Health Financial Systems Kind	lred Hospital No	rthwest Indiana		In Lie	u of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CF	• • • •				
payments made since the beginning of the cost repor	ting period beir	ng deemed overpay	yments (42	USC 1395g).	OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO	RT CERTIFICATION	I Provider CCN:	15-2012	Period:	Worksheet S
AND SETTLEMENT SUMMARY				From 09/01/2017 To 08/31/2018	Parts I-III Date/Time Prepared:
					12/10/2018 3:21 pm
PART I - COST REPORT STATUS					
Provider 1. [X] Electronically filed cost repuse only 2. [] Manually submitted cost report				Date:	Time:
3. [ 0] If this is an amended report 4. [ F] Medicare Utilization. Enter "	enter the numbe	r of times the p 'L" for low.	orovider re	submitted this c	ost report
Contractor 5. [1]Cost Report Status 6. Date	Recei ved:			PR Date:	
use only (1) As Submitted 7. Contr	actor No.	For this Dravida	11. C	ontractor's Vend	or Code: 4
(2) Settled without Audit 8. [N] (3) Settled with Audit 9. [N]	Final Report fo	r this Provider	CCN 12. L		mes reopened = 0-9.
(4) Reopened				fidiniber of th	
(5) Amended					
PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI		THIS COST DEDOD			
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND					
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O					
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA	Y RESULT.				
CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	ADMI NI STRATOR	OF PROVIDER(S)			
I HEREBY CERTIFY that I have read the above	certification	statement and th	at I have	examined the acc	ompanyi ng
electronically filed or manually submitted					
Expenses prepared by Kindred Hospital North					
09/01/2017 and ending 08/31/2018 and to the					
correct, complete and prepared from the boo instructions, except as noted. I further c					
provision of health care services, and that					
compliance with such laws and regulations.					
[ ]I have read and agree with the above of	ertification st	atement. I certi	fv that I	intend my electr	oni c
signature on this certification statem					
	(Si gne	d)			
			or Adminis	strator of Provid	der(s)
			PRESIDENT C	OF REIMBURSEMENT	
		Title			
		Date			
Cast Canton Description		Title XV			
Cost Center Description	Title V 1.00	Part A 2.00	Part B 3.00	HI T 4, 00	Title XIX 5.00
PART III - SETTLEMENT SUMMARY	1.00	2.00	5.00	4.00	3.00
	0	1 265 504		0 0	0 1 00

1.00	Hospi tai	0	1, 265, 504	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	1, 265, 504	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.

PLL	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DAT	A I	Provi de	r CCN: 1	5-2012	Period: From 09/0	1/2017	Worksheet Part I	S-2
									Date/Time	
	1.00	2.0			3. 00			4.00	12/10/201	8 3:21
	Hospital and Hospital Health Care Co		50	`				4.00		
	Street: 5454 Hohman Avenue, 5th Fl.	P0 Box:								1
0	City: Hammond	State: II		p Code:			ty: Lake	D		2
		Component Nai		CCN Imber	CBSA Number	Provi de Type	r Date Certifie		ent System , O, or N)	
		1.00		. 00	3.00	4.00	5.00	V 6. 00		XI X 3. 00
	Hospital and Hospital-Based Componen		2	. 00	3.00	4.00	5.00	0.00	<u>)   7.00   c</u>	5.00
0	Hospi tal	Kindred Hospital		2012	23844	2	08/01/19	96 N	P	P 3
0	Subprovider - IPF	Northwest Indiana								4
	Subprovider - IRF									5
	Subprovider - (Other)			1						6
0	Swing Beds - SNF									7
	Swing Beds - NF									8
	Hospital-Based SNF									9
	Hospital-Based NF									10
00 00	Hospital-Based OLTC Hospital-Based HHA									11
	Separately Certified ASC									12
	Hospi tal -Based Hospi ce									14
00	Hospital-Based Health Clinic - RHC									15
00	Hospital-Based Health Clinic - FQHC			1						16
00	Hospital-Based (CMHC) I									17
	Renal Dialysis									18
00	Other						<b></b>			19
							Fro 1.		To: 2.00	
00	Cost Reporting Period (mm/dd/yyyy)						09/01		08/31/20	018 20
00	Type of Control (see instructions)							ŀ		21
00	Inpatient PPS Information	currently receive		ts for	dienron	ortionato		1	N	
00	Does this facility qualify and is it share hospital adjustment, in accord							1	IN IN	22
	for yes or "N" for no. Is this facil									
	amendment hospital?) In column 2, en				(.)	(_) (	0			
01	Did this hospital receive interim un				cost re	eporting	1	I	N	22
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to									
	for no for the portion of the cost r (see instructions)	eporting period of	ccurring o	n or ar	ter Ucto	oper I.				
02	is this a newly merged hospital that	requires final un	ncompensati	ed care	navmen	ts to be	1	I	N	22
02	determined at cost report settlement							•		
	or "N" for no, for the portion of th						-			
	in column 2, "Y" for yes or "N" for	no, for the portio	on of the o	cost re	porting	period o	n			
	or after October 1.									
	Did this hospital receive a geograph							1	N	22
	of the OMB standards for delineating									
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column									
	cost reporting period occurring on o									
	hospital contain at least 100 but no		•				h			
	42 CFR 412.105)? Enter in column 3,									
00	Which method is used to determine Me						n	2	N	23
	1, enter 1 if date of admission, 2 i method of identifying the days in th	2			0		.			
