	N.	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 s this hospital part of a Multicampu Enter "Y" for yes or "N" for no.	s hospital that has o	ne or more campu	ises in diffe	erent CBS/	As?	N	165. 0
	Name O	County 1.00		p Code 3.00	CBSA 4. 00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)		1. 00	2.00	3.00	4. 00		0 166. 00
166. 01							0 166. 0
166. 02 166. 03							0 166. 0: 0 166. 0:
100. 03							0 100. 0.
Health Information Technology (HIT) i	ncentive in the Ameri	can Recovery and	d Reinvestme	nt Act		1.00	
167.00 s this provider a meaningful user un 168.00 f this provider is a CAH (line 105 i				, enter	the	N	167. 00 0168. 00
reasonable cost incurred for the HIT 168.01 If this provider is a CAH and is not	assets (see instructio a meaningful user, doo	ons) es this provider	qualify for	a hardsl			168. 0°
exception under §413.70(a)(6)(ii)? En					tor +bo		0140 0
169.00 If this provider is a meaningful user transition factor. (see instructions)	(TITIE TO/ IS Y) and	u is not a CAH (THE TUS IS	и), en	tei the	0.0	0169. 0

Health Financial Systems	Kindred Hospital Nort	hwest Indiana	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 152012 Period: V						
			From 09/01/2015	Part I			
			To 08/31/2016	Date/Time Pre	pared:		
				1/13/2017 9:5			
	Endi ng						
			1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)		170. 00					
				1.00			
171.00 If line 167 is "Y", does this prov	ider have any days for indiv	iduals enrolled in secti	on 1876	N	171. 00		
Medicare cost plans reported on Wk	st. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes ar	nd "N" for no.				
(see instructions)							

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 152012	Peri od: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part II Date/Time Pro 1/13/2017 9:5	epared
		<u> </u>		Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO ro	chancas Ent	1.00	2.00	
	mm/dd/yyyy format.	N TOT ALL NO TE	sponses. Enti	er arr dates in t	ine	
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N		1.
00	reporting period? If yes, enter the date of the change in a	column 2. (see	instructions			'
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2. 00	3. 00	2.
00	yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	mn 3, "V" for				
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other	offices, drug der or its of the board	Y			3.
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certacountant? Column 2: If yes, enter "A" for Audited, "C" to "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	03/31/2017	4.
00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit red	conciliation.		V /N	1 1 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider i	s N		6.
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		Ü	N		8
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	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	the current	N		10
00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11
					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			ost reporting	Y N	12 13
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymo	ents waived? If	ves, see in:	structions.	N	14
	Bed Complement					
00	Did total beds available change from the prior cost reporti		yes, see ins [.] ~t A		t B	15
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	10/31/2016	Y	10/31/2016	16
00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for	N		N		17
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
. 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 Papert used to file this	N		N		18
	but are not included on the PS&R Report used to file this					

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Financial Systems Kindred Hospital N AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 152012	Peri od:	eu of Form CMS- Worksheet S-2	
		1, 5, 4, 45	00.11 102012	From 09/01/2015 To 08/31/2016	Part II	epared:
		Descri	pti on	Y/N	Y/N	T am
		0		1. 00	3. 00	
20. 00				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	N		N		21.00
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	SPI TALS)		1.00	
	Capi tal Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to appraisa	als made duri	ng the cost		23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entere	this cost ror	porting ported?		24. 00	
24. 00	If yes, see instructions	ed filto duffing t	tilis cost rep	borting perrou?		24.00
25. 00	Have there been new capitalized leases entered into during	the cost report	ting period?	If yes, see		25. 00
	instructions.			_		1
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions	ne cost reportir	ng period? If	f yes, see		26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reporting	neriod?lf	ves submit		27. 00
_7.00	copy.	o cost reporting	g perrou. Tr	yes, subiii t		27.00
	Interest Expense					
28. 00	Were new Loans, mortgage agreements or letters of credit er	ntered into duri	ng the cost	reporting		28. 0
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	hand funds (Dak	at Sarvica Pa	scorvo Eund)		29. 0
. 7. 00	treated as a funded depreciation account? If yes, see instr		ot service ke	eserve runu)		29.0
30. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see		30.0
	instructions.					
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new o	debt? If yes,	see		31.00
	Instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser	rvi ces furni shed	d through cor	ntractual		32.00
	arrangements with suppliers of services? If yes, see instru		· ·			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertainino	g to competit	tive bidding? If		33. 0
	no, see instructions. Provider-Based Physicians					-
34. 00		rangement with	provi der-bas	sed physicians?		34.0
	If yes, see instructions.	· ····g·······························	p. 21. 22.			
35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the բ	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		36.00
37. 00		repared by the h	nome office?	Y		37. 00
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different f	from that of	Y	12/31/2016	38.00
				T T	1 12/31/2010	J 30. U
		d of the home റി	ffice.			
38. 00	the provider? If yes, enter in column 2 the fiscal year end			N	12,00,000	39.00
38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	er chain compone	ents? If yes,			
38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	er chain compone	ents? If yes,	N N		
38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	er chain compone	ents? If yes,			
38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	er chain compone	ents? If yes, If yes, see	N	00	39. 00 40. 00
38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	home office? I	ents? If yes, If yes, see	N 2.		40. 00
38. 00 39. 00 40. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	er chain compone home office? I	ents? If yes, If yes, see	N		40.00
38. 00 39. 00 40. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	home office? I	ents? If yes, If yes, see	N 2.		40. 00
38. 00 39. 00 40. 00 41. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	home office? I	ents? If yes, f yes, see	N 2. DAVIS		41.00
38. 00 39. 00 40. 00 41. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	home office? I	ents? If yes, f yes, see	N 2. DAVIS		40.00
38. 00 39. 00 40. 00 41. 00 42. 00 43. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	home office? I	ents? If yes, f yes, see	N 2. DAVIS	00	41.00

Heal th	Financial Systems	Kindred Hospital	North	west Indiana			In Lie	u of Form (CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der CCI	N: 152012		i od:	Worksheet	S-2	
						To	m 09/01/2015 08/31/2016		Droi	oorod.
						10	06/31/2010	1/13/2017	9: 5	B am
				3.00						
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the t		REIM	BURSEMENT MAN	IAGER					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	ecti vel y.								

| Peri od: | Worksheet S-3 | From 09/01/2015 | Part | To 08/31/2016 | Date/Time Prepared: Health Financial Systems Kindred Hospital Northwest Indiana HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCI Provi der CCN: 152012

					1	0 08/31/2016	1/13/2017 9:5	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	oomponent.	Line Number	110.	or beas	Avai I abl e	oran nodi s	11 (10)	
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		56				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						Ö	6. 00
7. 00	Total Adults and Peds. (exclude observation			56	20, 496	0.00	ł	7. 00
7.00	beds) (see instructions)			00	20, 170	0.00		7.00
8.00	INTENSIVE CARE UNIT	31. 00		0		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)			56	20, 496	0.00	0	
15. 00	CAH visits			00	20, 170	0.00	0	15. 00
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			0	
20. 00	NURSING FACILITY	111.00		ū	Ĭ		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)			56				27. 00
28. 00	Observation Bed Days			30			0	28. 00
29. 00	Ambul ance Tri ps						l o	29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see l'istruction)							31.00
32. 00	Labor & delivery days (see instructions)			0				32.00
32. 00	Total ancillary labor & delivery room			U				32.00
32.01	outpatient days (see instructions)							32.01
33 00	LTCH non-covered days							33. 00
33.00	LIGHT HOTE COVERED Days		ı		I	l .	I	33.00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152012

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

1/13/2017 9:58 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 10.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 11, 626 14, 905 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 1, 004 2 00 HMO and other (see instructions) 305 2 00 3.00 HMO IPF Subprovider 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 0 0 6.00 11, 626 7.00 Total Adults and Peds. (exclude observation 14, 905 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 C 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) 11,626 14, 905 0.00 126.80 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 0.00 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 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) 0.00 126.80 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 Labor & delivery days (see instructions) 0 32.00 32.00 Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions)

37

33.00 LTCH non-covered days

Health Financial Systems Kindred Hospital Northwest Indiana HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCM | Peri od: | Worksheet S-3 | From 09/01/2015 | Part I | To 08/31/2016 | Date/Time Prepared: Provi der CCN: 152012

					00/31/2010	1/13/2017 9: 58	
		Full Time		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	459	0	571	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)			34	6		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	I NTENSI VE CARE UNI T						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			450			13.00
14.00	Total (see instructions)	0. 00	0	459	0	571	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	0.00					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
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25 27. 00
27. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					28.00
28. 00							
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)						29. 00 30. 00
31.00	Employee discount days (see instruction) Employee discount days - IRF						30.00
31.00	Labor & delivery days (see instructions)						31.00
	Total ancillary labor & delivery room						32. 00 32. 01
32. 01	outpatient days (see instructions)						32. UI
33. 00	LTCH non-covered days						33. 00
55.00	LIGHT HOT COVERED Days	ı I		1	l		55.00

					To	08/31/2016	Date/Time Pre	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	1/13/2017 9:58 Average Hourly	s alli
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	7, 881, 396	0	7, 881, 396	263, 680. 89	29. 89	1. 00
1.00	instructions)	200.00	7, 001, 390		7, 661, 390	203, 000. 07	29.09	1.00
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
0.00	B		C		J	0.00	0.00	0.00
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	o	0	0.00		
6.00	Non-physician-Part B	04.00	C	0	ŭ	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							
8. 00	programs) Home office personnel		C	0	0	0.00	0.00	8. 00
9. 00	SNF	44. 00	C	0	0	0.00		
10. 00	Excluded area salaries (see		C	18, 834	18, 834	405.00	46. 50	10. 00
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		2, 130, 379	0	2, 130, 379	29, 902. 00	71. 25	11. 00
12. 00	Care Contract Labor: Top Level		C	o	0	0.00	0.00	12. 00
12.00	management and other		C			0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		169, 700	o	169, 700	1, 078. 00	157. 42	13. 00
	A - Administrative							
14. 00	Home office salaries & wage-related costs		1, 072, 824	0	1, 072, 824	17, 587. 28	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
10.00	Physicians Part A - Teaching				J	0.00	0.00	10.00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		965, 304	0	965, 304		I	17. 00
17.00	instructions)		900, 304		905, 304			17.00
18. 00	Wage-related costs (other)		C	0	0			18. 00
19. 00	(see instructions) Excluded areas		2, 312	0	2, 312			19. 00
20. 00	Non-physician anesthetist Part		2, 312	Ö	2,312			20. 00
21 00	A			0				21 00
21.00	Non-physician anesthetist Part B		C	,	U			21. 00
22. 00	Physician Part A -		C	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		C		0			22. 01
	Physician Part B		C		_			23. 00
24. 00	Wage-related costs (RHC/FQHC)		C					24. 00
25. 00	Interns & residents (in an approved program)		C	0	0			25. 00
	OVERHEAD COSTS - DIRECT SALARIE							
	Employee Benefits Department	4. 00	68, 096		,	1, 367. 57		
27. 00 28. 00	Administrative & General Administrative & General under	5. 00	954, 419 11, 817			25, 368. 58 264. 00		
	contract (see inst.)							
	Maintenance & Repairs	6. 00	C			0.00		
30. 00 31. 00	Operation of Plant Laundry & Linen Service	7. 00 8. 00	C	_) 0	0. 00 0. 00		
32. 00	Housekeepi ng	9. 00	C		ő	0.00		
33. 00	Housekeeping under contract		C	0	0	0.00	0. 00	33. 00
34. 00	(see instructions) Dietary	10. 00	34, 643	o	34, 643	1, 742. 00	19. 89	34. 00
35. 00	Di etary under contract (see	10.00	33, 165			275. 00		
36. 00	instructions) Cafeteria	11. 00	C	o		0. 00	0. 00	36. 00
	Maintenance of Personnel	12. 00	C		-	0.00		37. 00
38. 00	Nursing Administration	13. 00	651, 944			16, 290. 00	40. 02	38. 00
39. 00 40. 00	Central Services and Supply Pharmacy	14. 00 15. 00	72, 711 627, 684			4, 320. 00 16, 183. 00		39. 00 40. 00
- 0.00	i nar macy	15.00	027, 004	ı	027,004	10, 103.00	I 30. 79	70.00

Health Financial Systems	Ki nd	lred Hospital I	Northwest India	na	In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 152012 F	Peri od:	Worksheet S-3	
					rom 09/01/2015		
	To 08/31/201				Date/Time Prep 1/13/2017 9:58		
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col . 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	396, 152	0	396, 152	13, 483. 00	29. 38	41. 00
Records Library							
42.00 Social Service	17. 00	221, 480	-18, 834	202, 646	4, 356. 00	46. 52	42.00
43.00 Other General Service	18. 00	() 0	(0.00	0.00	43. 00

instructions)

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 152012 Worksheet S-3 Peri od: From 09/01/2015 To 08/31/2016 Part III Date/Time Prepared: 1/13/2017 9:58 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 7, 926, 378 7, 926, 378 264, 219. 89 30.00 1.00 instructions) 2.00 Excluded area salaries (see 0 18, 834 18, 834 405.00 46. 50 2.00 instructions) 3.00 Subtotal salaries (line 1 7, 926, 378 -18, 834 7, 907, 544 263, 814. 89 29.97 3.00 minus line 2) 4.00 Subtotal other wages & related 3, 372, 903 3, 372, 903 48, 567. 28 69. 45 4.00 costs (see inst.) Subtotal wage-related costs 5.00 965, 304 C 965, 304 0.00 12. 21 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 12, 264, 585 -18, 834 12, 245, 751 312, 382. 17 39 20 7.00 Total overhead cost (see 3, 072, 111 -18, 834 3, 053, 277 83, 649. 15 36. 50 7.00

Health Financial Systems	Kindred Hospital Northwest Indiana	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 152012	Period: Worksheet S-3 From 09/01/2015 Part IV
		To 09/21/2016 Pate/Time Propared

			3/31/2016	Part IV Date/Time Pre 1/13/2017 9:58	
				Amount	o aiii
				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 Plan Administration fees			0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan			0	6. 00
7.00	Employee Managed Care Program Administration Fees			0	7. 00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			265, 396	8. 00
9.00	Prescription Drug Plan			0	9. 00
10.00	Dental, Hearing and Vision Plan			-3, 643	10.00
11.00	Life Insurance (If employee is owner or beneficiary)			4, 323	11. 00
	Accident Insurance (If employee is owner or beneficiary)			0	12. 00
	Disability Insurance (If employee is owner or beneficiary)			29, 405	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14. 00
15. 00	'Workers' Compensation Insurance			51, 506	
16.00	Retirement Health Care Cost (Only current year, not the extraordi	nary accrual required by FAS	B 106.	0	16. 00
	Non cumulative portion)				
	TAXES				
	FICA-Employers Portion Only			570, 518	
	Medicare Taxes - Employers Portion Only			0	18. 00
	Unemployment Insurance			0	19. 00
20.00	State or Federal Unemployment Taxes			21, 315	20. 00
	OTHER TO BE A SECOND TO THE PARTY OF THE PAR				
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Repor	ted on lines 1 through 4 abo	ve. (see	0	21. 00
22.00	instructions))			0	22.00
	Day Care Cost and Allowances Tuition Reimbursement			0 26, 485	22. 00 23. 00
				· ·	
24.00	Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost			965, 305	24. 00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00
25.00	OTHER WAGE RELATED COSTS (SPECITI)		ı	U	25.00