	used in the prior cost reporting per									
			In-State	In-Sta		ut-of	Out-of	Medi ca	aid Othe	er
			Medi cai d	Medi ca	aid S	State	State	HMO da	ays   Medic	ai d
			paid days	eligil		di cai d	Medi cai d		day	'S
				unpai		d days	eligible			
		-	1.00	days 2. 00		3.00	unpai d 4. 00	5.00	) 6.0	0
00	If this provider is an IPPS hospital	, enter the	0		0	<u>3.00</u> 0	4.00	5.00	0	0 24
	in-state Medicaid paid days in colum		0		Ĭ	Ĭ	0		-	) <sup>2</sup>
	Medicaid eligible unpaid days in col									
	out-of-state Medicaid paid days in c	olumn 3,								
	out-of-state Medicaid eligible unpai									
	4, Medicaid HMO paid and eligible bu									
	column 5, and other Medicaid days in		~				-		0	0-
	If this provider is an IRF, enter th Medicaid paid days in column 1, the		0		0	0	0		0	25
00	web cald bald days in collimp 1 the	in-state								
00									1	
00	Medicaid eligible unpaid days in col	umn 2,								
00		umn 2, 3, out-of-state								

SPI T <i>i</i>	Financial Systems Kindred Hosp AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		orthwest Indian Provider CC		Period: From 09/01/ To 08/31/	2017	u of For Workshe Part I Date/Ti 12/10/2	et S-2 me Pre	pared
					Urban/Rur	al S	Date of	Geogr	
00	Enter your standard geographic classification (not wa	ge) sta	atus at the bec	inning of th	1.00 e	1	2.0	0	26.0
	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 enter the effective date of the geographic reclassifi	ge) sta "2" fo	atus at the end or rural. If ap	l of the cost pplicable,		1			27.0
00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35. C
					Begi nni r	ig:	Endi		
00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for numbe	1.00 r		2.0	00	36.
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	S.				0			37.
01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the	e MDH <sup>.</sup>	transitional pa	yment in	N	Ū			37.
00	accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions) If line 37 is 1, enter the beginning and ending dates	of MDH	istatus. If li	ne 37 is					38.
	greater than 1, subscript this line for the number of enter subsequent dates.	peri o	ds in excess of	f one and					
					Y/N 1.00		Y/ 2.0		
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil- with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii eage re	)? Enter in co equirements in	lumn 1 "Y" accordance	e N		N		39.
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	er 1. I	Enter "Y" for y				Ν		40.
	no in column 2, for discharges on or after October 1.	(see i	nstructrons)		-	V	XVIII	XIX	-
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for a	di sproporti onat	e share in a	ccordance	Ν	N	N	45.
	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					Ν	N	N	46.
00	Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment					N N	N N	N N	47. 48.
	Teaching Hospitals Is this a hospital involved in training residents in a	approve	ed GME programs	? Enter "Y"	for yes	N			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 o h of tl ", comp	r "N" for no ir nis cost report plete Worksheet	n column 1. I ing period?	f column 1 Enter "Y"				57.
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemei	nt for physicia	ins' servi ces	as				58.
	Are costs claimed on line 100 of Worksheet A? If yes					N			59.
				NAHE 413.85 Y/N	5 Workshee Line #	+	Pass-Th Qualifi Criteric	cation	
00			anata for	1.00	2.00		3.0	0	
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (	see ins	structions)	N					60.
		Y/N	IME	Direct GME	IME		Di rect	GME	
00	Did your bespital receive ETE clate under ACA	1.00	2.00	3.00	4.00	0.00	5.0		21
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	
	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								61.
	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								61.
	ACA). (see instructions)								61.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΓΑ	Provider C		Period: From 09/01/2017 To 08/31/2018		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
<ul> <li>61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line)</li> </ul>						61. 04 61. 05
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	) O. 00	61. 10
51. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser				ried for which	0.00	(2.00
52.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a second secon	tions)					62.00 62.01
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ram. (s	see instructio			0.00	02.01
b3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63.00
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
			Site			
Section 5504 of the ACA Base Year FTE Residents in No	nprovi	der Settings	1.00 This base yea	2.00 2.00	<u> </u>	
period that begins on or after July 1, 2009 and befor	e June	30, 2010.				
64.00       Enter in column 1, if line 63 is yes, or your facility trained residents       0.00       0.00       0.00         in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)       0.00       0.00       0.00						64. OC
Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEsin	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2.00	3.00	4.00	5.00	-

SPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ATA Provi der		riod: om 09/01/2017	Worksheet S-2 Part I	2
			To		Date/Time Pre	pared
	Program Name	Program Code	Unweighted	Unweighted	12/10/2018 3: Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
-	1.00	2.00	Si te 3. 00	4.00	5.00	-
00 Enter in column 1, if line 63	1.00	2.00	0.00	4.00		65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of 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)						
			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	10301 181	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settir	ngsEffective fo	r cost reporti	ng periods	
FTEs attributable to rotations of Enter in column 2 the number of u						
FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column	3 the ratio of	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
FTEs that trained in your hospita	al. Enter in column <u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTËs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program	al. Enter in column <u>column 2)). (see in</u>	3 the ratio of structions)	FTĔs Nonprovi der	FTEsin	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column <u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	al. Enter in column <u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col . 3 + col . 4)) 5.00 0.000000	_
FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u>	3 the ratio of structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000	
FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u> <u>255</u> ychiatric Facility (	3 the ratio of structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000	
FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Pf 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic (see instructions)	Al. Enter in column <u>column 2)). (see in</u> Program Name 1.00 1.00 PS ychiatric Facility ( the facility have a afore November 15, 2 umn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it cor n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 ntain an IPF subplation sing program in the yes or "N" for nu sin a new teach yes or "N" for nu	FTES in Hospital 4.00 0.00 0.00 1.0 rovider? N he most b. (see ing 0.	(col . 3 + col . 4)) 5.00 0.000000	70.
FTEs that trained in your hospita (column 1 divided by (column 1 + (column 1 divided by (column 1 + ) 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)           Inpatient Psychiatric Facility Pf 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.           00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic	PS ychiatric Facility ( the facility have a effore November 15, 2 umn 2: Did this fac A 12. 424 (d)(1)(iii cate which program y y PPS nabilitation Facilit	3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it cor n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for ear began during thi	FTËs Nonprovi der Si te 3.00 0.00 number si na newteachi yes or "N" for nu s cost reporting	FTES in Hospital 4.00 0.00 0.00 1.0 rovider? N he most b. (see ing 0.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	_

Heal th	Financial Systems Kindred Hospital N	lorthwest India	na	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Pre 12/10/2018 3:	epared:
					1.00	-
	Long Term Care Hospital PPS					
80. 00 81. 00	Is this a long term care hospital (LTCH)? Enter "Y" for ye Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.	s and "N" for or all of the	no. cost reportin	g period? Enter	Y Y	80.00 81.00
	TEFRA Providers				••	
86.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i Did this facility establish a new Other subprovider (exclud §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85.00 86.00
	Is this hospital an extended neoplastic disease care hospit 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under section		Ν	87.00
				V	XIX	_
	Title V and XIX Services			1.00	2.00	
90.00	Does this facility have title V and/or XIX inpatient hospit	al services? E	nter "Y" for	N	Y	90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through			Ν	Ν	91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the app Are title XIX NF patients occupying title XVIII SNF beds (d	ual certificat			Ν	92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applic Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	Ν	93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	Ν	94.00
95 00	applicable column. If line 94 is "Y", enter the reduction percentage in the ap	nlicable colum	n	0.00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			N	N N	96.00
	If line 96 is "Y", enter the reduction percentage in the ap			0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"	nterns and res for yes or "N"	idents post for no in	Y	Y	98.00
98 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the r	eporting of ch	arges on Wkst	. Y	Y	98.01
70101	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.					
98. 02	Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			Y	Y	98. 02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a cri	tical access h	ospital (CAH)	N	N	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.					
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i			N	Ν	98.04
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in				Y	98.05
	column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	Y	98.06
	Rural Providers					
	Does this hospital qualify as a CAH?			N .		105.00
	If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)			t		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum					107.00
	yes, the GME elimination is not made on Wkst. B, Pt. I, col			t		
100.00	reimbursed. If yes complete Wkst. D-2, Pt. II.			N		100.00
	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 Sche	dulle? See 42	N		108.00
		Physi cal	Occupationa		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.					
					1.00	_
110.00	Did this hospital participate in the Rural Community Hospit				1.00 N	110.00
	Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	lf yes,		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN		Period: From 09/01/20 To 08/31/20	)17 Part I )18 Date/Ti	eet S-2 ime Prepar 2018 3:21	
		1.00	2.	00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Com Health Integration Project (FCHIP) demonstration for this cost reporting pe "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, en integration prong of the FCHIP demo in which this CAH is participating in c Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	riod? Enter ter the olumn 2.	N			11.00
		1	1.00 2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 3 either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.	"E", enter care (inclu definition	in column udes	N		15.00
I16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" I17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" no.		"N" for	N Y		16.00 17.00
I18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence.	the policy	is	1	11	18.00
craminiade. Enter 2 m the portey is occurrence.	Premiums	Losses	Insur	rance	
	1.00	2.00	3.	00	
18.01 List amounts of malpractice premiums and paid losses:	90, 01	8	0	84, 995 11	18. 0
		1.00	2.		
<ul> <li>18.02 Are malpractice premiums and paid losses reported in a cost center other th Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein.</li> <li>19.00 D0 NOT USE THIS LINE</li> </ul>		N		11	18. 0: 19. 0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru Enter in column 2, "Y" for yes or "N" for no.	for yes or Outpatient	N	Ν	N 12	20. 00
21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	charged to	N		12	21.00
22.00 Does the cost report contain healthcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		N		12	22. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f	orno.lf	N		12	25. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the certifi	cation date			12	26. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certific	ation date			12	27. 0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certific	ation date			12	28. 0
in column 1 and termination date, if applicable, in column 2. 29.001f this is a Medicare certified lung transplant center, enter the certifica	tion date ir	ו		12	29. 0
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the certified pancreas transplant center, enter the certification of the in column 2.	fication			13	30. 0
date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	ti fi cati on			13	31. 0
32.00 If this is a Medicare certified islet transplant center, enter the certific	ation date			13	32.0
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	ation date			13	33. 0
34.00 If this is an organ procurement organization (OPO), enter the OPO number in and termination date, if applicable, in column 2.	column 1			13	34.00
All Providers 40.00 Are there any related organization or home office costs as defined in CMS P chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home o		Y	189	003 14	40. 00

HOSPI FAL. ADD FRSH FAL HEALTH CARE COMPLEX IDENTIFICATION DATA         Proof der CR: 15-201         Period To 00/37/2018         Period To 00/37/2018         Period To 00/37/2018         Period To 00/37/2018           14         100         2.00         2.00         3.00         3.00         10.00           14         100         2.00         3.00         3.00         11.00         11.00           14         0.000         5.000         1.000         10.001         10.001         11.00           12         0.0001         5.0000         1.000         1.000         11.00         11.00           12         0.0001 Model INALTINEAD DIRATING         Nontractor's Ame and contractor's Ame	Health Financial Systems	Kindred Hospit	al Northwest India	na	In Lie	u of Form CMS-	2552-10		
Image: The stall by is part of a chain argsmitation, enter on Lines 141 through 143 the name and address of the name of the contractor name and contractor name and address of the name of the contractor name and contractor name and address of the name of the contractor name and contractor name and address of the name of the contractor name and contractor name and address of the name of the contractor name and contractor name and address of the name of the contractor name and contractor name and address of the name of the contractor name and contractor name and address of the name of the contractor name and contractor name and address of the name of the contractor name and contractor name andit name anamateril name and contractor name and contractor name	HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC				2		
In         1.00         In         3.00         In         3.00           If         This Rec11ity is pret of a chain organization, entrine 11 entroph 143 the mean address of the the second preters of the second preters of the the second preters of the second preters o						Date/Time Pre	epared:		