Heal th	n Financial Systems Kind	dred Hospital Nor	thwest India	na	In Lie	u of Form CMS-	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 09/01/2015 To 08/31/2016	Date/Time Pre 1/13/2017 9:5	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	o alli
	cost center bescription	Jai ai i es	other	+ col . 2)	ons (See A-6)	Trial Balance	
				+ (01. 2)	ons (see A-o)	(col . 3 +-	
		1 00	2.00	2 00	4.00	col . 4)	
	OFNEDAL CEDIUSE OCCT OFNEDO	1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS					4 4/4 554	
1. 00	00100 CAP REL COSTS-BLDG & FIXT		1, 484, 246				1
2.00	00200 CAP REL COSTS-MVBLE EQUIP		588, 902			607, 771	1
3.00	00300 OTHER CAP REL COSTS		20, 451	20, 45	1 -20, 451	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	68, 096	1, 054, 556	1, 122, 65	2 0	1, 122, 652	
5.00	00500 ADMINISTRATIVE & GENERAL	954, 419	2, 385, 680	3, 340, 09	9 0	3, 340, 099	5. 00
7.00	00700 OPERATION OF PLANT	0	100, 839	100, 83	9 235, 823	336, 662	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	79, 239	79, 23	9 0	79, 239	8. 00
9.00	00900 HOUSEKEEPI NG	0	0		88, 434	88, 434	9.00
10.00	01000 DI ETARY	34, 643	306, 682	341, 32		341, 325	1
11. 00	01100 CAFETERI A	0	0		0	0	1
13. 00		651, 944	8, 979	660, 92	3 0	660, 923	1
14. 00		72, 711	10, 033			82, 744	1
15. 00		627, 684	33, 587			661, 271	1
16. 00		396, 152	101, 678			497, 830	1
17. 00		221, 480	4, 987				1
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	221, 400	4, 707	220, 40	7 - 17, 230	201, 209	17.00
30. 00		3, 797, 208	1 257 000	5, 155, 19	7 0	E 1EE 107	30.00
31. 00		3, 797, 200	1, 357, 989		0		1
			0		0		1
44. 00		<u> </u>	0		J U	0	44. 00
FO 00	ANCILLARY SERVICE COST CENTERS	02.002	1 0/2 202	1 045 200	- 0	1 045 205	
50.00		83, 082	1, 862, 203			.,	1
54. 00		0	929, 192			929, 192	1
60.00		45, 648	1, 189, 273			1, 234, 921	
65. 00		928, 329	50, 236			978, 565	1
66. 00		0	968, 151	968, 15	0	968, 151	1
67. 00		0	0	1	0	0	
68. 00		0	0		0	0	
71. 00		0	836, 709			836, 709	1
73. 00		0	1, 364, 831			1, 364, 831	1
74. 00		0	526, 379	526, 37	9 0	526, 379	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0	•	0		1
91. 00		0	0		0 0	0	91.00
05.00	OTHER REIMBURSABLE COST CENTERS						05.00
95.00		0	0	•	0		
98. 00		0	0		0	0	98. 00
110 0	SPECIAL PURPOSE COST CENTERS	7 001 207	15 274 022	22 14/ 21/	10.050	22 12/ 0/0	110 00
118. 0	O SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	7, 881, 396	15, 264, 822	23, 146, 21	-19, 258	23, 126, 960	1118.00
100 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			I			100 00
		0	0	1	0		190. 00 192. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		
	0 07950 NONALLOWABLE CLINICAL LIAISON	0	0		19, 258		194.00
	1 07951 I DLE SPACE	0	0	1	0		194. 01
	2 07952 REGIONAL OFFICE	0	0	1	0		194. 02
	3 07953 DISTRICT OFFICE	0	0	1	0		194. 03
	4 07954 NON MCR CERTIFIED UNIT	0	0	1	0		194. 04
	5 07955 REG NURSG OFFICE	0	0		0		194. 05
	6 07956 CONTACT CENTER	0	0		0 0		194. 06
	7 07957 CENTRALIZED ADMISSIONS DEPT	0	0		0 0		194. 07
	8 07959 OTHER NONREIMBURSABLE - OPEN	0	0	(0 0		194. 08
	9 07958 VISITOR MEALS	0	0	(0 0		194. 09
	0 07962 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194. 10
	1 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	(0		194. 11
200. 0	O TOTAL (SUM OF LINES 118-199)	7, 881, 396	15, 264, 822	23, 146, 21	8 0	23, 146, 218	200. 00

Health FinancialSystemsKindred HospitalNorthwest IndianaRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSESProvider CCI

Health Financial Systems Kin	dred Hospital No	rthwest Indiana		In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (Provi der CC	N: 152012	Peri od:	Worksheet A	
				From 09/01/2015		
				To 08/31/2016	Date/Time Pre	
				L	1/13/2017 9:5	o8 am
Cost Center Description		Net Expenses				
		or Allocation				
OFWERN OFRICE COOT OFWERN	6.00	7. 00				
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT	8, 482	1, 170, 053				1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	-46, 077	561, 694				2. 00
3.00 00300 OTHER CAP REL COSTS	0	0				3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 896	1, 118, 756				4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-96, 781	3, 243, 318				5. 00
7.00 00700 OPERATION OF PLANT	-2, 270	334, 392				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	79, 239				8. 00
9. 00 00900 HOUSEKEEPI NG	0	88, 434				9. 00
10. 00 01000 DI ETARY	o	341, 325				10.00
11. 00 01100 CAFETERI A	O	o				11. 00
13.00 01300 NURSING ADMINISTRATION	0	660, 923				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	82, 744				14. 00
15. 00 01500 PHARMACY	o o	661, 271				15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-258	497, 572				16. 00
17. 00 01700 SOCIAL SERVICE	-250	207, 209				17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	201, 209				17.00
	127 224	E 027 0/2				1 20 00
· · · · · · · · · · · · · · · · · · ·	-127, 234	5, 027, 963				30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0				31.00
44. 00 O4400 SKILLED NURSING FACILITY	0	0				44. 00
ANCILLARY SERVICE COST CENTERS		1 000 015				
50. 00 05000 OPERATI NG ROOM	-6, 370	1, 938, 915				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	929, 192				54. 00
60. 00 06000 LABORATORY	-1, 033	1, 233, 888				60.00
65. 00 06500 RESPI RATORY THERAPY	26, 699	1, 005, 264				65. 00
66. 00 06600 PHYSI CAL THERAPY	-74, 274	893, 877				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	836, 709				71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 364, 831				73. 00
74. 00 07400 RENAL DI ALYSI S	12, 196	538, 575				74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	l ol	o				91.00
OTHER REIMBURSABLE COST CENTERS		-				
95. 00 09500 AMBULANCE SERVI CES	0	0				95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	o	o				98. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	0				70.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-310, 816	22, 816, 144				118. 00
NONREI MBURSABLE COST CENTERS	-310,010	22,010,144				1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	0	0				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	-1				
194. 00 07950 NONALLOWABLE CLINICAL LIAISON	0	19, 258				194. 00
194. 01 07951 I DLE SPACE	0	0				194. 01
194. 02 07952 REGIONAL OFFICE	0	0				194. 02
194. 03 07953 DI STRI CT OFFI CE	0	0				194. 03
194. 04 07954 NON MCR CERTIFIED UNIT	0	0				194. 04
194. 05 07955 REG NURSG OFFICE	0	0				194. 05
194. 06 07956 CONTACT CENTER	0	0				194. 06
194.07 07957 CENTRALIZED ADMISSIONS DEPT	0	0				194. 07
194.08 07959 OTHER NONREIMBURSABLE - OPEN	0	0				194. 08
194.09 07958 VISITOR MEALS	0	0				194. 09
194.10 07962 OTHER NONREIMBURSABLE COST CENTERS	0	ol				194. 10
194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	ol				194. 11
200.00 TOTAL (SUM OF LINES 118-199)	-310, 816	22, 835, 402				200. 00
						-

Health Financial Systems		Ki n	dred Hospi tal	Northwest India	ana	In Lie	u of Form CMS-	-2552-10
RECLASS	SIFICATIONS			Provi der	CCN: 152012	Peri od:	Worksheet A-	6
						From 09/01/2015 To 08/31/2016	Date/Time Pro 1/13/2017 9:	epared: 58 am
		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	18, 834	424				1. 00
	LI AI SON							
	TOTALS		18, 834	424				
	F - RECLASS HOUSEKEEPING & MA	AI NTENANCE						
1.00	HOUSEKEEPI NG	9. 00	0	88, 434				1. 00
2.00	OPERATION OF PLANT	7. 00	0	235, 823				2. 00
	TOTALS		— — — _ō	324, 257				
500.00	Grand Total: Increases		18, 834	324, 681				500.00

Health Financial Systems		Kin	ndred Hospital	Northwest Indiana			In Lieu of Form CMS-25		
RECLASS	SIFICATIONS				Provi der	CCN: 152012	Peri od:	Worksheet A-6	5
							From 09/01/2015	Doto/Time Des	anamad.
							To 08/31/2016	Date/Time Pro 1/13/2017 9:5	
	Decreases								
	Cost Center	Li ne #	Sal ary	0	ther	Wkst. A-7 Ref			
	6. 00	7. 00	8. 00	9	. 00	10.00			
	A - RECLASS NON ALLOWABLE CAS	SE MANAGER					_		
1.00	SOCI AL SERVI CE	1700	18, 834		424		o		1. 00
	TOTALS		18, 834		424				
	F - RECLASS HOUSEKEEPING & MA	AI NTENANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0		88, 434	1	0		1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0		235, 823	1	ol		2. 00
	TOTALS		0		324, 257				
500.00	Grand Total: Decreases		18, 834		324, 681				500. 00

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: 152012 Peri od: Worksheet A-7 From 09/01/2015 Part I Date/Time Prepared: 08/31/2016 1/13/2017 9:58 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 0 1.00 0 0 2.00 Land Improvements 0 0 2.00 0 3. 00 3.00 Buildings and Fixtures 0 Building Improvements 0 4.00 185, 120 1,016 1,016 0 4.00 5.00 Fixed Equipment 0 0 5.00 0 6.00 Movable Equipment 2, 124, 738 95, 071 95, 071 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 2, 309, 858 96, 087 96, 087 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 2, 309, 858 96, 087 0 10.00 10.00 96, 087 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 0 0 3.00 0) 4.00 Building Improvements 186, 136 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 2, 219, 809 6.00 7.00 HIT designated Assets 0 7.00

2, 405, 945

2, 405, 945

0

Heal th	n Financial Systems Kind	dred Hospital N	orthwest India	na	In Lie	eu of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 152012	Peri od: From 09/01/2015	Worksheet A-7 Part II	
					To 08/31/2016	Date/Time Pre	pared:
	,					1/13/2017 9:5	8 am
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10. 00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK						
1. 00	CAP REL COSTS-BLDG & FLXT	3, 810		1	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	216, 044		1	0	0	2. 00
3. 00	Total (sum of lines 1-2)	219, 854			0 0	0	3. 00
			F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 484, 246	•			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	588, 902				2. 00
3.00	Total (sum of lines 1-2)	0	2, 073, 148	1			3. 00

Heal th	n Financial Systems Kind	dred Hospital N	orthwest India	na	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		
					Го 08/31/2016	Date/Time Prep 1/13/2017 9:58	parea: 8 am
		COME	PUTATION OF RAT	TIOS	ALLOCATION OF		o un
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		Г		1		
1.00	CAP REL COSTS-BLDG & FLXT	186, 136		186, 13	1	144	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 219, 809		2, 219, 80	1	1, 714	2. 00
3.00	Total (sum of lines 1-2)	2, 405, 945		2, 405, 94			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5	·		
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	1, 438	0	1, 58:	12, 942	1, 156, 179	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	17, 155	0	18, 86	9 169, 967	372, 858	2. 00
3.00	Total (sum of lines 1-2)	18, 593	0	20, 45	1 182, 909	1, 529, 037	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
					Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)	,	

0 0 0 12.00

-506 1, 714 1, 208 13.00

1, 438 17, 155 18, 593 14. 00

0 0 0 15.00

1, 170, 053 1. 00 561, 694 2. 00 1, 731, 747 3. 00

11. 00

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

1.00

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

Provi der CCN: 152012

Peri od:

From 09/01/2015 08/31/2016 Date/Time Prepared: 1/13/2017 9:58 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL 1. 00 OCAP REL COSTS-BLDG & FIXT 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 В -3.882 ADMINISTRATIVE & GENERAL 4 00 5 00 discounts (chapter 8) 5.00 Refunds and rebates of 0 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -8, 361 ADMI NI STRATI VE & GENERAL 7.00 5.00 7.00 Α stations excluded) (chapter 8.00 Tel evi si on and radio servi ce -2, 270 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 -93, 187 10.00 Provider-based physician A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 771, 408 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests 0 0.00 14.00 Rental of quarters to employee 0 15.00 15.00 0.00 and others 0.00 16.00 16.00 Sale of medical and surgical supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents -2,813 MEDICAL RECORDS & LIBRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing school (tuition, fees, 19.00 19 00 0 00 books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 0 00 22 00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 A - 8 - 365.00 23.00 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 66.00 24.00 A-8-3 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL O 26.00 1.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29 00 29 00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30. 99 Hospice (non-distinct) (see 30.00 30.99 instructions) 31.00 Adjustment for speech OSPEECH PATHOLOGY 68 00 31.00 A - 8 - 3pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest 33 00 0 00 33 00 O MI SCELLANEOUS INCOME -11, 660 ADMINI STRATI VE & GENERAL 33.01 В 5.00 0 33.01

Provi der CCN: 152012

Peri od:

From 09/01/2015 08/31/2016 Date/Time Prepared: 1/13/2017 9:58 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 33. 02 33. 02 0.00 33.03 0 0.00 33.03 33.04 0.00 33.04 33.05 OCCUPATIONAL INCENTIVE INCOME -13, 103 ADMINI STRATI VE & GENERAL 33.05 Α 5.00 33 06 0 00 33 06 33.07 0.00 33.07 33.08 MEDICARE BAD DEBT - PART A -709, 544 ADMINI STRATI VE & GENERAL 5.00 33.08 33 09 0 00 O 33 09 OTHER MEDICARE NON ALLOWABLE -443 ADMINISTRATIVE & GENERAL 33.10 Α 5.00 33.10 33.11 OTHER OPERATING - PATIENT -2, 633 ADMI NI STRATI VE & GENERAL 5.00 33.11 RELATI ONS 33.12 OTHER OPERATING - PUBLIC -1, 137 ADMI NI STRATI VE & GENERAL 5.00 33. 12 Α RELATI ONS OTHER OPERATING - MARKETING -87, 592 ADMI NI STRATI VE & GENERAL 33.13 Δ 5.00 33.13 33. 14 OTHER OPERATING - INTEREST -27 ADMINISTRATIVE & GENERAL 5.00 33.14 33. 15 0.00 33. 15 33.16 0.00 33.16 0 33.17 0.00 33.17 33.18 0 0.00 33.18 33. 19 33. 19 0.00 33 20 OTHER OPERATING - TRADE SHOW -1. 100 ADMINISTRATIVE & GENERAL 5 00 33 20 Α BOOTH 33, 21 0.00 33. 21 33.22 0.00 33.22 CHARITABLE CONTRIBUTIONS -13, 012 ADMI NI STRATI VE & GENERAL 33. 23 5.00 33. 23 Α 33. 24 0.00 33. 24 33. 25 0.00 33. 25 33. 26 0.00 33. 26 33. 27 0.00 0 33, 27 AGGREGATE CAPITAL EROSION -21, 649 ADMI NI STRATI VE & GENERAL 33.28 Α 5.00 33.28 33. 29 0.00 33.29 33.30 0.00 33.30 33.31 0.00 0 33. 31 33.32 0.00 33.32 33. 33 EMP BEN - ADMISSION BONUS -4, 047 ADMINI STRATI VE & GENERAL 5.00 33.33 MALPRACTICE TAIL LIABILITY -19, 536 ADMI NI STRATI VE & GENERAL 33.34 5.00 33.34 33.35 0.00 33.35 33.36 0 0.00 33.36 0 33.37 0.00 33.37 33.38 0.00 ol 33.38 33.39 0 0.00 33.39 33.40 0 0.00 33.40 33.41 0.00 33.41 33 42 0.000 33 42 33.43 DISTRICT OFFICE SALES AND -42, 894 ADMINISTRATIVE & GENERAL 5.00 33.43 Α MARKETI NG DISTRICT OFC SALES AND MKT -3, 896 EMPLOYEE BENEFITS DEPARTMENT 33.44 Α 4.00 33.44 BENEFITS 33.45 BUSINESS INTERRUPTIONS INS -650 CAP REL COSTS-BLDG & FIXT 1.00 12 33.45 Α PREMI UM MEDICARE VS BOOK BLDG 34.00 8, 116 CAP REL COSTS-BLDG & FIXT 1.00 34.00 MEDICARE VS BOOK MOV EQUIP -106, 253 CAP REL COSTS-MVBLE EQUIP 34.01 2.00 34.01 34.02 0.00 34.02 ASSET ADD-ON BLDG 1,016 CAP REL COSTS-BLDG & FIXT 34.03 Α 1.00 34 03 34.04 ASSET ADD-ON MOV EQUIP 60, 185 CAP REL COSTS-MVBLE EQUIP 2.00 34.04 34.05 0.00 34.05 34.06 0.00 34.06 34.07 0.00 34.07 34.08 NON ALLOWABLE LOBBYING FEES -1, 843 ADMINI STRATI VE & GENERAL 5.00 34.08 34.09 0.00 34.09 34.10 0.00 34.10 34.11 0.00 34 11 34. 12 34.12 0.00 PATIENT PHONE - DEPREC EQUIP -9 CAP REL COSTS-MVBLE EQUIP 2.00 34. 13 34.13 Α 34.14 0 0.00 34.14 34. 15 0 0.00 34. 15 34.16 0 0 0.00 34. 16 34. 17 0.000 34.17 34. 18 0.00 0 34. 18

35. 23

35. 24

35. 25

50.00

0.00

0.00

0.00

ADJUSTMENTS TO EXPENSES Provi der CCN: 152012 Peri od: Worksheet A-8 From 09/01/2015 08/31/2016 Date/Time Prepared: 1/13/2017 9:58 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. 1.00 2.00 3.00 4.00 5.00 34. 19 34. 19 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 34. 20 34. 20 0.00 0 34. 21 0.00 34. 21 34. 22 0.00 34. 22 0.00 ol 34 23 34 23 34.24 0.00 34.24 34. 25 0.00 34. 25 0.00 34. 26 34 26 O 34.27 0.00 34.27 34. 28 0.00 34. 28 35.00 0.00 35.00 35 01 35 01 0 00 35.02 0.00 35.02 35.03 0.00 35.03 35.04 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 o 35.08 PHYSICIAN FEE ADJUSTMENT 5, 310 MEDICAL RECORDS & LIBRARY 35.09 35.09 Α 16.00 35.10 0.00 35. 10 PHYSICIAN FEE ADJUSTMENT -72,660 ADULTS & PEDIATRICS 30.00 35. 11 35. 11 35, 12 0.00 35, 12 ol 35.13 0.00 35.13 35. 14 PHYSICIAN FEE ADJUSTMENT -6, 370 OPERATING ROOM 50.00 35.14 35. 15 35. 15 0.00 35.16 0.00 0 35.16 PHYSICIAN FEE ADJUSTMENT 48, 600 RESPIRATORY THERAPY 35. 17 Α 65.00 35.17 35. 18 0.00 35. 18 35. 19 0.00 35. 19 35, 20 35. 20 0.00 PHYSICIAN FEE ADJUSTMENT 35. 21 Α 25, 120 RENAL DIALYSIS 74.00 35. 21 35. 22 35. 22 0 0.00

0

0

-310, 816

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

35, 23

35. 24

35. 25

50.00

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

⁽²⁾ Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

* 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.