If this facility is part of a chain organization, enter on Lines 141 through 143 the name and address of the pane attrice and enter the name and address of the time of the contractor and end organization multic contractor is name.           141. 00kmar:         KLIMED REALTRORE OPENTING         Contractor's Number: 05901         141. 00           143. 00 try:         LOUISY LLE         State:         KY         Zip Code:         40002           143. 00 try:         LOUISY LLE         State:         KY         Zip Code:         40002           144. 00 Are provider based physicians' costs included in Worksheet A?         1.00         2.00         Y         146. 00           146. 00 F costs for renail services per Chain or no colum 2.         1.00         2.00         Y         146. 00           146. 00 F costs for renail services per Chain or no colum 2.         1.00         2.00         Y         146. 00           146. 00 F costs for renail services per Chain or no colum 2.         1.00         2.00         Y         146. 00           146. 00 Bit there a charge in the order of all cost order Y.         Y         Y         146. 00         Y           146. 00 Bit there a charge in the order of all cost order Y.         Y per so 'Y'' for no.         N         148. 00           146. 00 Bit there a charge in the order of all cost order Y''' for yes or 'Y'' for no.         N         N	1 00		2 00		3 00	12/10/2018 3:	21 pm		
111.00[kass:::::::::::::::::::::::::::::::::::		n organization, enter		ugh 143 the na		of the			
IIC         Display         STRVICTS         Pipe           142.001/ret         CONSTINCT         Status:         KV         Zip Code:         4022         143.00           144.001/ret         Display         Lip Code:         4022         143.00           144.001/ret         Display         Lip Code:         4022         143.00           144.001/ret         Display         Display         Y         144.00           144.001/ret         Display         Display         Y         144.00           145.001         Forces         To return         Y         144.00           146.008         Enter         Y Forces         Y         144.00           146.008         Enter         Y Forces         Y Forces         Y         146.00           146.008         Enter         Y Forces         Y Force         N         147.00         N         147.00           146.008         Enter         Y Force         Y Force         Y Force         N         147.00         N         147.00         N         147.00         N         147.00         N         N         147.00         N         N         147.00         N         N         147.00         N         N </td <td></td> <td></td> <td></td> <td></td> <td>r's Number 0590</td> <td>)1</td> <td>141 00</td>					r's Number 0590	)1	141 00		
143.00/011Y									
144.00[Are provider based physicilians" costs included in Worksheet A?     1.00     1.00     1.44.00       145.00[If costs for renal services are claimed on West. A. Line 74, are the costs for home costs for home costs for renal services and posed physicilians and the services and posed for the services of the serv				7. 0. 1	1000		1		
144.00@Arc provider based physicians' costs included in Worksheet A?       Y       144.00@Arc provider based physicians' costs included in Worksheet A?       Y       144.00@Arc provider based physicians' costs included in Worksheet A?         145.00@ If costs for renal services are yet alimed on Wet, A, Time 7A, are the costs for for an isome for the cost for for an isome account of the cost reporting period? Yet for yes or "N" for no in column 1. (See USE Public 15-2, chapter 40, 54020) IF       Y       146.00         146.00@ Ass the cost allocation methodology changed from the previously filed cost report?       N       N       N         147.00@ Ass there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       N       N         148.00@ Ass there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       N       147.00         149.00@ Ass there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       N       N       148.00         150.00@ Ass there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       N       N       N       140.00         150.00@ Ass there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       N       N       N       N       N       N       140.00         150.00@ Ass the facility contain a provider that goal files for an advision of the advision	143. 00 CITY: LOUISVILLE	State:	KY	ZIP Code:	4020	12	143.00		
It coll         It coll <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
145.00[0] F costs for renal services are claimed on Wist. A. Tine 74, are the costs for homologinal services are claimed on Wist. A. Tine 74, are the costs for this cost reporting homologinal services are claimed on Wist. A. Tine 74, are the costs for this cost reporting the cost report of this cost report of the cost report of this cost report of this cost report of this cost report of the cost report of the cost report of this cost report of the cost cost cost cost cost cost cost cost	144.00 Are provider based physicians' cos	sts included in Worksh	eet A?			Y	144.00		
Inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1. If column 1. If column 1.         Image: Column 1.					1.00	2.00	1		
no. does the diaysis facility include Medicare utilization for this cost reporting period? There ''' for yes or ''N' for no in column 2.       146.00         146.00       Base the cost allocation methodology changed from the previously filed cost report?       N       146.00         148.00       Nemer the sparraval date (mn/dd/yyyy) in column 2.       N       146.00         148.00       Nemer the sparraval date (mn/dd/yyyy) in column 2.       N       N       N         148.00       Nemer the order of allocation? Enter ''Y' for yes or 'N' for no.       N       N       N       147.00         148.00%       The order column 3.       So or 'N' for no.       N       N       N       N       149.00         149.00%       The order column 3.       So or 'N' for no.       N       N       N       N       149.00         149.00%       The order column 3.       So or 'N' for no.       N       N       N       N       N       149.00         145.00%       The order column 3.       So or 'N' for no.       N       N       N       N       N       N       N       N       N       N       N       150.00       N       N       N       N       150.00       N       N       N       N       155.00       150.00       150.00       150.					Y		145.00		
146.00Hess the cost all coation is ethodol agy changed from the previously filed cost report?       N       146.00         Enter "Y" for yes or "N" for no is column 1. (See CMS Pub. 15-2, chapter 40, \$4020) IF       N       146.00         147.00Mss there a change in the statistical basis? Enter "Y" for yes or "N" for no.       N       147.00         148.00Mss there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       147.00         148.00Mss there a change in the simplified cost finding method? Enter "Y" for yes or "N" for no.       N       147.00         148.00Mss there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.       N       147.00         148.00Mss there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.       N       N       148.00         148.00Mss there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.       N       N       N       148.00         155.00Shaprovider - IF       N       N       N       N       N       N       155.00         155.00Shaprovider       N       N       N       N       N       N       155.00         155.00Shaprovider       N       N       N       N       N       N       155.00         155.00Shaprovider       N       N       N       N       N	no, does the dialysis facility ind	lude Medicare utiliza							
Inter         "Y"         Tor yes or "N" for no in column 1.         See CMS Pub.         15-2, chapter 40, §4020) If           147.00[Mes there a change in the order of allocation? Enter "Y" for yes or "N" for no.         N         147.00           148.00[Mes there a change in the order of allocation? Enter "Y" for yes or "N" for no.         N         147.00           149.00[Mes there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.         N         147.00           149.00[Mes there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.         N         N         N           160.00         2.00         3.00         4.00           Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or instead change of the simplified cost in the optication of the lower of costs of the lower of			eviously filed cost	t report?	N		146.00		
Intervent         Intervent         Intervent           147.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.         N <t< td=""><td>Enter "Y" for yes or "N" for no ir</td><td>column 1. (See CMS P</td><td></td><td></td><td></td><td></td><td></td></t<>	Enter "Y" for yes or "N" for no ir	column 1. (See CMS P							
147.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.       N       147.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.       N       147.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.       N       148.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.       N       148.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no for each component for the application of the lower of costs         148.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)       N	yes, enter the approval date (mm/o	ld/yyyy) in column 2.							
148. 00@kas there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       148. 00         149. 00@kas there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       148. 00         149. 00@kas there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       148. 00         149. 00@kas there a change in the order of allocation? Enter "Y" for yes or "N" for no.       N       N       148. 00         149. 00@kas there a change in the order of allocation? Enter "Y" for yes or "N" for no.       0.00       4.00       4.00         150. 00%browider - IPF       N       N       N       N       N       N       155. 00         155. 00%browider - IPF       N       N       N       N       N       N       N       156. 00         155. 00%browider - IPF       N       N       N       N       N       N       156. 00         156. 00%browider - IPF       N       N       N       N       N       N       156. 00         156. 00%browider       IPF       N       N       N       N       N       N       166. 00         161. 00[LF1 Line 165 is yes, for each       0       1.00       2.00       2.00       4.00       5.00       0.00       166. 00						1.00	-		
149.00         Name         <									
Part A         Part B         Title V         Title VIX           1:00         2:00         3:00         4:00           Dees this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. (See 42 CFR \$43:13)         Title XIX           155:00/blospital         N <td< td=""><td></td><td></td><td></td><td></td><td>no</td><td></td><td></td></td<>					no				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CR §413.13)           155. 00/bioptial         N <td>The second secon</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	The second secon								
Image: bit of the second of the sec									
155. 00 visprital       N									
157. CO[Subprovider - 1RF       N       N       N       N       N       N       157. CO[Subprovider - 1RF       158. CO         158. CO[SUMPK01DER       N       160.00       CO	155.00Hospi tal			N	N	N			
158. col Supercovi DER       N       N       N       N       N       N       N       N       N       N       N       156. col         159. col SNF       N       N       N       N       N       N       N       N       N       160. col         Mul ti campus       1.00       1.00       1.00       1.00       160. col       160. col <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
160:00Howe HEALTH AGENCY       N       N       N       N       N       N       N       160:00         161:00[CMHC       N       N       N       N       N       N       100         Multicampus         1:00         Multicampus         1:00         Name       County       State       Zip Code       CBSA       FTE/Campus         1:00       1:00       2:00       3:00       4:00       5:00         County       State       Zip Code       CBSA       FTE/Campus         County in column 1, state in column 2; zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)       0       0:00       166:00       0       0:00       166:02         1:00       2:00       3:00       4:00       0:00       166:00         Idea th information Technology (HIT) incentive in the American Recovery and Reinvestment Act       0:00       166:02       0:00       166:02         1:00       1:00       2:00       1:00       2:00       1:00       168:00         Itel th information Technology (HIT) incentive in the American Recovery and Reinvestment Act       1:00       <			N		IN IN	IN IN			
161.00/CMHC       N       N       N       N       161.00         Multicampus       1.00       1.00       1.00       1.00       1.00       1.00         165.00 [s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?       N       165.00       165.00       165.00       1.00       2.00       3.00       4.00       5.00       166.00         166.00 [f 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, FIE/Campus in column 2, zip code in column 3, CBSA in colum 4, FIE/Campus in columa 1, state in column 2, zip code in colum 3, CBSA in colum 4, FIE/Campus in columa 1, the American Recovery and Reinvestment Act       0.000166.01       0.00166.02         166.01       0.00166.02       0.00166.03       0.00166.03       0.00166.03       0.00166.03         Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act       N       167.00       166.00         1.00       1.00       1.00       166.00       0.00166.03       166.00         1.00       1.00       1.00       166.00       0.00166.01       1.00       166.00       1.00       166.00       1.00       166.00       1.00       1.00       1.00       1.00       1.00       1.00       166.00       1									
Multicampus         1.00           165.00[s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAS?         N         165.00           Inter "V" for yes or "N" for no.         Name         County         State         Zip Code         CBSA         FTE/Campus           166.00[If line 165 is yes, for each         0         1.00         2.00         3.00         4.00         5.00           166.00[If line 165 is yes, for each         0         1.00         2.00         3.00         4.00         5.00           166.01         column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)         0         0.00166.01         0.00166.02           166.02         0.00         1.00         2.00         3.00         4.00         5.00           166.03         0.00166.03         0.00166.03         0.00166.03         0.00166.03         0.00166.03           166.04         1.00         1.00         1.00         1.00         1.00         168.00           166.05         166.01         1.00         0.00166.03         0.00166.03         1.00         168.00           166.01         166.02         0.00166.03         0.00166.03         1.00         168.00         1.00         168.00 <tr< td=""><td></td><td></td><td>N</td><td></td><td></td><td></td><td>1</td></tr<>			N				1		
Wull Licangus         Image: Construction of a Multicampus hospital that has one or more campuses in different CBSAs?         N         165.00           165.00         Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?         N         165.00           Inter "V" for yes or "N" for no.         Name         County         State         Zip Code         CBSA         FTE/Campus           166.00         I inter 165 is yes, for each         0         1.00         2.00         3.00         4.00         5.00           166.00         I column 1, state in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)         0         0.00166.01         0.00166.02           166.01         0.00166.02         0         0.00166.03         0.00166.03         0.00166.03           Heal th Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act         1.00         1.00         168.00         1.00           166.03         I is provider a meaningful user under \$188(n)? Enter "Y" for yes or "N" for no.         N         167.00         168.00           168.00 If this provider is a CAH and is not a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)         N         168.00         168.00           169.00 If this provider is a CAH and is not a meaningful user, dues this provider qualify for a hards						IN IN	101.00		
165.00       Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAS?       N       165.00         Enter "Y" for yes or "N" for no.       0       1.00       2.00       3.00       4.00       5.00         166.00       I line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 3, CBSA in colum 1, EFE/Campus in column 5 (see instructions)       0       0       0.00       166.01       0       0.00       166.00       0.00       166.01       0.00       166.01       0.00       166.03       0.00       166.04       0.00       166.04       0.00       166.05       0.00       166.05       0.00       166.05       0.00       166.05       0.00       166.05       0.00       166.06       0.00       166.06       0.0	Mul 41 a annua					1.00			
Enter "Y" for yes or "N" for no.       Name       County       State       Zip       Code       CBSA       FTE/Campus         166.00       0       1.00       2.00       3.00       4.00       5.00         166.01       file for the name in column 1, state in column 3, cesta in column 4, FTE/Campus in column 5 (see instructions)       0 <t< td=""><td></td><td>ampus hospital that has</td><td>s one or more campu</td><td>uses in differ</td><td>ent CBSAs?</td><td>N</td><td>165.00</td></t<>		ampus hospital that has	s one or more campu	uses in differ	ent CBSAs?	N	165.00		