Therapy Services

Hospital Related services

891, 646

102, 035

2, 932, 128

965, 920

102, 035

2, 160, 720

4.01

4 22

5.00

 nde net been peeted to merkenest hij cordina i didn'er bij the dinearte arrematie eneard be rhared to the eneart in ordinaria.									
			Related Organization(s) and/	or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2.00	3. 00	4. 00	5. 00					
 B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:							

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

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

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 - Chicago North	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:

66. 00 PHYSI CAL THERAPY

60. 00 LABORATORY

- 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.

4.01

4 22

5.00

Health Financial Systems		Kindred Hospital Northwest Indiana				In Lieu of Form CMS-2552-10			
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATI	ONS AND HOME	Provi der Co	CN: 152012	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 09/01/2015		
							To 08/31/2016	Date/Time Pre	
								1/13/2017 9:5	8 am
	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 TRANS	ACTIONS WIT	H RELATED O	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:							
1.00	845, 682	C)						1. 00
2.00	0	C							2. 00
3.00	0	C							3. 00
4.00	0	C							4. 00
4.01	-74, 274	C							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 22

5.00

		cordinate i dilaret Er the dimedite difference of cordinate be find out out the partition						
	Related Organization(s)							
	and/or Home Office							
	Type of Business							
	6. 00							
-	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6. 00	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	Lab	1	10. 00
100.00		10	00.00

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

o

4 22

5.00

771, 408

- 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.

PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 152012 Peri od: Worksheet A-8-2 From 09/01/2015 08/31/2016 Date/Time Prepared: 1/13/2017 9:58 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7. 00 65. 00 DR. A 171, 400 1. 00 1.00 19,800 19,800 132 30.00 DR. B 2.00 1, 350 1, 350 171, 400 0 2.00 3.00 16.00 DR. C 5, 310 171, 400 3.00 5, 310 31 74. 00 DR. D 171, 400 4.00 25, 120 25, 120 148 4.00 0 30. 00 DR. 5.00 Ε 41, 625 0 41, 625 171, 400 252 5.00 6.00 30.00 DR. F 45, 240 45, 240 171, 400 302 6.00 65. 00 DR. G 7.00 28, 800 0 28, 800 171, 400 192 7.00 60. 00 DR. H 219, 500 8.00 8.00 2.405 0 2.405 13 9.00 30. 00 DR. I 11, 270 171, 400 0 9.00 10.00 30.00 DR. J 1, 400 1,400 171, 400 8 10.00 182<u>,</u> 320 169, 700 1,078 12, 620 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1.00 2.00 8.00 9.00 12. 00 13.00 14.00 1. 00 1.00 65.00 DR. A 10,877 544 0 0 2.00 30.00 DR. B 0 0 0 0 2.00 3.00 16.00 DR. C 2, 555 0 0 0 3.00 128 0 12, 196 4.00 74. 00 DR. D 0 0 0 0 0 0 0 610 4.00 30. 00 DR. E 5.00 20, 766 1,038 5 00 0 6.00 30.00 DR. F 24, 886 1, 244 0 6.00 7.00 65.00 DR. G 15, 822 791 0 0 7.00 60.00 DR. H 0 0 8.00 1, 372 69 8.00 30. 00 DR. I 9.00 0 9.00 10.00 30. 00 DR. J 659 33 0 0 10.00 89, 133 200.00 4, 457 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCF Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 65. 00 DR. A 1. 00 1.00 0 10,877 8, 923 8, 923 30.00 DR. B 2.00 0 1,350 2.00 3.00 16.00 DR. C 0 2, 555 2, 755 2, 755 3.00 74. 00 DR. D 30. 00 DR. E 0 4.00 12, 196 12, 924 12, 924 4.00 5.00 20, 766 20,859 20,859 5 00 6.00 30.00 DR. F 0 24, 886 20, 354 20, 354 6.00 7.00 65.00 DR. G 0 15, 822 12, 978 12, 978 7.00 60.00 DR. H 0 1,033 8.00 1, 372 1,033 8.00 30. 00 DR. I 9.00 O 11, 270 9.00 10.00 30. 00 DR. J 0 659 741 741 10.00

89, 133

80, 567

93, 187

200.00

200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 152012 Peri od: Worksheet B From 09/01/2015 Part I Date/Time Prepared: 08/31/2016 1/13/2017 9:58 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 1, 170, 053 00100 CAP REL COSTS-BLDG & FLXT 1, 170, 053 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 561, 694 561, 694 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 118, 756 13, 555 6,507 1, 138, 818 4.00 00500 ADMINISTRATIVE & GENERAL 3, 478, 462 5 00 3, 243, 318 64, 885 31, 149 139, 110 5 00 7.00 00700 OPERATION OF PLANT 334, 392 C 0 0 334, 392 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 79, 239 0 0 79, 239 8.00 9.00 00900 HOUSEKEEPI NG 88, 434 0 88, 434 9.00 0 0 01000 DI ETARY 10.00 341, 325 0 5.049 346, 374 10 00 C 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 660, 923 12, 849 95, 023 13.00 6, 168 774, 963 13.00 01400 CENTRAL SERVICES & SUPPLY 82, 744 10, 598 131, 185 14.00 25, 569 12, 274 14.00 01500 PHARMACY 661, 271 91, 487 752, 758 15.00 C 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 497, 572 30, 901 14,834 57, 741 601, 048 16.00 01700 SOCIAL SERVICE 17.00 207, 209 17, 346 8, 327 29, 536 262, 418 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 027, 963 796, 159 382, 204 553, 458 6, 759, 784 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 1, 938, 915 12, 110 1, 951, 025 50.00 \cap 05400 RADI OLOGY-DI AGNOSTI C 929, 192 929, 192 54.00 0 54.00 60.00 06000 LABORATORY 1, 233, 888 43, 685 20, 971 6, 653 1, 305, 197 60.00 1, 140, 572 65.00 06500 RESPIRATORY THERAPY 1,005,264 135, 308 65.00 0 66.00 06600 PHYSI CAL THERAPY 893, 877 165, 104 79, 260 0 1, 138, 241 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 o 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 836, 709 C 0 836, 709 71.00 1, 364, 831 07300 DRUGS CHARGED TO PATIENTS 73.00 0 1, 364, 831 73.00 07400 RENAL DIALYSIS 74.00 538, 575 0 538, 575 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 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 1, 170, 053 561, 694 1, 136, 073 22, 813, 399 118. 00 118 00 SUBTOTALS (SUM OF LINES 1-117) 22, 816, 144 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 194. 00 07950 NONALLOWABLE CLINICAL LIAISON 2, 745 22, 003 194. 00 19, 258 0 0 194. 01 07951 I DLE SPACE 0 0 0 0 194. 01 194. 02 07952 REGIONAL OFFICE 0 0 0 0 194. 02 0 0 194. 03 07953 DISTRICT OFFICE 0 0 194. 03 194. 04 07954 NON MCR CERTIFIED UNIT 0 0 194, 04 Ω 0 194. 05 07955 REG NURSG OFFICE 0 0 o 0 194. 05 194.06 07956 CONTACT CENTER 0 194. 06 0 0 0 0 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 0 0 194. 07 0 194. 08 07959 OTHER NONREIMBURSABLE - OPEN 0 0 194.08 Ω 0 194.09 07958 VISITOR MEALS 0 194. 09 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 10 194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 0 194 11 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201.00 1, 170, 053 1, 138, 818 22, 835, 402 202. 00 202.00 TOTAL (sum lines 118-201) 22, 835, 402 561.694

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 152012

					1/13/2017 9:5	8 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						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	3, 478, 462					5. 00
7.00 00700 OPERATION OF PLANT	60, 091	394, 483				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	14, 239	0	93, 478			8. 00
9. 00 00900 HOUSEKEEPI NG	15, 892	0	0	104, 326		9. 00
10. 00 01000 DI ETARY	62, 244	0	0	0	408, 618	10.00
11. 00 01100 CAFETERI A	0	0	0	0	0	11. 00
13.00 O1300 NURSING ADMINISTRATION	139, 262	4, 643	0	1, 228	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	23, 574	9, 240	0	2, 444	0	14.00
15. 00 01500 PHARMACY	135, 271	0	0	0	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	108, 009	11, 167	0	2, 953	0	16. 00
17. 00 01700 SOCIAL SERVICE	47, 157	6, 268		1, 658	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 214, 741	287, 713	93, 478	76, 089	408, 618	30.00
31.00 03100 INTENSIVE CARE UNIT	o	. 0	. 0	ol	0	31. 00
44.00 04400 SKILLED NURSING FACILITY	O	0	0	o	0	44.00
ANCILLARY SERVICE COST CENTERS	-1	-	-			
50. 00 05000 OPERATING ROOM	350, 601	0	0	0	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	166, 977	0	0	· ·	0	54.00
60. 00 06000 LABORATORY	234, 545	15, 787	1	4, 175	0	60.00
65. 00 06500 RESPIRATORY THERAPY	204, 962		0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	204, 543	59, 665	0	15, 779	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	20.70.0	0,,000	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0	0	o o	0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	150, 357	0	0	o o	0	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	245, 261	0	0	o o	0	73. 00
74. 00 07400 RENAL DI ALYSI S	96, 782	0	١	o o	0	74. 00
OUTPATIENT SERVICE COST CENTERS	70, 702			<u> </u>		74.00
90. 00 09000 CLINIC	O	0	0	O	0	90.00
91. 00 09100 EMERGENCY		0			0	91. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			<u> </u>		71.00
95. 00 09500 AMBULANCE SERVI CES	O	0	0	o	0	95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0		l .	0	98. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>		70.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 474, 508	394, 483	93, 478	104, 326	408, 618	110 00
NONREI MBURSABLE COST CENTERS	3,474,300	394, 403	93, 470	104, 320	400, 010	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l	0	0	ام		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES		0				190.00
194. OO 07950 NONALLOWABLE CLINICAL LIAISON	3, 954	0				194. 00
194. 01 07951 I DLE SPACE	3, 934	0				194. 00
	0	0		0		194. 01
194. 02 07952 REGIONAL OFFICE	0	0	0	0		
194. 03 07953 DI STRI CT OFFI CE	0	0	0	0		194. 03
194. 04 07954 NON MCR CERTIFIED UNIT	0	0	0	0		194. 04
194. 05 07955 REG NURSG OFFICE	0	0	0	0		194. 05
194. 06 07956 CONTACT CENTER	0	0	0	0		194. 06
194. 07 07957 CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194. 07
194. 08 07959 OTHER NONREI MBURSABLE - OPEN	0	0	0	0		194. 08
194. 09 07958 VI SI TOR MEALS	0	0	0	0		194. 09
194. 10 07962 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 10
194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	이	0	194. 11
200.00 Cross Foot Adjustments	_	=	_	_	=	200.00
201.00 Negative Cost Centers	0	0	0 00	0		201. 00
202.00 TOTAL (sum lines 118-201)	3, 478, 462	394, 483	93, 478	104, 326	408, 618	202.00

1/13/2017 9:58 am

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 152012

Period: Worksheet B From 09/01/2015 Part I To 08/31/2016 Date/Time Prepared:

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 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 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 11.00 01300 NURSING ADMINISTRATION 0 920, 096 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 166, 443 14 00 15.00 01500 PHARMACY 0 0 1,631 889, 660 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 78 723, 255 16.00 Ω 01700 SOCIAL SERVICE 0 17.00 0 0 17.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 907, 137 267, 271 1,934 268 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 0 04400 SKILLED NURSING FACILITY 0 0 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 12, 959 С 48, 766 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0000000 17, 299 54.00 0 54.00 06000 LABORATORY 64, 876 60.00 0 262 60.00 65.00 06500 RESPIRATORY THERAPY 0 101 0 101, 471 65.00 0 06600 PHYSI CAL THERAPY 66.00 215 32, 196 66.00 67 00 06700 OCCUPATIONAL THERAPY Ω O 67 00 Ω 06800 SPEECH PATHOLOGY 0 68.00 C 0 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 162, 222 0 31, 989 71.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 889, 392 140,004 73.00 07400 RENAL DIALYSIS 19, 383 74.00 0 0 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 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 0 118.00 920, 096 166, 443 889, 660 723, 255 118. 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 0 0000000000000 0 0 192.00 0 0 194.00 07950 NONALLOWABLE CLINICAL LIAISON 0 0 194.00 194. 01 07951 I DLE SPACE 0 0 0 0 0 0 0 0 0 0 194. 01 194. 02 07952 REGIONAL OFFICE 0 0 194. 02 0 0 0 194. 03 194. 03 07953 DISTRICT OFFICE 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 C 194. 08 07959 OTHER NONREI MBURSABLE - OPEN 0 194. 08 194. 09 07958 VISITOR MEALS 0 0 194. 09 0 0 194. 10 07962 OTHER NONRELMBURSABLE COST CENTERS 0 194, 10 C 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 0 201, 00 0 202.00 TOTAL (sum lines 118-201) 920, 096 166, 443 889, 660 723, 255 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 152012 Peri od: Worksheet B From 09/01/2015 Part I 08/31/2016 Date/Time Prepared: 1/13/2017 9:58 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 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 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 317, 501 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10, 334, 534 10, 334, 534 30.00 317, 501 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 50.00 05000 OPERATING ROOM 0 O 2, 363, 351 2, 363, 351 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 1, 113, 468 1, 113, 468 54.00 60.00 06000 LABORATORY 1, 624, 842 1, 624, 842 60.00 06500 RESPIRATORY THERAPY 0 65.00 00000 1, 447, 106 1, 447, 106 65.00 0 06600 PHYSI CAL THERAPY 1, 450, 639 1, 450, 639 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 C 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 1, 181, 277 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 181, 277 0 71.00 71.00 ō 2, 639, 488 07300 DRUGS CHARGED TO PATIENTS 2, 639, 488 73.00 73.00 74.00 07400 RENAL DIALYSIS 654, 740 654, 740 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 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 118.00 317, 501 22, 809, 445 0 22, 809, 445 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 \cap 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 00000000000 0 0 192.00 194. 00 07950 NONALLOWABLE CLINICAL LIAISON 25, 957 0 25, 957 194.00 194. 01 07951 I DLE SPACE 0 194. 01 C 0 0 194. 02 07952 REGIONAL OFFICE 0 0 194. 02 194. 03 07953 DISTRICT OFFICE 0 194.03 194. 04 07954 NON MCR CERTIFIED UNIT 0 0 0 0 194. 04 0 194. 05 07955 REG NURSG OFFICE 194 05 C 194.06 07956 CONTACT CENTER 194.06 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 194. 07 0 0 194. 08 07959 OTHER NONREI MBURSABLE - OPEN 194. 08 194. 09 194. 09 07958 VISITOR MEALS 0 194. 10 07962 OTHER NONREI MBURSABLE COST CENTERS 0 194. 10 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 194. 11 0 0 200.00 Cross Foot Adjustments 200. 00 Ω 0 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 317, 501 22, 835, 402 22, 835, 402 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Peri od:

Provi der CCN: 152012 From 09/01/2015 Part II Date/Time Prepared: 08/31/2016 1/13/2017 9:58 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** DEPARTMENT Capi tal 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 13, 555 6,507 20, 062 20, 062 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 152, 357 64, 885 31, 149 248, 391 2, 451 5.00 00700 OPERATION OF PLANT 7 00 O 7 00 0 0 C 00800 LAUNDRY & LINEN SERVICE 8.00 0 C 0 0 0 8.00 9.00 00900 HOUSEKEEPI NG 0 0 0 9.00 01000 DI ETARY 0 0 0 ol 89 10.00 10 00 Ω 01100 CAFETERI A 11.00 0 0 Λ 11.00 13.00 01300 NURSING ADMINISTRATION 12, 849 6.168 19, 017 1, 674 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 0 25, 569 12, 274 37, 843 187 14.00 01500 PHARMACY 15 00 15 00 1 612 01600 MEDICAL RECORDS & LIBRARY 16.00 30, 901 14,834 45, 735 1,017 16.00 01700 SOCIAL SERVICE 8, 327 520 17.00 17.00 17, 346 25, 673 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 796, 159 9, 750 30 00 03000 ADULTS & PEDIATRICS 0 382, 204 1, 178, 363 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 04400 SKILLED NURSING FACILITY 44.00 44.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 213 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 06000 LABORATORY 117 60.00 0 43, 685 20, 971 64, 656 60.00 06500 RESPIRATORY THERAPY 65.00 2.384 65.00 06600 PHYSI CAL THERAPY 165, 104 79, 260 66.00 244.364 0 66.00 06700 OCCUPATIONAL THERAPY 0 0 0 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 0 0 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 71.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 74.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 0 0 0 0 09100 EMERGENCY 0 91.00 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) 152, 357 1, 170, 053 561, 694 1, 884, 104 20, 014 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 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 48 194. 00 194. 01 07951 I DLE SPACE 0 0 194, 01 0 194. 02 07952 REGIONAL OFFICE 0 0 194. 02 194. 03 07953 DISTRICT OFFICE 0 0 0 0 0 0 0 0 194. 03 194. 04 07954 NON MCR CERTIFIED UNIT 0 0 194.04 0 194. 05 194.05 07955 REG NURSG OFFICE 0 194.06 07956 CONTACT CENTER 0 194. 06 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 0 194. 07 194. 08 07959 OTHER NONREI MBURSABLE - OPEN 0 0 194. 08 Ω 194. 09 07958 VISITOR MEALS C 0 0 194, 09 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 10 0 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 194. 11 200 00 Cross Foot Adjustments 0 200 00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118-201) 1, 170, 053 1, 884, 104 20, 062 202. 00 202.00 152, 357 561, 694

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					1/13/2017 9:5	8 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 & FIXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	250, 842					5. 00
7.00 O0700 OPERATION OF PLANT	4, 333	4, 333				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 027	0	1, 027			8. 00
9. 00 00900 HOUSEKEEPI NG	1, 146	0	0	1, 146		9. 00
10. 00 01000 DI ETARY	4, 489	0	0	0	4, 578	10. 00
11. 00 01100 CAFETERI A	0	0	0	0	0	11. 00
13.00 O1300 NURSING ADMINISTRATION	10, 043	51	0	13	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 700	101	0	27	0	14. 00
15. 00 01500 PHARMACY	9, 755	0	0	0	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	7, 789	123	0	32	0	16. 00
17. 00 01700 SOCIAL SERVICE	3, 401	69	0	18	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	87, 596	3, 161	1, 027	837	4, 578	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	o	0	31.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	o	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	25, 283	0	0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 041	0	l 0	ol	0	54.00
60. 00 06000 LABORATORY	16, 914	173	0	46	0	60.00
65. 00 06500 RESPIRATORY THERAPY	14, 781	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	14, 750	655	-	173	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	10, 843	0	0	0	0	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	17, 687	0	0	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	6, 979	0	0		0	74.00
OUTPATIENT SERVICE COST CENTERS	0,717			<u> </u>		74.00
90. 00 09000 CLI NI C	0	0	0	o	0	90.00
91. 00 09100 EMERGENCY	0	Ö		l .	0	91.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		71.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	ol	0	95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0			l .	0	98. 00
SPECIAL PURPOSE COST CENTERS	0	0		<u> </u>		70.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	250, 557	4, 333	1, 027	1, 146	/ E70	118. 00
NONREI MBURSABLE COST CENTERS	250, 557	4, 333	1,027	1, 140	4, 376	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ام		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	0		0		190.00
194. OO 07950 NONALLOWABLE CLINICAL LIAISON	285	0		0		194. 00
	285	0	0	0		
194. 01 07951 I DLE SPACE	0	0	0	0		194. 01
194. 02 07952 REGIONAL OFFICE	0	0	0	0		194. 02
194. 03 07953 DI STRI CT OFFI CE	0	0	0	0		194. 03
194. 04 07954 NON MCR CERTIFIED UNIT	0	0	0	0		194. 04
194. 05 07955 REG NURSG OFFICE	0	0	0	0		194. 05
194. 06 07956 CONTACT CENTER	0	0	0	0		194. 06
194. 07 07957 CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194. 07
194. 08 07959 OTHER NONREI MBURSABLE - OPEN	0	0	1	-		194. 08
194. 09 07958 VISITOR MEALS	0	0	0	0		194. 09
194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 10
194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194. 11
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	250, 842	4, 333	1, 027	1, 146	4, 578	202. 00

Health Financial Systems Kindred Hospital Northwest Indiana In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 152012 Peri od: Worksheet B From 09/01/2015 Part II 08/31/2016 Date/Time Prepared: 1/13/2017 9:58 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 11.00 01300 NURSING ADMINISTRATION 0 13.00 30, 798 13.00 01400 CENTRAL SERVICES & SUPPLY 39, 858 14.00 14 00 0 15.00 01500 PHARMACY 0 391 11, 758 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 19 54, 715 16.00 Ω 01700 SOCIAL SERVICE 0 17.00 0 0 0 17.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 20, 218 30.364 463 30.00 03100 INTENSIVE CARE UNIT 0 o 31.00 0 31.00 0 04400 SKILLED NURSING FACILITY 44.00 0 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 00000000 434 3, 689 50.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 1, 309 54.00 54.00 C 06000 LABORATORY 4, 908 60.00 0 63 60.00 65.00 06500 RESPIRATORY THERAPY 0 24 0 7,677 65.00 0 06600 PHYSI CAL THERAPY 66.00 0 51 2, 436 66.00 67 00 06700 OCCUPATIONAL THERAPY 0 0 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 C 0 Ω 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 38, 847 0 2, 420 71.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 11, 754 10, 592 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 0 1, 466 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 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 0 30, 798 39, 858 54, 715 118. 00 118.00 11, 758 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 190. 00 000000000000000 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

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0 194. 08

0 194. 09

0 194, 10

0 194. 11

0 201, 00

54, 715 202. 00

200. 00

194.06 07956 CONTACT CENTER

194. 09 07958 VISITOR MEALS

200.00

201.00

202.00

194. 07 07957 CENTRALIZED ADMISSIONS DEPT

194. 08 07959 OTHER NONREI MBURSABLE - OPEN

194. 10 07962 OTHER NONRELMBURSABLE COST CENTERS

Cross Foot Adjustments

Negative Cost Centers

194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION

TOTAL (sum lines 118-201)

ALLUCA	ITION OF CAPITAL RELATED COSTS		Provider		om 09/01/2015 o 08/31/2016	Part II Date/Time Prepared: 1/13/2017 9:58 am
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown	Total	
		17. 00	24. 00	Adjustments 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 14. 00 15. 00 16. 00 17. 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 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	29, 681				1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
30.00	03000 ADULTS & PEDI ATRI CS	29, 681	1, 366, 042	0	1, 366, 042	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0	0	31.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		29, 619	0	29, 619	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	13, 350		13, 350	54.00
60.00	06000 LABORATORY	o	86, 877	0	86, 877	60.00
65.00	06500 RESPIRATORY THERAPY	o	24, 866	0	24, 866	65. 00
66, 00	06600 PHYSI CAL THERAPY	o	262, 429		262, 429	66. 00
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	0	52, 110	o o	52, 110	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	40, 033		40, 033	73. 00
	07400 RENAL DIALYSIS	0	8, 445	l o	8, 445	74. 00
	OUTPATIENT SERVICE COST CENTERS	-1	-,		-,,	
90.00	09000 CLI NI C	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0		0	91.00
	OTHER REIMBURSABLE COST CENTERS				'	
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98. 00
	SPECIAL PURPOSE COST CENTERS					
118.00		29, 681	1, 883, 771	0	1, 883, 771	118. 00
400.00	NONREI MBURSABLE COST CENTERS			1	2	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	192.00
	07950 NONALLOWABLE CLINICAL LIAISON	0	333	0	333	194. 00
	07951 I DLE SPACE	0	0		0	194. 01
	07952 REGIONAL OFFICE	0	0	0	0	194. 02
	07953 DI STRI CT OFFI CE	0	0	0	0	194. 03
	07954 NON MCR CERTIFIED UNIT 07955 REG NURSG OFFICE	0	0	0	0	194. 04 194. 05
	07956 CONTACT CENTER	0	0	0	0	194. 06
	07957 CENTRALIZED ADMISSIONS DEPT		0	0	0	194. 07
	07959 OTHER NONREIMBURSABLE - OPEN		0		0	194. 07
	07958 VISITOR MEALS		0	0	0	194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS		0	l o	ol O	194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	ا	n	ő	o	194. 11
200.00			0	ő	0	200. 00
201.00	, ,		0	ő	o	201. 00
202.00		29, 681	1, 884, 104		1, 884, 104	202. 00
		. '			'	•

					From 09/01/2015 Fo 08/31/2016	Date/Time Pre 1/13/2017 9:5	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVI CE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT OO500 ADMINISTRATIVE & GENERAL OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE	18, 213 211 1, 010 0	18, 213 211 1, 010	7, 813, 300		19, 356, 940 334, 392 79, 239	7. 00
9. 00 10. 00	00900 HOUSEKEEPING 01000 DI ETARY	0	0	34, 643	0 0	88, 434 346, 374	9. 00
11. 00 13. 00 14. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0 200 398	0 200 398	72, 71	0	774, 963 131, 185	13. 00 14. 00
15. 00 16. 00 17. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 481 270	0 481 270	396, 152	0	752, 758 601, 048 262, 418	16. 00
30. 00 31. 00 44. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04400 SKILLED NURSING FACILITY	12, 393 0 0	12, 393 0		0	0	31.00
44.00	ANCI LLARY SERVI CE COST CENTERS	0		′1	<u> </u>	<u> </u>	1 44.00
50. 00 54. 00 60. 00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0 0 680	0 0 680) (0	1	54. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 2, 570	2, 570	928, 329		1, 305, 197 1, 140, 572 1, 138, 241	65. 00
67. 00 68. 00 71. 00	O6700 OCCUPATIONAL THERAPY O6800 SPEECH PATHOLOGY O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	0		0 0 0	0 0 836, 709	68. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	1, 364, 831 538, 575	1
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0	0		0 0		
95. 00 98. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS	0	0				
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	18, 213	18, 213	7, 794, 466	-3, 478, 462	19, 334, 937	118. 00
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0) (0 0	0	190. 00 192. 00
194. 01	07950 NONALLOWABLE CLINICAL LIAISON 07951 IDLE SPACE 07952 REGIONAL OFFICE	0 0	0 0 0	18, 834		0	194. 00 194. 01 194. 02
194. 04	07953 DISTRICT OFFICE 07954 NON MCR CERTIFIED UNIT 07955 REG NURSG OFFICE	0	0) (0 0	0	194. 03 194. 04 194. 05
194. 06 194. 07	07956 CONTACT CENTER 07957 CENTRALIZED ADMISSIONS DEPT	0	0		0 0	0	194. 06 194. 07
194. 09	07959 OTHER NONREIMBURSABLE - OPEN 07958 VISITOR MEALS 07962 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0 0 0	0	194. 08 194. 09 194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments	0	C		0	l	194. 11 200. 00 201. 00
202.00	Part I)	1, 170, 053 64. 242739	561, 694 30. 840279			3, 478, 462 0. 179701	
204.00	Cost to be allocated (per Wkst. B, Part II)	04. 242/39	30. 040279	20, 062	2	250, 842	204. 00
205.00	Unit cost multiplier (Wkst. B, Part			0. 002568	3	0. 012959	205. 00

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 152012 Peri od: Worksheet B-1 From 09/01/2015 08/31/2016 Date/Time Prepared: 1/13/2017 9:58 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET (MEALS SERVED) (CAFETERI A PLANT (SQUARE FEET (PATIENT DAYS) #4) FTES) #3) 8.00 9.00 11.00 10.00 7.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 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 5.00 00700 OPERATION OF PLANT 16, 992 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 14, 905 8.00 00900 HOUSEKEEPI NG 9.00 0 16, 992 9.00 10.00 01000 DI ETARY 0 25, 421 10.00 11.00 01100 CAFETERI A 114 11.00 0 01300 NURSING ADMINISTRATION 13.00 13.00 200 C 200 0 8 14.00 01400 CENTRAL SERVICES & SUPPLY 398 C 398 0 2 14.00 15.00 01500 PHARMACY C 0 15.00 01600 MEDICAL RECORDS & LIBRARY 481 481 0 16.00 C 16.00 01700 SOCIAL SERVICE 17.00 270 0 270 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 70 30.00 03000 ADULTS & PEDIATRICS 12, 393 14, 905 12, 393 25, 421 30.00 03100 INTENSIVE CARE UNIT 31.00 31 00 0 0 04400 SKILLED NURSING FACILITY 0 44.00 0 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 O Ω 54 00 54 00 0 60.00 06000 LABORATORY 680 0 680 2 60.00 06500 RESPIRATORY THERAPY 65.00 0 14 65.00 66 00 06600 PHYSI CAL THERAPY 2 570 2 570 Ω 66 00 06700 OCCUPATIONAL THERAPY 67.00 0 C 0 0 67.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 0 71.00 o 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω 0 0 73 00 07400 RENAL DIALYSIS 74.00 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C Э 0 0 0 0 90.00 09100 EMERGENCY 0 0 0 0 91.00 91.00 0 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 16, 992 14, 905 16, 992 25, 421 114 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192 00 r 194.00 07950 NONALLOWABLE CLINICAL LIAISON 000000000000 0 0 0 0 0 0 0 0 0 0 0 194.00 194. 01 07951 I DLE SPACE 0 0 194. 01 194. 02 07952 REGIONAL OFFICE 0 194, 02 0 0 194. 03 07953 DISTRICT OFFICE 0 0 0 194. 03 194.04 07954 NON MCR CERTIFIED UNIT 0 194. 04 194. 05 07955 REG NURSG OFFICE 0 194. 05 194.06 07956 CONTACT CENTER 0 0 194. 06 194. 07 07957 CENTRALIZED ADMISSIONS DEPT 0 194. 07 194. 08 07959 OTHER NONREI MBURSABLE - OPEN 0 194. 08 0 194. 09 07958 VISITOR MEALS 0 194, 09 C 0 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 10 194. 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, 394, 483 93, 478 104, 326 408, 618 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 23. 215807 6. 271587 6. 139713 16.074033 0.000000 203.00 0 204.00 204.00 Cost to be allocated (per Wkst. B, 4,333 1,027 1, 146 4,578 Part II) 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.255002 0.068903 0.067444 0.180087 111)

Kindred Hospital Northwest Indiana In Lieu of Form CMS-2552-10

Provider CCN: 152012 Period: From 09/01/2015 Period: From 09/01/2015 Period: From 09/01/2015 Period: Period: From 09/01/2015 Period: P