0       1.00       2.00       3.00       4.00       5.00         166.00 If line 165 is yes, for each campus enter the name in column 1, state in column 2, zip code in column 3, state in column 4, FTE/Campus in column 5 (see instructions)       0       0.00 166.00         166.01 fb6.02 is used in column 5 (see instructions)       0       0.00 166.01       0.00 166.02         166.02 is used in column 4, FTE/Campus in column 5 (see instructions)       0       0.00 166.01       0.00 166.02         166.03       0       0.00 166.01       0.00 166.02       0.00 166.02         167.00 is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no.       N       167.00         168.01 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)       N       167.00         169.00 if this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the reasonable cost incurred for the HIT assets (see instructions)       N       168.01         169.00 if this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       Beginning       Ending         169.00 if this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       1.00       2.00         170.00 Enter in column 1 and 2 the EHB beginning date and			•						
166. 00 If Line 165 is yes, for each campus enter the name in column 0, county in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)       0. 00 166. 00         166. 01       0. 00 166. 01         166. 03       0. 00 166. 01         Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act         167. 00 is this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)       N       167. 00         168. 00 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413. 70(a) (b) (ii)? Enter "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       N       167. 00         169. 00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       N       168. 00         169. 00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       168. 01         170. 00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)       1.00       2.00         171. 00 If Line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on WKst. S-3, Pt. I, Line 2, col. 6? Enter "Y" for yes and "W" for no in column 1. If column 1 is yes, enter the number of section       0       01711.00							-		
0, county in column 1, state in column 2, zip code in colum 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)       0.00 166.01         166.01       0.00 166.02         166.03       0.00 166.03         Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act         167.00       1.00         Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act         168.00       1.00         N         Information Technology (HIT) incentive in the American Recovery and Reinvestment Act         168.00       1f this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)       N       167.00         168.00       If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)       N       0.00169.00         If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       0.00169.00         If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       1.00       2.00         If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see	166.00 If line 165 is yes, for each	0	1.00	2.00 0	4.00		166.00		
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)       0.00166.01         166.01       0.00166.02         166.03       0.00166.02         166.03       0.00166.02         166.04       0.00166.02         166.05       0.00166.02         166.06       0.00166.02         166.07       0.00166.02         166.08       1.00         166.09       1.00         166.01       1.00         166.02       1.00         166.03       1.00         166.04       1.00         166.05       1.00         166.06       1.00         166.07       1.00         166.08       1.00         166.09       1.00         168.001       this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no.         168.01       this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under \$413.70(a) (a) ((b) (i)? Enter "Y" for yes or "N" for no. (see instructions)         169.00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)         170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									
CBSA in column 4, FTE/Campus in column 5 (see instructions)       0.00166.01         166.01       0.00166.02         166.03       0.00166.03 <ul> <li>Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</li> <li>1.00</li> <li>168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)</li> <li>168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a) (6) (ii)? Enter "Y" for yes or "N" for no. (see instructions)</li> <li>169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)</li> <li>169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)</li> <li>170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)</li> <li>1.00</li> <li>1.00<!--</td--><td></td><td></td><td></td><td></td><td></td><td></td><td></td></li></ul>									
166. 01       0. 00 166. 01         166. 02       0. 00 166. 02         166. 03       0. 00 166. 03         Image: Colspan="2">Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2">Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no.         Image: Colspan="2" Term "Y" for yes or "N" for no. <td "y"="" colspan="2" for="" or<="" td="" term="" yes=""><td>CBSA in column 4, FTE/Campus in</td><td></td><td></td><td></td><td></td><td></td><td></td></td>	<td>CBSA in column 4, FTE/Campus in</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		CBSA in column 4, FTE/Campus in						
166. 02       0.00       166. 02       0.00       166. 02         166. 03       0.00       166. 03       0.00       166. 03         Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act         167. 00       Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no.       N       167. 00         168. 00       If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)       N       168. 00         169. 00       If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under \$413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)       N       168. 01         169. 00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       168. 01       0.00         169. 00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       0.00       168. 01         170. 00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)       1.00       2.00         171. 00       If line 167 is "Y", does this provider nave any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter       N </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0.00</td> <td>166 01</td>						0.00	166 01		
Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act       1.00         Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act       1.00         167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.       N       167.00         168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)       N       168.00         168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)       168.01         169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the user (line 167 is "N"), enter the user (line 167 is "N"), enter the user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the user (line 167 is "Y", does this provider have any days for individuals enrolled in number of section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter N       0       0171.00         171.00 If line 167 is "Y", for no in column 1. If column 1 is yes, enter the number of section       N       0171.00									
Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act         167.00       Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.       N       167.00         168.00       If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)       N       167.00         168.01       If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)       168.01         169.00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       0.00       168.01         170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)       170.00       170.00       2.00         171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       0       171.00	166.03					0.00	166. 03		
Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act         167.00       Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.       N       167.00         168.00       If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)       N       167.00         168.01       If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)       168.01         169.00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       0.00       168.01         170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)       170.00       170.00       2.00         171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       0       171.00						1.00	-		
168.00       If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)       0168.00       0168.00         168.01       If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a) (6) (ii)? Enter "Y" for yes or "N" for no. (see instructions)       168.01       168.01         169.00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       0.00169.00         170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)       170.00       170.00         171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       0 171.00					t Act				
reasonable cost incurred for the HIT assets (see instructions)       168.01       169.00       169.00       169.00       169.00       169.00       169.00       169.00       170.00       170.00       170.00       170.00       170.00       170.00       170.00       170.00       170.00       170.00       170.00       170.00       171.00       171.00       171.00       171.00       171.00       1									
168.01       If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)       168.01         169.00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       0.00         169.00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       0.00         170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)       170.00         171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       N       0				e 16/15 "Y"),	enter the	l l	168.00		
169.00       If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)       0.00169.00         Image: transition factor. (see instructions)       Beginning       Ending         1.00       2.00       1.00       2.00         Image: transition factor. (see instructions)       170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)       170.00         Image: transition factor. (see instructions)       170.00       1.00       2.00         Image: transition factor. (see instructions)       170.00       1.00       2.00         Image: transition factor. (see instructions)       171.00       1.00       2.00         Image: transition factor. (see instructions)       171.00       1.00       2.00         Image: transition factor. (see instructions)       1.00       2.00       1.00         Image: transition factor. (see instructions)       1.00       2.00       1.00         Image: transition factor. (see instructions)       1.00       2.00       1.00       1.00         Image: transition factor. (see instructions)       Image: transition factor. (see instructions)       1.00       1.00       1.00         Image: transition factor. (see instructions)       Image: transis transition factor. (see instructions) <td>168.01 If this provider is a CAH and is r</td> <td>not a meaningful user,</td> <td>does this provider</td> <td></td> <td>a hardshi p</td> <td></td> <td>168. 01</td>	168.01 If this provider is a CAH and is r	not a meaningful user,	does this provider		a hardshi p		168. 01		
transition factor. (see instructions)         Beginning       Ending         Beginning       Ending         1.00       2.00       1.00       2.00         170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting       170.00       170.00         period respectively (mm/dd/yyyy)       170.00       1.00       2.00         171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter       N       0         "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       171.00       171.00					N") enter the	0.00	169 00		
1.00       2.00         170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting       170.00         period respectively (mm/dd/yyyy)       170.00         171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       N       0						0.00			
170.00       Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)       170.00       170.00         171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       N       0171.00							-		
period respectively (mm/dd/yyyy)       1.00       2.00         171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       N       0171.00	170.00 Enter in columns 1 and 2 the EHR k	eginning date and end	ing date for the re	eporting	1.00	2.00	170.00		
171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       N       0 171.00									
171.00       If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section       N       0 171.00					1.00	2 00	-		
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section	171.00 If line 167 is "Y", does this prov	vider have any days fo	r individuals enrol	lled in			171.00		
			yes, enter the num	55, 51 3661101	`				

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Date/Time Pre 12/10/2018 3:	epared:
				Y/N 1.00	Date 2.00	+
	General Instruction: Enter Y for all YES responses. Enter N fo	or all NO re	sponses. Ente			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					4
. 00	Has the provider changed ownership immediately prior to the be			N		1.00
	reporting period? If yes, enter the date of the change in colu		Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Proc	gram?lf	N			2.0
	yes, enter in column 2 the date of termination and in column 3	3, "V" for				
	voluntary or "I" for involuntary.					
8.00	Is the provider involved in business transactions, including m contracts, with individuals or entities (e.g., chain home offi		Y			3.0
	or medical supply companies) that are related to the provider					
	officers, medical staff, management personnel, or members of t					
	of directors through ownership, control, or family and other s					
	relationships? (see instructions)				-	
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Certifi	ed Public	Y	A	03/31/2019	4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for	Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date availa					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconc		N			5.0
	Those on the fifted financial statements? If yes, submit recond			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
o. 00	Column 1: Are costs claimed for nursing school? Column 2: If	fyes, is th	ne provider is	s N		6.00
	the legal operator of the program?					
. 00	Are costs claimed for Allied Health Programs? If "Y" see instr			N		7.00
8. 00	Were nursing school and/or allied health programs approved and	d/or renewed	during the	N		8.00
9.00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gra	aduate medic	al education	Ν		9.00
	program in the current cost report? If yes, see instructions.					
0.00	Was an approved Intern and Resident GME program initiated or r	renewed in t	he current	N		10.0
	cost reporting period? If yes, see instructions.					
1.00	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		11.00
	Treaching Program on worksheet A? IT yes, see this tructions.				Y/N	
					1.00	
	Bad Debts					
2.00	Is the provider seeking reimbursement for bad debts? If yes, s				Y	12.00
	If line 12 is yes, did the provider's bad debt collection poli	cy change d	luring this co	ost reporting	N	13.00
3.00	period? If yes, submit copy.			structions	N	14.00
		waiwad2 If	Ever cooling	STIUCTIONS.	IN	14.00
3. 00 4. 00	If line 12 is yes, were patient deductibles and/or co-payments	s waived? If	yes, see in:			
4. 00				tructions.	N	15.00
4. 00	If line 12 is yes, were patient deductibles and/or co-payments Bed Complement	period? If Par		Par	N N	15.00
4. 00	If line 12 is yes, were patient deductibles and/or co-payments Bed Complement	period? If Par Y/N	yes, see ins t A Date	Par Y/N	t B Date	15.00
4.00	If line 12 is yes, were patient deductibles and/or co-payments Bed Complement Did total beds available change from the prior cost reporting	period? If Par	yes, see ins <sup>.</sup> t A	Par	t B	15.0
4.00	If line 12 is yes, were patient deductibles and/or co-payments Bed Complement Did total beds available change from the prior cost reporting PS&R Data	period? If Par Y/N 1.00	yes, see ins t A Date 2.00	Par Y/N 3.00	t B Date 4.00	
4. 00	If line 12 is yes, were patient deductibles and/or co-payments Bed Complement Did total beds available change from the prior cost reporting	period? If Par Y/N	yes, see ins t A Date	Par Y/N 3.00	t B Date	
4.00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         PS&R Data         Was the cost report prepared using the PS&R Report only?	period? If Par Y/N 1.00	yes, see ins t A Date 2.00	Par Y/N 3.00	t B Date 4.00	