COST Center Description	
CONTEND CONT	00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
CONTED CROSS CROST CRO	00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
REQUIS REVENUE	14, 905 1 14, 905 3 0 3
CEMERAL SERVICE COST CENTERS 13.00	14, 905 1 14, 905 3 0 3
GENERAL SERVICE COST CENTERS	14, 905 1 14, 905 3 0 3
2. 00	14, 905 14, 905 3 0 3
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	14, 905 14, 905 3 0 3
5. 00	14, 905 14, 905 3 0 3
7. 00 00700 OPERATI ON OF PLANT S. 00 00800 LAUNDRY & LI NEN SERVI CE O 00900 HOUSEKEEPI NG 10. 00 1000 DI ETARY O 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 71 14. 00 01400 CENTRAL SERVI CES & SUPPLY O 858, 475 15. 00 01500 PHARMACY O 8, 414 1, 365, 243 16. 00 01600 MEDI CAL RECORDS & LI BRARY O 400 O 82, 280, 743 17. 00 O 1700 SOCI AL SERVI CE O 0 O 0	14, 905 14, 905 3 0 3
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINISTRATI ON 71 14. 00 01100 CAFETERI A 15. 00 01500 PHARMACY 0 858, 475 15. 00 01500 PHARMACY 0 8, 414 1, 365, 243 16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 400 0 82, 280, 743 17. 00 01700 SOCI AL SERVICE 05 COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 905 14, 905 3 0 3
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01300 NURSI NG ADMIN ISTRATI ON 13. 00 01300 NURSI NG ADMIN ISTRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LIBRARY 17. 00 01700 SOCIA LISERVI CE 18. 00 01700 SOCIA LISERVI CE 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 905 14, 905 3 0 3
11. 00	14, 905 14, 905 0 3
13. 00 01300 NURSING ADMINISTRATION 71 14. 00 01400 CENTRAL SERVICES & SUPPLY 0 858, 475 15. 00 01500 PHARMACY 0 85, 414 1, 365, 243 16. 00 01600 MEDICAL RECORDS & LIBRARY 0 400 0 82, 280, 743 17. 00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 1NPATI ENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 70 9, 973 412 30, 405, 494 31. 00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 44. 00 04400 SKI LLED NURSING FACILITY 0 0 0 0 0 0 0 ANCILLARY SERVICE COST CENTERS 50. 00 05000 DERRATING ROOM 1 0 0 5, 547, 859 54. 00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 5, 547, 859 65. 00 05000 PERSPIRATORY 1 0 1, 353 0 7, 380, 632 65. 00 06000 LABORATORY 0 1, 353 0 7, 380, 632 65. 00 06000 LABORATORY 0 1, 107 0 3, 662, 775 67. 00 06000 PERSPIRATORY THERAPY 0 1, 107 0 3, 662, 775 67. 00 06700 OCCUPATIONAL THERAPY 0 1, 107 0 3, 662, 775 67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 07300 DRUGS CHARGED TO PATIENTS 0 836, 709 0 3, 639, 206 673. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0, 3, 639, 206 674. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 00 0 0 0 0 01 0 0 0 0 01 0 0 0 0	14, 905 14, 905 0 3
14, 00 01400 CENTRAL SERVICES & SUPPLY 0 858, 475 1, 365, 243 1, 365, 243 1, 360, 001600 MEDICAL RECORDS & LI BRARY 0 400 0 0 0 0 0 0 0	14, 905 1 14, 905 3 0 3
15. 00	14, 905 14, 905 3 0 3
16. 00	14, 905 1 14, 905 3 0 3
17. 00	14, 905 1 14, 905 3 0 3
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 70 9,973 412 30,405,494 31. 00 03100 INTENSI VE CARE UNI T 0 0 0 0 0 0 0 0 0	14, 905 3 0 3
31.00	0 3
44. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 1 0 0 5, 547, 859 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 1, 968, 068 60. 00 06000 LABORATORY 0 1, 353 0 7, 380, 632 65. 00 06500 RESPI RATORY THERAPY 0 519 0 11, 543, 913 66. 00 06600 PHYSI CAL THERAPY 0 1, 107 0 3, 662, 775 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 836, 709 0 3, 639, 206 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 1, 364, 831 15, 927, 659 74. 00 07400 RENAL DI ALYSI S 0 0 0 1, 364, 831 15, 927, 659 0. 00 09000 CLI NI C 0 0 0 0 0 91. 00 09100 EMERGENCY 0	0 4
Solid Discord Discor	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 1, 968, 068 60. 00 06000 LABORATORY 0 1, 353 0 7, 380, 632 65. 00 06500 RESPI RATORY THERAPY 0 519 0 11, 543, 913 66. 00 06600 PHYSI CAL THERAPY 0 1, 107 0 3, 662, 775 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1, 364, 831 15, 927, 659 74. 00 07400 RENAL DI ALYSI S 0 0 0 2, 205, 137 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0700 OPSDOI AMBULANCE SERVI CES 0 0 0 0	0 5
60. 00	0 5 0 5
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66. 00 06600 PHYSI CAL THERAPY 0 1, 107 0 3, 662, 775 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 836, 709 0 3, 639, 206 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 1, 364, 831 15, 927, 659 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 2, 205, 137 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09100 EMERGENCY 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0THER REI MBURSABLE COST CENTERS 95. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 SPECI AL PURPOSE COST CENTERS	0 6
68. 00	0 6
71. 00	0 6
73. 00	0 6
74. 00	0 7
OUTPATIENT SERVICE COST CENTERS O	0 7
90. 00	
OTHER REI MBURSABLE COST CENTERS 95. 00	0 9
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 9
98. 00 O O O O O O O O O O O O O O O O O O	
SPECIAL PURPOSE COST CENTERS	0 9
	9
118.00 SUBTOTALS (SUM OF LINES 1-117) 71 858,475 1,365,243 82,280,743	14, 905 11
NONREI MBURSABLE COST CENTERS	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0	0 19
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0	0 19
194. 00 07950 NONALLOWABLE CLINICAL LIAISON 0 0 0	0 19
194. 01 07951 I DLE SPACE 0 0 0 0 194. 02 07952 REGI ONAL OFFI CE 0 0 0 0	0 19 0 19
194. 03 07953 DI STRI CT OFFI CE 0 0 0 0	0 19
194. 04 07954 NON MCR CERTIFIED UNIT 0 0 0	0 19
194. 05 07955 REG NURSG OFFICE 0 0 0	0 19
194.06 07956 CONTACT CENTER 0 0 0 0	0 19
194.07 07957 CENTRALIZED ADMISSIONS DEPT 0 0 0 0	0 19
194. 08 07959 OTHER NONREI MBURSABLE - OPEN	0 19
194. 09 07958 VI SI TOR MEALS 0 0 0 0 0 0 194. 10 07962 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0	0 19 0 19
194. IOIO7962 OTHER NONRETMBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 11 07961 NONRETMB NEW BUSINESS IMPLEMENTATION 0 0 0 0	
200.00 Cross Foot Adjustments	∩ l1Q
201.00 Negative Cost Centers	0 19 20
202.00 Cost to be allocated (per Wkst. B, 920,096 166,443 889,660 723,255	
Part I)	20
	20 20 317, 501 20
204.00 Cost to be allocated (per Wkst. B, 30,798 39,858 11,758 54,715 Part II)	20 20 317, 501 20 . 301644
	20 20 317, 501 20
	20 20 317, 501 20 . 301644

COMPUTA	TION OF RATIO OF COSTS TO CHARGES	·	Provi der		Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Pre 1/13/2017 9:5	pared: 8 am
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
	NEATHERT BOUTING OFFICE OF COST OFFICE	1.00	2. 00	3.00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS	10.004.504	ı	10.004.50		10.07/.100	
	03000 ADULTS & PEDI ATRI CS	10, 334, 534		10, 334, 53	41, 954	10, 376, 488	
	03100 INTENSIVE CARE UNIT	0			0	0	31.00
	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	0.0/0.054	ı	0.040.05	4 0	0.040.054	F0 00
	05000 OPERATING ROOM	2, 363, 351		2, 363, 35		2, 363, 351	
1	05400 RADI OLOGY-DI AGNOSTI C	1, 113, 468	ł .	1, 113, 46		1, 113, 468	1
	06000 LABORATORY	1, 624, 842		1, 624, 84		1, 625, 875	1
	06500 RESPI RATORY THERAPY	1, 447, 106	ł .	1, 447, 10		1, 469, 007	•
	06600 PHYSI CAL THERAPY	1, 450, 639	0	1, 450, 63	9	1, 450, 639	
1	06700 OCCUPATIONAL THERAPY	0	0			0	67. 00
	D6800 SPEECH PATHOLOGY D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1 101 277	0	1 101 27	0	1 101 277	68. 00 71. 00
	07300 DRUGS CHARGED TO PATTENTS	1, 181, 277		1, 181, 27		1, 181, 277	
1		2, 639, 488 654, 740		2, 639, 48		2, 639, 488	•
	07400 RENAL DIALYSIS DUTPATIENT SERVICE COST CENTERS	034,740		654, 74	0 12, 924	667, 664	74.00
	09000 CLINIC	0			ol ol	0	90.00
	09100 EMERGENCY	0			0 0	0	91.00
	OTHER REIMBURSABLE COST CENTERS				0 0	0	71.00
	09500 AMBULANCE SERVICES					0	95. 00
1	09850 OTHER REIMBURSABLE COST CENTERS	0			0	0	98.00
200.00	Subtotal (see instructions)	22, 809, 445	0	22, 809, 44	5 77, 812	•	
200.00	Less Observation Beds	22,007,445		22,009,44	0 77,012		201.00
201.00	Total (see instructions)	22, 809, 445	0	22, 809, 44	5 77, 812		
202.00	Total (See Thistractions)	22,007,443	1	22,007,44	5 11,012	22,007,237	1202.00

Health Financial Systems Kindred Hospital Northwest Indiana In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 152012 Peri od: Worksheet C From 09/01/2015 Part I 08/31/2016 Date/Time Prepared: 1/13/2017 9:58 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 30, 405, 494 30, 405, 494 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 0. 425993 0.000000 50.00 5, 547, 859 5, 547, 859 50.00 05000 OPERATING ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 968, 068 1, 968, 068 0.565767 0.000000 54.00 60.00 06000 LABORATORY 7, 380, 632 7, 380, 632 0. 220149 0.000000 60.00 06500 RESPIRATORY THERAPY 11, 543, 913 0.125357 65.00 11, 543, 913 0 0.000000 65.00 06600 PHYSI CAL THERAPY 0 3, 662, 775 0.396049 0.000000 66.00 3, 662, 775 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 3, 639, 206 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 639, 206 0 0.324597 0.000000 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 15, 927, 659 0 15, 927, 659 0.165717 0.000000 73.00 07400 RENAL DIALYSIS 2, 205, 137 2, 205, 137 0. 296916 0.000000 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0.000000 0.00000091.00 OTHER REIMBURSABLE COST CENTERS

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82, 280, 743

82, 280, 743

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82, 280, 743

82, 280, 743

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95.00

98.00

200.00

201.00

202. 00

95.00

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201.00

202.00

09500 AMBULANCE SERVICES

98.00 09850 OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

			10 00/31/2010	1/13/2017 9:58 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 O4400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 425993			50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 565767			54. 00
60. 00 06000 LABORATORY	0. 220289			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 127254			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 396049			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. 324597			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 165717			73. 00
74. 00 07400 RENAL DIALYSIS	0. 302777			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

1, 181, 277

2, 639, 488

22, 809, 445

22, 809, 445

0

654, 740

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77, 812

77, 812

12, 924

1, 181, 277

2, 639, 488

667, 664

0 90.00

0

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0 98.00

22, 887, 257 200. 00

22, 887, 257 202. 00

71.00

73.00

74.00

91.00

95.00

0 201.00

1, 181, 277

2, 639, 488

22, 809, 445

22, 809, 445

654, 740

0

0

0

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

09850 OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

09500 AMBULANCE SERVICES

07400 RENAL DIALYSIS

09000 CLI NI C

09100 EMERGENCY

71.00

73.00

74.00

90.00

91.00

95.00

98.00

200.00

201.00

202.00

Health Fi	nancial Systems Kind	dred Hospital No	rthwest India	na	In Lie	u of Form CMS-2	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES	·	Provi der		Period: From 09/01/2015 To 08/31/2016		
			Ti t	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03	000 ADULTS & PEDIATRICS	30, 405, 494		30, 405, 49	4		30. 00
31. 00 03	100 INTENSIVE CARE UNIT	0			0		31. 00
44. 00 04	400 SKILLED NURSING FACILITY	0			0		44. 00
	CILLARY SERVICE COST CENTERS						
50.00 05	OOO OPERATING ROOM	5, 547, 859	0	5, 547, 85	9 0. 425993	0.000000	50.00
	400 RADI OLOGY-DI AGNOSTI C	1, 968, 068	0	1, 968, 06		0. 000000	
60.00 06	000 LABORATORY	7, 380, 632	0	7, 380, 63	2 0. 220149	0.000000	60.00
65. 00 06	500 RESPI RATORY THERAPY	11, 543, 913	0	11, 543, 91	3 0. 125357	0.000000	65. 00
66. 00 06	600 PHYSI CAL THERAPY	3, 662, 775	0	3, 662, 77	5 0. 396049	0.000000	66. 00
67. 00 06	700 OCCUPATIONAL THERAPY	0	0		0. 000000	0.000000	67. 00
68. 00 06	800 SPEECH PATHOLOGY	0	0		0. 000000	0.000000	68. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 639, 206	0	3, 639, 20	6 0. 324597	0.000000	71. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	15, 927, 659	0	15, 927, 65	9 0. 165717	0.000000	73. 00
74. 00 07	400 RENAL DIALYSIS	2, 205, 137	0	2, 205, 13	7 0. 296916	0.000000	74.00
OU ⁻	TPATIENT SERVICE COST CENTERS						
90.00 09	000 CLI NI C	0	0		0. 000000	0. 000000	90.00
91.00 09	100 EMERGENCY	0	0		0. 000000	0.000000	91.00
ОТІ	HER REIMBURSABLE COST CENTERS						
95. 00 09	500 AMBULANCE SERVICES	0	0		0. 000000	0. 000000	95. 00
98. 00 09	850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0. 000000	98. 00
200.00	Subtotal (see instructions)	82, 280, 743	0	82, 280, 74	3		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	82, 280, 743	0	82, 280, 74	3		202. 00

				1/13/2017 9:58 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
60. 00 06000 LABORATORY	0. 000000			60. 00
65. 00 06500 RESPIRATORY THERAPY	0. 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 DIALYSIS	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 Kir	ndred Hospital N	Northwest India	na	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 09/01/2015 To 08/31/2016		narodi
				10 00/31/2010	1/13/2017 9:5	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,	-	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 366, 042	. 0	1, 366, 04	2 14, 905	91. 65	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)	1, 366, 042		1, 366, 04	14, 905		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	11, 626	1, 065, 523		·		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)	11, 626	1, 065, 523				200. 00

Health Financial Systems Kind	dred Hospital N	lorthwest India	na	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od:	Worksheet D	
				From 09/01/2015		
				To 08/31/2016	Date/Time Pre 1/13/2017 9:5	
Title XVIII Hospital PPS						O alli
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)		ĺ	
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	29, 619	5, 547, 859	0.00533	9 3, 516, 682	18, 776	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 350	1, 968, 068	0. 00678	1, 841, 140	12, 488	54. 00
60. 00 06000 LABORATORY	86, 877	7, 380, 632	0. 01177	1 5, 660, 959	66, 635	60.00
65. 00 06500 RESPIRATORY THERAPY	24, 866	11, 543, 913	0.00215	4 8, 214, 835	17, 695	65.00
66. 00 06600 PHYSI CAL THERAPY	262, 429	3, 662, 775	0. 07164	8 2, 833, 532	203, 017	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	52, 110	3, 639, 206	0. 01431	9 2, 977, 585	42, 636	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	40, 033	15, 927, 659	0. 00251	3 11, 902, 114	29, 910	73. 00
74. 00 07400 RENAL DIALYSIS	8, 445	2, 205, 137	0. 00383	0 1, 711, 903	6, 557	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000			90.00
91. 00 09100 EMERGENCY	0	0	0.00000	0	0	91. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.00000	0 0	0	98. 00
200.00 Total (lines 50-199)	517, 729	51, 875, 249		38, 658, 750	397, 714	200. 00

Health Financial Systems Kind	dred Hospital N	lorthwest India	ina	In Li∈	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS		CCN: 152012	Period: From 09/01/2015 To 08/31/2016	Date/Time Pre 1/13/2017 9:5	
			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	at Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C)	0 0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	l c		0	0	31.00
44.00 04400 SKILLED NURSING FACILITY	0	l c			0	44.00
200.00 Total (lines 30-199)	0	l c		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
		·		Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7.00	8.00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	14, 905	0.00	11, 62	26 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	1	ol o		44.00
200.00 Total (lines 30-199)	14, 905	l .	11, 62	26 0		200. 00

Health Financial Systems Kindred Hospital Northwest Indiana In Lieu of Form CMS-2552-10							
APP0RT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der	CCN: 152012	Peri od:	Worksheet D	
THROUG	H COSTS				From 09/01/2015		
					To 08/31/2016	Date/Time Pre 1/13/2017 9:5	pared:
			Ti +	e XVIII	Hospi tal	PPS	o alli
	Cost Center Description	Non Physician				Total Cost	
	oost center bescriptron	Anesthetist	ival strig scribble	Airred fiedi	Medi cal	(sum of col 1	
		Cost			Education Cost		
		0031			Eddod (1 on oost	4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			•		•	
50.00	05000 OPERATI NG ROOM	0	(D	0 0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		ol .	0 0	0	54.00
60.00	06000 LABORATORY	0		ol .	0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0		o	0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0		o	0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		o	0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0		o	0 0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		o	0 0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		o	0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0		o	0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	(O	0 0	0	90.00
91.00	09100 EMERGENCY	0	(O	0 0	0	91.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98. 00
200.00	Total (lines 50-199)	0		o	0 0	0	200. 00

APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 152012 Peri od: From 09/01/2015	Heal th	Health Financial Systems Kindred Hospital Northwest Indiana In Lieu of Form CMS-2552-10							
To 08/31/2016 Date/Time Prepared: 1/13/2017 9: 58 am PPS	APPORT	TONMENT 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			
Total Outpatient Out				Ti +I	e XVIII	Hosni tal		o alli	
Outpatient Cost (sum of Col (sum of Sul (sum of Col (sum of Sul (sum of Col (sum of Sul		Cost Center Description	Total						
Cost (sum of col 2, 3 and 4)		cost center beserver on							
Col 2, 3 and 4 A Col 2, 3 and 4 A Col 3, 7 Col 6 + col 3, 7 Col 6 + col 3, 7 Col 6, 4 Col 7, 3 Col 6, 4 Col 7, 3 Col 6, 4 Col 7, 3 Col 7,									
A) 7) 6.00 7.00 8.00 9.00 10.00							onal ges		
ANCILLARY SERVICE COST CENTERS S. 00 7. 00 8. 00 9. 00 10. 00				",	''				
ANCILLARY SERVICE COST CENTERS				7. 00	8, 00	• • • • • • • • • • • • • • • • • • • •	10. 00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 1, 968, 068 0.000000 0.000000 1, 841, 140 54. 00 60. 00 06000 LABORATORY 0 7, 380, 632 0.000000 0.000000 5, 660, 959 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 11, 543, 913 0.000000 0.000000 8, 214, 835 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 3, 662, 775 0.000000 0.000000 2, 833, 532 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0.000000 0.000000 0.000000 0.000000 0.68.00 68. 00 06800 SPEECH PATHOLOGY 0 0 0.000000 0.000000 0.000000 0.000000 0.68.00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3, 639, 206 0.000000 0.000000 0.000000 2, 977, 585 71.00 74. 00 07400 RENAL DI ALYSI S 0 2, 205, 137 0.000000 0.000000 1, 711, 903 74.00 0THER REI MBURSABLE COST CENTERS 0		ANCILLARY SERVICE COST CENTERS							
60. 00	50.00	05000 OPERATING ROOM	0	5, 547, 859	0.00000	0. 000000	3, 516, 682	50.00	
65. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 968, 068	0.00000	0. 000000	1, 841, 140	54.00	
66. 00 06600 PHYSI CAL THERAPY 0 3, 662, 775 0.000000 0.000000 2, 833, 532 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0.000000 0.000000 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0.000000 0.000000 0 68. 00 071.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 3, 639, 206 0.000000 0.000000 2, 977, 585 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 15, 927, 659 0.000000 0.000000 11, 902, 114 73. 00 74. 00 07400 RENAL DI ALYSI S 0 2, 205, 137 0.000000 0.000000 1, 711, 903 74. 00 000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.00000	60.00	06000 LABORATORY	0	7, 380, 632	0.00000	0. 000000	5, 660, 959	60.00	
67. 00	65.00	06500 RESPIRATORY THERAPY	0	11, 543, 913	0.00000	0. 000000	8, 214, 835	65. 00	
68. 00	66.00	06600 PHYSI CAL THERAPY	0	3, 662, 775	0.00000	0. 000000	2, 833, 532	66. 00	
71. 00	67.00	06700 OCCUPATI ONAL THERAPY	0	O	0.00000	0. 000000	0	67. 00	
73. 00	68.00	06800 SPEECH PATHOLOGY	0	0	0.00000	0. 000000	0	68. 00	
74. 00 07400 RENAL DI ALYSI S 0 2, 205, 137 0.000000 0.000000 1, 711, 903 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 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 639, 206	0.00000	0. 000000	2, 977, 585	71. 00	
OUTPATIENT SERVICE COST CENTERS O O O O O O O O O	73.00	07300 DRUGS CHARGED TO PATIENTS	0	15, 927, 659	0.00000	0. 000000	11, 902, 114	73. 00	
90. 00	74.00	07400 RENAL DIALYSIS	0	2, 205, 137	0.00000	0. 000000	1, 711, 903	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 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 95. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0.000000 0.000000 0 98. 00	90.00	09000 CLI NI C	0	0	0.00000	0. 000000	0	90. 00	
95. 00	91.00	09100 EMERGENCY	0	0	0.00000	0. 000000	0	91. 00	
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0		OTHER REIMBURSABLE COST CENTERS							
	95.00	09500 AMBULANCE SERVICES						95. 00	
200. 00 Total (Lines 50-199) 0 51, 875, 249 38, 658, 750 200. 00	98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.00000	0. 000000	0	98. 00	
	200.00	Total (lines 50-199)	0	51, 875, 249			38, 658, 750	200. 00	

Health Financial Systems	Kindred Hospital North	west Indiana	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 152012	From 09/01/2015	Worksheet D Part IV Date/Time Prepared: 1/13/2017 9:58 am

							1/13/201/ 9:5	am <u>8</u> د
				Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	0ut	patient	Outpati ent			
		Program	Р	rogram	Program			
		Pass-Through	C	harges	Pass-Through			
		Costs (col. 8			Costs (col. 9			
		x col. 10)			x col. 12)			
		11. 00		12.00	13.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0		0)		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0)		54.00
60.00	06000 LABORATORY	0		0		O		60.00
65.00	06500 RESPI RATORY THERAPY	0		0		O		65.00
66.00	06600 PHYSI CAL THERAPY	0		0		O		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0		O		67. 00
68. 00	06800 SPEECH PATHOLOGY	0		0		O		68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		O		71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0		O		73. 00
74.00	07400 RENAL DIALYSIS	o		0		O		74. 00
	OUTPATIENT SERVICE COST CENTERS							Ī
90.00	09000 CLI NI C	0		0	()		90. 00
91.00	09100 EMERGENCY	o		0		O		91. 00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES							95. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	l o		0		o		98. 00
200.00	Total (lines 50-199)	0		0		D		200. 00

Heal th	Financial Systems Kindred Hospital North	west Indiana	In Lie	u of Form CMS-2	2552-10		
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 152012	Peri od:	Worksheet D-1			
	From 09/01/2015 To 08/31/2016 E						
		Title XVIII	Hospi tal	1/13/2017 9: 5 PPS	o an		
	Cost Center Description	THE XVIII	nospi tui	110			
				1. 00			
	PART I - ALL PROVIDER COMPONENTS						
	I NPATI ENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		14, 905	1.00		
2.00	Inpatient days (including private room days, excluding swing-be			14, 905	2. 00		
3.00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	71	3. 00		
	do not complete this line.						
4. 00	Semi-private room days (excluding swing-bed and observation bed			14, 834	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private roor	n days) through Decembe	r 31 of the cost	0	5. 00		
	reporting period			_			
6.00	Total swing-bed SNF type inpatient days (including private roor	n days) after December	31 of the cost	0	6. 00		
7. 00	reporting period (if calendar year, enter 0 on this line)	daya) +brayab Dagamban	21 of the cost	0	7. 00		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period						
8.00	Total swing-bed NF type inpatient days (including private room	0	8. 00				
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00				
9.00	Total inpatient days including private room days applicable to	11, 626	9. 00				
	newborn days)	,					
10.00							
	through December 31 of the cost reporting period (see instructi	ons)	,				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, en						
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12. 00		
40.00	through December 31 of the cost reporting period				40.00		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00		
14. 00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program			0	14. 00		
15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed	uays)	0			
16. 00	Nursery days (title V or XIX only)			0			
10.00	SWING BED ADJUSTMENT				10.00		
17. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost	0.00	17. 00		
	reporting period	o in ough becomes of e		0.00			
18. 00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18. 00		
	reporting period						
19.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00		
	reporting period						
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00		
	reporting period				21. 00		
21. 00							
22. 00							
22.00	5 x line 17)	11 of the cost mar	a ported (lir- (^	22.00		
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	or the cost reportin	g period (rine 6	0	23. 00		
	A TITIE 10)						

		1. 00	
	PART I - ALL PROVIDER COMPONENTS		4
	I NPATI ENT DAYS	44.005	-
00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14, 905	
00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14, 905	
00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	71	
	do not complete this line.		
00	Semi-private room days (excluding swing-bed and observation bed days)	14, 834	
00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0)
	reporting period		
00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	
	reporting period (if calendar year, enter 0 on this line)		
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	1
	reporting period		
00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	
	reporting period (if calendar year, enter 0 on this line)		
00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	11, 626	
	newborn days)		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	1
	through December 31 of the cost reporting period (see instructions)	_	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	1
00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	1
00	through December 31 of the cost reporting period	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	1
. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	1
. 00	Total nursery days (title V or XIX only)	0	1
. 00	Nursery days (title V or XIX only)	0	
. 00	SWING BED ADJUSTMENT	U	' '
00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	1
00	reporting period	0.00	Ί'
. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	1
. 00	reporting period	0.00	Ί'
. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	1
	report in g peri od	0.00	'
. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	1 2
	reporting period		
. 00	Total general inpatient routine service cost (see instructions)	10, 376, 488	2
. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	1 2
	5 x line 17)		
. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	2
	x line 18)		
. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	2
	7 x line 19)		
. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	2
	x line 20)		
. 00	Total swing-bed cost (see instructions)	0	
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10, 376, 488	1 2
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	00 105 101	١.
. 00		30, 405, 494	
. 00	Private room charges (excluding swing-bed charges)	189, 499	
	Semi-private room charges (excluding swing-bed charges)	30, 215, 995	1 .
. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 341270	
. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	2, 669. 00	
. 00		2, 036. 94	
. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	632.06	
. 00	Average per diem private room cost differential (line 34 x line 31)	215. 70	
. 00	Private room cost differential adjustment (line 3 x line 35)	15, 315	
. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	10, 361, 173	3
	27 minus line 36)		-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		+
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	/0/ 17	١,
. 00	Adjusted general inpatient routine service cost per diem (see instructions)	696. 17	
	Program general inpatient routine service cost (line 9 x line 38)	8, 093, 672	
	Medically necessary private room cost applicable to the Program (Line 14 v Line 25)	/\	
0.00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 8, 093, 672	

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 152012	Peri od: From 09/01/2015	Worksheet D-1		
					To 08/31/2016	Date/Time Pre	pared:	
			Ti tl	e XVIII	Hospi tal	1/13/2017 9: 5 PPS	8 am	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)		
		1.00	2.00	3.00	4. 00	5. 00		
42. 00	NURSERY (title V & XIX only)						42. 00	
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.0	00 0	0	43.00	
44. 00	CORONARY CARE UNIT	0		0.	50	0	44.00	
	BURN INTENSIVE CARE UNIT						45. 00	
	SURGICAL INTENSIVE CARE UNIT						46. 00	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1. 00		
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	I, line 200)			9, 411, 597	48. 00	
	Total Program inpatient costs (sum of lines			ons)		17, 505, 269	49. 00	
FO 00	PASS THROUGH COST ADJUSTMENTS			W	6.0	4 0/5 500	F0 00	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (Tron	n WKST. D, Sur	n or Parts I and	1, 065, 523	50.00	
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	397, 714	51.00	
	and IV)							
52. 00 53. 00	Total Program excludable cost (sum of lines !	,	lated non phy	eician anosti	notict and	1, 463, 237 16, 042, 032		
33.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program di scharges					0		
	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00	
57. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (1	ine 56 minus	line 53)			
58. 00	Bonus payment (see instructions)	ing cost and to	inger amount (i	THE CO III HGS	11110 00)	ő		
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, เ	updated and co	ompounded by the	0.00	59. 00	
40.00	market basket Lesser of lines 53/54 or 55 from prior year of	act ropert ur	datad by the m	markat backat		0.00	60.00	
60. 00 61. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	1	
01.00	which operating costs (line 53) are less than					Ĭ	01.00	
	amount (line 56), otherwise enter zero (see i	nstructions)			Ü			
	Relief payment (see instructions)					0		
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63.00	
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00	
	instructions)(title XVIII only)							
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the d	cost reportin	g period (See	0	65. 00	
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66. 00	
	CAH (see instructions)	·	·		3,			
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	of the cost re	eporting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after [ecember 31 of	the cost ren	orting period	0	68. 00	
00.00	(line 13 x line 20)	2 00010 4. 10. 2			or ering porrod		00.00	
69. 00	Total title V or XIX swing-bed NF inpatient i					0	69. 00	
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU				<u> </u>	Γ	70.00	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	-			1		71.00	
72. 00	Program routine service cost (line 9 x line)		2 . 2	,			72.00	
73. 00	Medically necessary private room cost applica		•	,			73. 00	
74. 00	Total Program general inpatient routine servi	•					74.00	
75. 00	Capital-related cost allocated to inpatient (routine service	costs (from V	vorksheet B, l	art II, column		75. 00	
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00	
	Program capital -related costs (line 9 x line						77. 00	
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00	
	Aggregate charges to beneficiaries for excess				11 70)		79.00	
8U. UU	Total Program routine service costs for compa	arison to the c	:ust iimitatior	i ciine /8 Mii	ius Line 791	l .	80.00	

		Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
1.00 2.00 3.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00			Inpatient Cost	Inpatient Days			(col. 3 x col.	
MINISTRY (CHE IV A XIX ONLY)			1.00	2.00		4.00		
Internsive Curr Type Input on Hospitul Units	42.00	NUDCEDY (+i +l o V o VIV only)	1.00	2.00	3.00	4.00	5.00	42.00
INTERSIVE CARE WIT	42.00							42.00
44.00 CORDINARY CARE UNIT	43 00		0	0	0.00	0	0	43 00
45.00 BURNEL NITES IVEC CARE UNIT			0	0	0.00	0	U	
3.00 SURGICAL INTERSIVE CARE UNIT 46.00 Cost Conter Description 1.00								
47.00 OTHER SPECIAL CASE (SPECIFY) 47.00 COST Center Description 1.00								
Cost Centre Description 1.00 Program Impatient ancillary service cost (Mist. D-3. col. 3, line 200) 9. 48. 00 Program Impatient costs (sun of lines 41 through 48) (see instructions) 9. 49. 49. 00 Intra-1 Program Impatient costs (sun of lines 41 through 48) (see instructions) 9. 49. 49. 00 Intra-1 Program Impatient costs (sun of lines 41 through 48) (see instructions) 9. 49. 49. 00 Intra-1 Program Impatient costs (sun of lines 50 and 51) 9. 49. 49. 00 Intra-1 Program Impatient costs (sun of lines 50 and 51) 9. 40. 40. 40. 40. 40. 40. 40. 40. 40. 40								
1.00	17.00	. ,						17.00
48.00 Program Inpatient ancillary service cost (West D-3, col. 3, line 200) 9,411,597 48.00 Poss THROUGH COST ADJUSTNERTS 17,555,269 49.00 Poss Through Costs applicable to Program Inpatient routine services (from West, D. sum of Parts II and 1.065,522 50.00 Poss Through Costs applicable to Program Inpatient ancillary services (from West, D. sum of Parts II and 1.065,522 50.00 Poss Through Costs applicable to Program Inpatient ancillary services (from West, D. sum of Parts II and 1.065,522 50.00 Poss Through Costs applicable to Program Inpatient ancillary services (from West, D. sum of Parts II and 1.065,522 50.00 Poss Through Costs applicable to Program Inpatient poss (services of Costs) 16,042,032 50.00 Poss Through Costs (services of Costs) 16,042,032 50.00 16,042		occi contor boson per on					1. 00	
	48. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	3. line 200)				48. 00
MASS_INKOUGH_COSI_ADJUSTNEWIS					ons)			
50.00 Pass through costs applicable to Program inpatient routine services (From West. D., sum of Parts I and I 1, 066,523 50.00 1115 1				`				
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II and IV)	50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	1, 065, 523	50.00
and IV) 1,463,237 52.00 Total Program excludable cost (sum of lines 50 and 51) 1,463,237 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and ended aducation costs (line 49 minus line 52) 16,042,032 53.00		111)						
10.10 Total Program excludable cost (sum of lines 50 and 51) 1.463,237 52.00 1.60	51. 00	Pass through costs applicable to Program inpa	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	397, 714	51.00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and need and exclusion costs (line 44 minus line 52)								
medical education costs (line 49 minus line 52) TARKET ANDUM FAND LIMIT COMPUTATION Sh. 00 Program discharges 0.00 55.00 55.00 Toget amount per discharges 0.00 55.00 Toget amount (line 54 x line 55) 0.00 55.00 Toget amount (line 54 x line 55) 0.00 55.00 Toget amount (line 54 x line 55) 0.00 55.00 Toget amount (see instructions) 0.00 57.00 Toget amount (see instructions) 0.00 57.00 Toget amount (see instructions) 0.00 59.00 Toget amount (see instructions) 0.00 59.00 Toget amount (see instructions) 0.00 59.00 Toget amount (see instructions) 0.00 Toget amount (se								
TARGET ANOUNT AND LIMIT COMPUTATION 54.00 55.00 18 54.00 18 54.00 18 54.00 18 54.00 18 54.00 18 54.00 18 55.00 18 54.00 18 55.00 18 54.00 18 55.00 1	53. 00			elated, non-phy	/sician anesthe	tist, and	16, 042, 032	53. 00
54.00 Program discharges 0.0 54.00 55.00 Target amount from discharge 0.0 55.00 55.00 Target amount from discharge 0.0 55.00 55.00 Target amount from discharge 0.0 55.00 55.00 Target amount from discharges 0.0 55.0			52)					
1.00 Target amount (pine 54 x line 55) 0.00 55.00 0.00								
56.00 Target amount (Tine 54 x Tine 55) 57.00 Briference between adjusted inpatient operating cost and target amount (Tine 56 minus Tine 53) 58.00 Bonus payment (see instructions) 59.00 Lesser of Tines 53/54 or 55 from the cost reporting period ending 19%, updated and compounded by the market basket 0.00 Color of the start of t								
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 8.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the morket basket 0.00 6.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the morket basket 0.00 6.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 Lesser of lines 53/54 or 55 from prior year costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see Instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see Instructions) 0 64.00 Lesser of lines 63/64 or 10 Market 10 Lesser of 10 Lesser								
88.00 Bonus payment (see instructions) 9. 58.00 8.00 Bonus payment (see instructions) 9. 59.00 8.00 Bonus payment (see instructions) 9. 59.00 8.00 Bonus payment (see instructions) 9. 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 9. 60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 8. 62.00 Rice for payment (see instructions) 8. 63.00 All owable Inpatient cost plus incentive payment (see instructions) 8. 63.00 All owable Inpatient cost plus incentive payment (see instructions) 8. 64.00 All owable Inpatient cost plus incentive payment (see instructions) 8. 65.00 All owable Inpatient cost plus incentive payment (see instructions) 8. 65.00 All owable Inpatient cost plus incentive payment (see instructions) 8. 65.00 All owable Inpatient could not pay the payment (see instructions) 8. 65.00 Bonus payment (see instructions) 8. 65.00 All owable Inpatient could not pay the payment (see instructions) 8. 65.00 All owable Inpatient routine costs after December 31 of the cost reporting period (See instructions) 8. 65.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Comparison of the cost reporting period (see instructions) 8. 65.00 Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see instructions) 8. 67.00 Total Medicare swing-bed NF inpatient routine costs (line 67 - line 68) 8. 68.00 Total Medicare swing-bed NF inpatient routine costs (line 67 - line 68) 8. 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 - line 68) 8. 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 - line 68) 8. 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 - line 68) 8. 69.00 Total title V		,			. =			
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 19%, updated and compounded by the market basket 0.00 60.00		1	ing cost and ta	irget amount (I	ine 56 minus I	ine 53)		
market basket 0.00 (0.00 If lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 (0.00 If lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (lite XVII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (lite XVII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (lite XVIII only) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 69.00 Total ititle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine scosts (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine scosts (line 72 + line 73) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Program routine service cost (line 9 x line 71) 70.00 Program routine service cost (line 9 x line 71) 70.00 Program capital related costs (line 9 x line 77) 70.00 Program capital related costs (line 9 x line 77) 70.00 Total Program general inpatient routine service costs (from provider records) 80.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatie		1						
60.00 Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 61.00 61.10	59. 00		porting period	ending 1996, u	updated and com	pounded by the	0.00	59.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus Incentive payment (see instructions) 64.00 Medicare Swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) (see instructions) (see ins	40.00		oost roport ur	datad by the m	arkat backat		0.00	40.00
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78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine service costs (see instructions) 83. 00 Program inpatient ancillary services (see instructions) 84. 00 Utilization review - physician compensation (see instructions) 85. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Oscillatory 89. 00 Oscillatory 89		1						
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		,	•					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine service costs (see instructions) 80.00 Reasonable inpatient routine service costs limitation (line 78 minus line 79) 81.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 81.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 82.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 82.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 82.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 82.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 82.00 Reasonable inpatient routine service cost limitation (line 81) 82.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.		1 '	,					
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reason					*.	70)		
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Porgram inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 89.00				cost limitation	n (line 78 minu	s line 79)		
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 84.00 85.00 85.00 85.00		· ·						
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reservation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reservation bed days (see instructions)		1 .		* .				
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Occurrence of the content of the cost per diem (line 27 ÷ line 2) 88.00 Occurrence of the cost per diem (line 27 ÷ line 2) 89.00 Occurrence of the cost per diem (line 27 ÷ line 2)				15)				
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 86.00 86.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			,	nc)				
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00								
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	oo. uu			ii ougii 65)				ou. UU
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	Q7 OO						0	97 OO
				line 2)				
	23.00	(300)					١	

Health Financial Systems Kind	dred Hospital N	Northwest India	na	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 09/01/2015 To 08/31/2016	Date/Time Pre 1/13/2017 9:5	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	1, 366, 042	10, 376, 488	0. 13164	8 0	0	90. 00
91.00 Nursing School cost	C	10, 376, 488	0.00000	o o	0	91.00
92.00 Allied health cost	C	10, 376, 488	0.00000	ol o	0	92. 00
93.00 All other Medical Education	(10, 376, 488	0. 00000	ol o	0	93. 00

Heal th	Financial Systems Kindred Hospital Northwes	st Indiana	In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST PI	rovider CCN: 152012	Peri od:	Worksheet D-1		
			From 09/01/2015 To 08/31/2016	Date/Time Pre 1/13/2017 9:5		
		Title XIX	Hospi tal	Cost		
	Cost Center Description			1 00		
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, ex	kcluding newborn)		14, 905	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed a	and newborn days)		14, 905	2. 00	
3. 00	Private room days (excluding swing-bed and observation bed days). do not complete this line.	If you have only pri	vate room days,	71	3. 00	
4.00	Semi-private room days (excluding swing-bed and observation bed days	ays)		14, 834	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private room dareporting period	ays) through December	31 of the cost	0	5. 00	
6. 00						
7. 00						
8.00						
9. 00	Total inpatient days including private room days applicable to the newborn days)	0	9. 00			
10. 00						
11. 00						
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only through December 31 of the cost reporting period		e room days)	0	12. 00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX onlafter December 31 of the cost reporting period (if calendar year,			0	13. 00	
14. 00	Medically necessary private room days applicable to the Program (0	14. 00	
15. 00	Total nursery days (title V or XIX only)	sker daring swring bed t	ady 5)	0		
16. 00	Nursery days (title V or XIX only)			0		
	SWING BED ADJUSTMENT		'			
17. 00	Medicare rate for swing-bed SNF services applicable to services threporting period	nrough December 31 of	the cost	0. 00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to services af reporting period	fter December 31 of	the cost	0. 00	18. 00	
19. 00	Medicaid rate for swing-bed NF services applicable to services thr reporting period	rough December 31 of	the cost	0. 00	19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to services aft reporting period	ter December 31 of th	ne cost	0. 00	20. 00	
21. 00	Total general inpatient routine service cost (see instructions)			10, 334, 534	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December 31 5 x line 17)	1 of the cost reporti	ng period (line	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December 31 ox line 18)	of the cost reportino	g period (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through December 31	of the cost reportin	ng period (line	0	24. 00	

	COST CERTER DESCRIPTION	1. 00	
	PART I - ALL PROVIDER COMPONENTS	11.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14, 905	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14, 905	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	71	3. 00
	do not complete this line.	4.00.	
4.00	Semi-private room days (excluding swing-bed and observation bed days)	14, 834	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	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	· ·	7.00
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	0	9. 00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	U	12.00
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)	· ·	10.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10 00
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
20.00	reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10, 334, 534	21. 00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
23.00	x line 20)	O	25.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10, 334, 534	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	30, 405, 494	28. 00
29.00	Private room charges (excluding swing-bed charges)	189, 499	29. 00
	Semi-private room charges (excluding swing-bed charges)	30, 215, 995	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 339890	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	2, 669. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	2, 036. 94	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	632.06	
35. 00	Average per diem private room cost differential (line 34 x line 31)	214. 83	
36. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	15, 253 10, 319, 281	36.00
37. 00	27 minus line 36)	10, 319, 281	37. 00
	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)	692. 34	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	0	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00

	Financial Systems Kind ATION OF INPATIENT OPERATING COST	dred Hospital N		CCN: 152012	Peri od: From 09/01/2015			
						Date/Time Pre 1/13/2017 9:5		
	Coot Contan Decementian	Total	Total	le XIX Average Per	Hospi tal	Cost		
	Cost Center Description		Inpatient Days			Program Cost (col. 3 x col. 4)		
		1.00	2. 00	3.00	4. 00	5. 00		
42. 00	NURSERY (title V & XIX only)						42. 00	
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.0	00 0	0	43.00	
44. 00	CORONARY CARE UNIT			,			44. 00	
45.00	BURN INTENSIVE CARE UNIT						45. 00	
	SURGICAL INTENSIVE CARE UNIT						46. 00	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00	
	cost center bescription					1.00		
48. 00	Program inpatient ancillary service cost (Wks					0		
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instruction	ons)		0	49. 00	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	sarvicas (from	n Wket D sum	of Parts I and	1 0	50.00	
30.00	III)	atrent routine	services (110	ıı wkst. D, Suii	TOT TALLS I AND		30.00	
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (fr	rom Wkst. D, s	um of Parts II	0	51. 00	
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				0	52. 00	
53.00	Total Program inpatient operating cost exclud		elated, non-phy	sician anesth	etist, and	0	53.00	
	medical education costs (line 49 minus line !							
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	1	
57.00	Difference between adjusted inpatient operati	ing cost and ta	irget amount (I	ine 56 minus	line 53)	0		
	Bonus payment (see instructions)					0		
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996, t	updated and co	mpounded by the	0.00	59. 00	
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0.00	60.00	
61.00	If line 53/54 is less than the lower of lines					0	61. 00	
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	the target			
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62.00	
	Allowable Inpatient cost plus incentive payme	ent (see instru	ıcti ons)			0		
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	ner 31 of the d	rost renortino	neriod (See	0	65. 00	
00.00	instructions)(title XVIII only)	to arter become		oost roportring	perrou (occ		00.00	
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66. 00	
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	a costs through	December 31 (of the cost re	norting period	0	67.00	
07.00	(line 12 x line 19)	e costs till ougi	i becember 31 c	i the cost re	portring perrou	0	07.00	
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31 of	the cost repo	rting period	0	68. 00	
(0.00	(line 13 x line 20)		(1: /7 1:	. (0)			40.00	
69.00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU		0	69.00				
70. 00	Skilled nursing facility/other nursing facili		70. 00					
71. 00	Adjusted general inpatient routine service co	ost per diem (I	ine 70 ÷ line	2)			71. 00	
72. 00	Program routine service cost (line 9 x line						72. 00	
73.00	Medically necessary private room cost applicated Dragger general innetiant routing applications		•	,			73.00	
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•			art II column		74. 00 75. 00	
75.00	26. line 45)	outine Service	CUSIS (IIUII V	IOI KSHEEL D, F	art II, COTUIIII		/3.00	
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00	
77. 00	Program capital-related costs (line 9 x line						77. 00	
	Inpatient routine service cost (line 74 minus			4-2			78. 00 79. 00	
79 00								

Health Financial Systems Kin	dred Hospital	Northwest India	na	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 09/01/2015 To 08/31/2016		pared: 8 am
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 366, 042	10, 334, 534	0. 13218	2 0	0	90. 00
91.00 Nursing School cost		10, 334, 534	0.00000	0	0	91.00
92.00 Allied health cost		10, 334, 534	0.00000	0	0	92. 00
93.00 All other Medical Education		10, 334, 534	0. 00000	0	0	93. 00

	Financial Systems Kinc TONMENT OF COST OF SERVICES RENDERED BY INTER	dred Hospital N		CCN: 152012 P	eriod: rom 09/01/2015	Worksheet D-2 Date/Time Pre 1/13/2017 9:5 Health Care	pared:
	Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day AII Patients	Average Cost Per Day	Program Inpatient Days Title V	
	T	1.00	2. 00	3.00	4. 00	5. 00	
1. 00	PART I - NOT IN APPROVED TEACHING PROGRAM Total cost of services rendered	0.00	C	\			1.00
1.00	Hospital Inpatient Routine Services:	0.00		ή			1.00
2.00	ADULTS & PEDI ATRI CS	0.00	C	14, 905	0.00	0	2. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Subtotal (sum of lines 2 through 8)	0.00	c	0	0.00	0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY	0. 00	C	0	0. 00	0	10. 00 11. 00 12. 00 13. 00 14. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY CMHC AMBULATORY SURGICAL CENTER (D.P.) HOSPICE Subtotal (sum of lines 9 through 19)	0.00	C				15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
20.00	Justotal (Sull of Titles 7 through 17)	0.00		,		Titles V and	20.00
						XIX Outpatient and Title XVIII Part B Charges	
	Cost Center Description			(from Worksheet C. Part I, column 8, lines 88 through 93)		Title V	
	Washi tal Outnati ant Sarvi ses	1.00	2.00	3. 00	4. 00	5. 00	
	Hospital Outpatient Services: RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER Subtotal (sum of lines 21 through 26) Total (sum of lines 20 and 27)	0. 00 0. 00 0. 00 0. 00	C	0	0. 000000 0. 000000		21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
	Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22 1.00	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients 4.00		
	PART II - IN AN APPROVED TEACHING PROGRAM (TI					3.00	
	Hospital Inpatient Routine Services:	,			,		
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	C C			0. 00 0. 00 0. 00	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
35. 00 36. 00 37. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Subtotal (sum of lines 29, and 32 through 36)	0		0			35. 00 36. 00 37. 00
38. 00 39. 00 40. 00 41. 00 42. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY Total (sum of lines 37 through 41)	0		0		0.00	38. 00 39. 00 40. 00 41. 00 42. 00

Heal th	Financial Systems Kin	dred Hospi tal	Northwest India	na	In Lieu	u of Form CMS-2	2552-10
APPORT	TONMENT OF COST OF SERVICES RENDERED BY INTER	RNS AND RESIDI	ENTS Provi der	CCN: 152012	Peri od: From 09/01/2015	Worksheet D-2	
		_				Date/Time Pre 1/13/2017 9:5	
		Not In	Approved Teachin	g Program	In Approved Tea	aching Program	
	Cost Center Description	(from	Part I:)	Amount	(from Part II,	, col. 7, -)	
			1. 00	2.00	3.0	00	
	PART III - SUMMARY FOR TITLE XVIII (TO BE CO	1		AND II ARE US			
	Hospi tal						
43.00	Inpatient	col. 9, line	9. 00		0 line 37.00		43. 00
44. 00	Outpati ent	col. 9, line	27. 00		0		44. 00
45.00	Total Hospital (sum of lines 43 and 44)				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, line	13. 00		0col. 9, line 41	. 00	49. 00

	Financial Systems Kind TONMENT OF COST OF SERVICES RENDERED BY INTER	dred Hospital N NS AND RESIDEN ⁻		CCN: 152012 F	Period: From 09/01/2015 Fo 08/31/2016		epared:
			re Program			1/13/2017 9:5	am
		·	nt Days				
	Cost Center Description	Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	DART I NOT IN APPROVED TEACHING PROCESS	6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART I - NOT IN APPROVED TEACHING PROGRAM Total cost of services rendered	I	I				1.00
1.00	Hospital Inpatient Routine Services:						1.00
2.00	ADULTS & PEDI ATRI CS	11, 626	ł .		0	O	
3.00	INTENSIVE CARE UNIT	0	0		0	0	
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						4. 00 5. 00
6.00	SURGICAL INTENSIVE CARE UNIT						6. 00
7. 00	OTHER SPECIAL CARE (SPECIFY)						7. 00
8.00	NURSERY			,		O	8. 00 9. 00
9. 00 10. 00	Subtotal (sum of lines 2 through 8) SUBPROVIDER - IPF			,		C	10.00
11. 00	SUBPROVI DER - I RF						11. 00
12.00	SUBPROVI DER						12. 00
13. 00 14. 00	SKILLED NURSING FACILITY NURSING FACILITY	0	0	(0	0	13.00
15. 00	OTHER LONG TERM CARE						15. 00
16.00	HOME HEALTH AGENCY						16. 00
17. 00	CMHC						17. 00
18. 00 19. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						18. 00 19. 00
20. 00	4						20.00
		Titles V and >			nd XIX Outpatier (VIII Part B Cos		
			rges	<i>'</i>	WIII FAIL D COS	, t	
	Coot Conton Decement on	Title XVIII	Title XIX	Title V	Title XVIII	Title XIX	
	Cost Center Description	Part B			Part B		
	Hospital Outpatient Services:	6. 00	7. 00	8. 00	9. 00	10.00	
21. 00	RURAL HEALTH CLINIC						21. 00
22. 00	4						22. 00
23. 00	4	0			0	0	
24. 00 25. 00	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(0	0	24. 00 25. 00
26. 00	OTHER OUTPATIENT SERVICE COST CENTER						26. 00
27. 00	Subtotal (sum of lines 21 through 26)				0	0	
28. 00	Total (sum of lines 20 and 27)		_				28. 00
	Cost Center Description	Title XVIII Part B	Expenses Applicable to	PSA Adj. Interns &			
		Inpatient Days		Resi dents			
			(col. 5 x col.				
		4 00	6)	11 00	_		
	PART II - IN AN APPROVED TEACHING PROGRAM (T	6.00 TLE XVIII, PAR	7.00 T B INPATIENT	11.00 ROUTINE COSTS	ONLY)		
	Hospital Inpatient Routine Services:				,		
29. 00	ADULTS & PEDIATRICS	0			D		29. 00
30. 00 31. 00	Swing Bed - SNF Swing Bed - NF	0	0				30.00
32. 00	INTENSIVE CARE UNIT	0	0				32.00
33. 00	CORONARY CARE UNIT	1	1	1			33. 00
34 00			l .				34 00

24.00	EMERGENCY	0	0	0	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)						25. 00
26.00	OTHER OUTPATIENT SERVICE COST CENTER						26. 00
27.00	Subtotal (sum of lines 21 through 26)			0	0	0	27. 00
28. 00	Total (sum of lines 20 and 27)						28. 00
	Cost Center Description	Title XVIII	Expenses	PSA Adj.			
			Applicable to	Interns &			
		Inpatient Days	Title XVIII	Resi dents			
			(col. 5 x col.				
			6)				
		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:	_	_	_	I		
	ADULTS & PEDI ATRI CS	0	0	0			29. 00
	Swing Bed - SNF	0	0				30.00
	Swing Bed - NF	_	_	_			31. 00
	I NTENSI VE CARE UNIT	0	0	0			32. 00
	CORONARY CARE UNIT						33. 00
	BURN INTENSIVE CARE UNIT						34.00
	SURGI CAL INTENSI VE CARE UNI T						35. 00
	OTHER SPECIAL CARE (SPECIFY)		_	_			36. 00
37. 00	Subtotal (sum of lines 29, and 32 through 36)		O	0			37. 00
38.00	SUBPROVI DER - I PF						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			42. 00

Health Financial Systems Kin	dred Hospital No	orthwest Indiana	In Lie	u of Form CMS-255	2-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	RNS AND RESIDENTS	S Provider CCN: 152012	Peri od:	Worksheet D-2	
			From 09/01/2015 To 08/31/2016	Data /Tima Dranar	- o.d.
			10 08/31/2016	Date/Time Prepar 1/13/2017 9:58 a	eu: am
	In Approved	Total Title XVIII	Costs	17 107 2017 71 00 0	
	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 US	SED)		
Hospi tal	,				
43.00 Inpati ent	0		0		3. 00
44.00 Outpatient					4. 00
45.00 Total Hospital (sum of lines 43 and 44)	0 1	ine 22	0	4!	5. 00
46. 00 SUBPROVI DER - I PF				4.	6. 00
47. 00 SUBPROVI DER - I RF					7. 00
48. 00 SUBPROVI DER				48	8. 00
49.00 SKILLED NURSING FACILITY	0	ine 22	0	49	9. 00

111 41-	Figure in Contains			1 1:-	£ F CMC :	2552 40
	Financial Systems Kindred Hospital Northwent ANCILLARY SERVICE COST APPORTIONMENT		CCN: 152012	Period:	u of Form CMS-2 Worksheet D-3	
	ENT ANGILLARI SERVICE GOST AFFORTIONWENT			From 09/01/2015 To 08/31/2016	Date/Time Pre 1/13/2017 9:5	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col.	
				onal goo	2)	
			1.00	2. 00	3. 00	
	I NPATIENT ROUTINE SERVICE COST CENTERS		•			
30.00	03000 ADULTS & PEDI ATRI CS			23, 610, 643		30.00
31.00	03100 I NTENSI VE CARE UNI T			0		31. 00
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATI NG ROOM		0. 42599			
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 56576			
60.00	06000 LABORATORY		0. 22028			60.00
65. 00	06500 RESPI RATORY THERAPY		0. 1272			65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 39604		1, 122, 218	
67. 00	06700 OCCUPATI ONAL THERAPY		0.00000		0	07.00
68. 00	06800 SPEECH PATHOLOGY		0.00000		0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 32459			
	07300 DRUGS CHARGED TO PATIENTS		0. 1657			
74. 00	07400 RENAL DIALYSIS		0. 3027	77 1, 711, 903	518, 325	74. 00
	OUTPATIENT SERVICE COST CENTERS		T	1		
90.00	09000 CLI NI C		0.00000		0	
91. 00	09100 EMERGENCY		0.00000	00 0	0	91. 00
05 00	OTHER REIMBURSABLE COST CENTERS		1			05 00
95. 00 98. 00	O9500 AMBULANCE SERVICES O9850 OTHER REIMBURSABLE COST CENTERS		0. 00000	20	0	95. 00 98. 00
200.00			0.00000			
200.00		ino (1)		38, 658, 750		200.00
201.00		THE 61)		38, 658, 750		201.00
202.00	net charges (Title 200 militus Title 201)		I	30, 038, 730	I	1202.00

Part I

Peri od:

From 09/01/2015

08/31/2016 Date/Time Prepared: 1/13/2017 9:58 am Title XVIII Hospi tal PPS Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 16, 732, 120 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 11/23/2016 442, 100 0 3.01 3.02 0 3.02 3.03 3.03 0 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 3.54 \cap 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 442, 100 0 3.99 3.50-3.98) 17, 174, 220 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 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) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 33 0 6.01 6 02 SETTLEMENT TO PROGRAM O 0 6.02 7.00 Total Medicare program liability (see instructions) 17, 174, 253 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0 1 00 2 00 8.00 Name of Contractor 8.00

Health Financial Systems	Kindred Hospital North	west Indiana	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152012		Worksheet E-3
			From 09/01/2015	Part IV
			To 08/31/2016	Date/Time Prepared:
				1/13/2017 9:58 am
		T: +1 - \/\/	11	DDC

				1/13/201/ 9:5	8 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			17, 494, 578	
2.00	Outlier Payments			905, 128	2. 00
3.00	Total PPS Payments (sum of lines 1 and 2)			18, 399, 706	3. 00
4.00	Nursing and Allied Health Managed Care payments (see instructio	ns)		0	4. 00
5.00	Organ acquisition (DO NOT USE THIS LINE)				5. 00
6.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	6. 00
7.00	Subtotal (see instructions)			18, 399, 706	7. 00
8.00	Pri mary payer payments			0	8. 00
9.00	Subtotal (line 7 less line 8).			18, 399, 706	9. 00
10.00	Deducti bl es			28, 196	10. 00
11.00	Subtotal (line 9 minus line 10)			18, 371, 510	11. 00
12.00	Coinsurance			1, 311, 940	12.00
13.00	Subtotal (line 11 minus line 12)			17, 059, 570	13.00
14.00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		715, 659	14.00
15.00	Adjusted reimbursable bad debts (see instructions)			465, 178	15. 00
16.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		476, 754	16. 00
17.00	Subtotal (sum of lines 13 and 15)			17, 524, 748	17. 00
18.00	Direct graduate medical education payments (from Wkst. E-4, lin	e 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
21. 99	Recovery of Accelerated Depreciation			0	21. 99
22.00	Total amount payable to the provider (see instructions)			17, 524, 748	22. 00
22. 01	Sequestration adjustment (see instructions)			350, 495	22. 01
23.00	Interim payments			17, 174, 220	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)		33	25. 00
26.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, c	hapter 1,	0	26. 00
	§115. 2	·			
	TO BE COMPLETED BY CONTRACTOR				
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	The rate used to calculate the Time Value of Money (see instruc	tions)		0.00	52. 00
53.00	Time Value of Money (see instructions)			0	53. 00
	1			1	

Health Financial Systems	Kindred Hospital North	vest Indiana	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152012	Peri od:	Worksheet E-3

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 152012	Peri od:	Worksheet E-3	
			From 09/01/2015 To 08/31/2016	Part VII Date/Time Pre	nared·
			10 00/01/2010	1/13/2017 9:5	8 am
	<u> </u>	Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
	DART VILL CALCILLATION OF REIMBURGEMENT ALL OTHER HEALTH CERV	LCEC FOR TITLES V OR V	1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	ICES FOR TITLES V OR A	IN SERVICES		
1.00	Inpatient hospital/SNF/NF services		0		1.00
2. 00	Medical and other services			0	2.00
3. 00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges				0.00
8. 00 9. 00	Routine service charges		0	0	8. 00 9. 00
10. 00	Ancillary service charges Organ acquisition charges, net of revenue		0	U	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	
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for		n 0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 42	! CFR §413.13(e)	0.000000	0.000000	15 00
15. 00 16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		0.000000	0. 000000	15. 00 16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	17. 00
17.00	line 4) (see instructions)	TT TTHE TO EXCEEdS		O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru		0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0	0	21. 00
22. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c Other than outlier payments	ompleted for PPS provi	ders.	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	O	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00 31. 00
31. 00 32. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	0	32.00
33. 00	Coinsurance		0	0	33.00
34. 00			0	0	34. 00
	Utilization review		0	_	35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	36. 00
37. 00	OTHER ADJUSTMENTS		0	0	37. 00
37. 01	OTHER ADJUSTMENTS		0	0	37. 01
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	_	39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41. 00 42. 00	Interim payments Balance due provider/program (line 40 minus line 41)		0	0	41. 00 42. 00
42.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	0	0	42.00
10.00	chapter 1, §115.2	Ono 1 ub 10 Z,		O	10.00
			,		

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

Provi der CCN: 152012

| Period: | Worksheet G | From 09/01/2015 | To 08/31/2016 | Date/Time Prepared: 1/13/2017 9:58 am

					1/13/2017 9:5	8 am
		General Fund	Speci fi c	Endowment Fund	Pl ant Fund	
			Purpose Fund			
	I	1. 00	2. 00	3. 00	4. 00	
	CURRENT ASSETS	1	1	ام		
1.00	Cash on hand in banks	-898		0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00 3. 00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	5, 735, 311	0	0	0	4. 00
5.00	Other recei vable	1, 418		0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-1, 354, 970		0	0	6. 00
7. 00	Inventory	241, 220		Ö	0	7. 00
8. 00	Prepai d expenses	124, 888		Ö	0	8. 00
9.00	Other current assets	0	0	O	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4, 746, 969	0	0	0	11. 00
	FIXED ASSETS					
12.00	Land	0			0	
13. 00	Land improvements	0		0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	
15. 00	Bui I di ngs	0		0	0	15. 00
16. 00	Accumulated depreciation	0	0	0	0	16. 00
17. 00	Leasehold improvements	186, 136		0	0	17. 00
18.00	Accumulated depreciation	-183, 568		0	0	18. 00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	U	0	21. 00
22. 00	Accumulated depreciation	2 210 007	0	U	0	22. 00
23. 00	Major movable equipment Accumulated depreciation	2, 219, 807		0	0	23. 00 24. 00
24. 00 25. 00	Mi nor equi pment depreci abl e	-1, 370, 846		0	0	25. 00
26. 00	Accumulated depreciation		0	0	0	26. 00
27. 00	HIT designated Assets		0	0	0	27. 00
28. 00	Accumulated depreciation		0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e			Ö	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	851, 529		-	0	
00.00	OTHER ASSETS	0017027		5		00.00
31.00	Investments	0	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	3, 162, 500	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3, 162, 500	0	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	8, 760, 998	0	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	653, 050			0	37. 00
38. 00	Salaries, wages, and fees payable	497, 827		0	0	38. 00
39. 00	Payroll taxes payable	49, 094	0	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	O	0	41. 00
42.00	Accel erated payments	0			0	42.00
43.00	Due to other funds	1/4 515	0	0	0	
44.00	Other current liabilities	164, 515		_		44. 00 45. 00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	1, 364, 486	0	0	U	45.00
46. 00	Mortgage payable	0	0	O	0	46. 00
47. 00	Notes payable	Ö	_	0	0	47. 00
48. 00	Unsecured Loans	0	Ö	Ö	0	48. 00
49. 00	Other long term liabilities	-9, 295, 703		o	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	-9, 295, 703		0	0	50. 00
51.00	Total liabilities (sum of lines 45 and 50)	-7, 931, 217			0	
	CAPITAL ACCOUNTS					
52.00	General fund balance	16, 692, 215				52.00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
F0	repl acement, and expansi on	4, ,,,,				F0 0-
59.00	Total fund balances (sum of lines 52 thru 58)	16, 692, 215		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	8, 760, 998	0	O	0	60. 00
	J 7 /	I	I	ı I		l

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Kindred Hospital Northwest Indiana

Provider CCN: 152012 | Peri od: | Worksheet G-1 | From 09/01/2015 | To 08/31/2016 | Date/Time Prepared:

					10		1/13/2017 9:58	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	J dill
		1. 00	2.00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		15, 120, 271			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1, 571, 948					2.00
3.00	Total (sum of line 1 and line 2)		16, 692, 219			0		3.00
4.00	Additions (credit adjustments)	0			0		0	4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0			0		0	5.00
6.00		0			0		0	6.00
7.00		o			0		0	7.00
8.00		o			0		0	8.00
9.00		o			0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		16, 692, 219			0		11.00
12.00	Deductions (debit adjustments)	o			0		0	12.00
13. 00	INTERCOMPANY TRANSFERS\ROUNDING	4			0		ol	13. 00
14. 00		ol			0		ol	14.00
15. 00		0			0		0	15. 00
16. 00		o			0		0	16. 00
17. 00		o			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)	1	4			0	_	18. 00
19. 00	Fund balance at end of period per balance		16, 692, 215			0		19. 00
	sheet (line 11 minus line 18)		,,			_		
		Endowment Fund	PI ant	Fund				
		Endowment Fund		Fund				
		Endowment Fund 6.00	PI ant 7. 00	Fund 8. 00				
1. 00	Fund balances at beginning of period				0			1. 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6.00			0			1. 00 2. 00
		6.00			0			
2.00	Net income (loss) (from Wkst. G-3, line 29)	6.00						2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00						2. 00 3. 00
2.00 3.00 4.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments)	6.00						2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments)	6.00						2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments)	6.00						2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments)	6.00						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments)	6.00						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9)	6.00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) INTERCOMPANY TRANSFERS\ROUNDING	6.00			0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total deductions (sum of lines 12-17)	6.00			0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 152012 Peri od: Worksheet G-2 From 09/01/2015 Parts I & II Date/Time Prepared: 08/31/2016 1/13/2017 9:58 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 30, 405, 494 30, 405, 494 1.00 2.00 SUBPROVIDER - IPF 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) 30, 405, 494 30, 405, 494 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) 17.00 30, 405, 494 30, 405, 494 17.00 Total inpatient routine care services (sum of lines 10 and 16) 18.00 Ancillary services 51, 875, 249 51, 875, 249 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 82, 280, 743 82, 280, 743 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 28.00 G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 29.00 23, 146, 218 29.00 0 30.00 ADD (SPECIFY) 30.00 0 31.00 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 DEDUCT (SPECIFY) 37.00 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 23, 146, 218 43.00

to Wkst. G-3, line 4)

			u of Form CMS-2552-10		
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 152012	Peri od:	Worksheet G-3	
			From 09/01/2015 To 08/31/2016	Date/Time Pre	narod:
			10 00/31/2010	1/13/2017 9:5	
				1. 00	
1.00	.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			82, 280, 743	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			57, 580, 932	2.00
3.00	Net patient revenues (line 1 minus line 2)			24, 699, 811	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			23, 146, 218	4.00
5.00	Net income from service to patients (line 3 minus line 4)			1, 553, 593	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	00 Revenues from telephone and other miscellaneous communication services			0	8. 00
9.00	.00 Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			3, 882	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	00 Revenue from Laundry and Linen service			0	13.00
14.00	00 Revenue from meals sold to employees and guests			0	14.00
15.00	00 Revenue from rental of living quarters			0	15.00
16.00	O Revenue from sale of medical and surgical supplies to other than patients			0	16.00
17.00	O Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			2, 813	18.00
19.00	0 Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	00 Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
	MI SCELLANEOUS I NCOME			11, 660	
25. 00				18, 355	
26. 00	Total (line 5 plus line 25)			1, 571, 948	
27 00	OTHER EXPENSES			0	

28. 00

0 27. 00

1, 571, 948 29. 00

27. 00 OTHER EXPENSES

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)