4.00 5.00 6.00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 date of the PS&R Report used in columns 2 and 4 . (see instructions)	period? If Par Y/N 1.00 Y	yes, see ins t A Date 2.00	Par Y/N 3.00 Y	t B Date 4.00	16.00
4.00 5.00 6.00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 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	period? If Par Y/N 1.00	yes, see ins t A Date 2.00	Par Y/N 3.00	t B Date 4.00	16.0
4.00 5.00 6.00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 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 totals and the provider's records for allocation? If	period? If Par Y/N 1.00 Y	yes, see ins t A Date 2.00	Par Y/N 3.00 Y	t B Date 4.00	16.00
4.00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 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 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	period? If Par Y/N 1.00 Y	yes, see ins t A Date 2.00	Par Y/N 3.00 Y	t B Date 4.00	16.0
4. 00 5. 00 6. 00 7. 00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 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 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	period? If Par Y/N 1.00 Y	yes, see ins t A Date 2.00	Par Y/N 3.00 Y	t B Date 4.00	16.00
4.00 5.00 6.00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 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 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	period? If Par Y/N 1.00 Y	yes, see ins t A Date 2.00	Par Y/N 3.00 Y N	t B Date 4.00	16.00
4. 00 5. 00 6. 00 7. 00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 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 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	period? If Par Y/N 1.00 Y	yes, see ins t A Date 2.00	Par Y/N 3.00 Y N	t B Date 4.00	15. 00 16. 00 17. 00 18. 00
4.00 5.00 6.00 7.00 8.00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 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 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	period? If Par Y/N 1.00 Y N N	yes, see ins t A Date 2.00	Par Y/N 3.00 Y N N	t B Date 4.00	16. 00 17. 00 18. 00
4. 00 5. 00 6. 00 7. 00	If line 12 is yes, were patient deductibles and/or co-payments         Bed Complement         Did total beds available change from the prior cost reporting         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 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 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	period? If Par Y/N 1.00 Y	yes, see ins t A Date 2.00	Par Y/N 3.00 Y N	t B Date 4.00	16. 0

	Financial Systems Kindred Hospital N AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Iorthwest India Provider C	CN: 15-2012	Period: From 09/01/2017 To 08/31/2018	12/10/2018 3:	epared:
			ption	Y/N	<u>Y/N</u>	
	LE Line 1/ an 17 is use where adjustments made to DCOD	(	)	1.00	3.00	20.00
). 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
_	Report data for other bescribe the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
. 00	Was the cost report prepared only using the provider's	N		Ν		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPLTALS)		1.00	
	Capital Related Cost		001111(20)			1
2.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.0
3.00	Have changes occurred in the Medicare depreciation expense		als made duriı	ng the cost		23.00
I	reporting period? If yes, see instructions.					
4.00	Were new leases and/or amendments to existing leases entered	ed into during	this cost rep	orting period?		24.00
- 00	If yes, see instructions	the cost repor	ting pariod?	f yos soo		25.0
5.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting periou?	i yes, see		25.0
5.00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	na period? If	ves, see		26.0
	instructions.			J,		
7.00	Has the provider's capitalization policy changed during the	e cost reportin	g period? If	yes, submit		27.0
ſ	сору.					
	Interest Expense					
3. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into dur	ing the cost	reporting		28.0
9.00	Did the provider have a funded depreciation account and/or	bond funds (De	ht Service Re	serve Fund)		29.0
. 00	treated as a funded depreciation account? If yes, see instr					27.0
0. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see		30.0
I	instructions.					
1.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31.0
	instructions. Purchased Services					-
2.00	Have changes or new agreements occurred in patient care ser	rvi ces furni she	d through con	tractual		32.0
	arrangements with suppliers of services? If yes, see instru		a through con			02.0
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competiti	ve bidding? If		33.0
I	no, see instructions.			-		
ſ	Provi der-Based Physi ci ans					
. 00	Are services furnished at the provider facility under an ar	rrangement with	provi der-base	ed physi ci ans?		34.0
: 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agroomon	te with the p	covidor basod		35.0
5.00	physicians during the cost reporting period? If yes, see in		ts with the p	ovi dei -based		35.0
	priver or and darring the deet reporting periodi in yee, eee in			Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Ware home office eacts alsimed on the eact report?			Y		36.0
. 00	Were home office costs claimed on the cost report?					1
. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Ŷ		37.0
5. 00 7. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.			Y	12/31/2018	
5. 00 7. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	fice different	from that of		12/31/2018	
5.00 7.00 3.00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	fice different d of the home o	from that of ffice.	Y	12/31/2018	38.0
6. 00 7. 00 3. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	fice different d of the home o	from that of ffice.	Y Y	12/31/2018	38.0
5.00 7.00 3.00 9.00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end 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	fice different d of the home o er chain compon	from that of ffice. ents? If yes,	Y Y	12/31/2018	38. 00 39. 00
5.00 7.00 3.00 9.00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	fice different d of the home o er chain compon	from that of ffice. ents? If yes,	Y Y N	12/31/2018	37.00 38.00 39.00 40.00
5. 00 7. 00 3. 00 9. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end 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	Fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes, If yes, see	Y Y N N		38. 0 39. 0
5. 00 7. 00 3. 00 9. 00 0. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end 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.	Fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes,	Y Y N		38. 0 39. 0
5. 00 7. 00 8. 00 9. 00 0. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end 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.	Fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes, If yes, see	Y Y N N 2.		38. 0 39. 0 40. 0
<ul> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> </ul>	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end 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.	Fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes, If yes, see	Y Y N N		38.0 39.0 40.0
5. 00 7. 00 8. 00 9. 00 9. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end 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.	Fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes, If yes, see	Y Y N N 2.		38.0 39.0 40.0
5. 00 7. 00 3. 00 9. 00 0. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end 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,	Fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes, If yes, see 00	Y Y N N SI MPSON		38. 0 39. 0
5. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end 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, respectively.	Fice different d of the home o er chain compon home office? 1. DAVID	from that of ffice. ents? If yes, If yes, see 00	Y Y N N SI MPSON	00	38. 0 39. 0 40. 0 41. 0 42. 0

Heal th	Financial Systems	Kindred Hospital	Nort	hwest India	na		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CC	CN: 15-2012	Peri		Worksheet S-2 Part II	2
						To		Date/Time Pre 12/10/2018 3:	epared: 21 pm
				3.	00				
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the	title/position	REI	MBURSEMENT !	MANAGER				41.00
	held by the cost report preparer in colu	mns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the c	ost report							42.00
	preparer.								
43.00	Enter the telephone number and email add	ress of the cost							43.00
	report preparer in columns 1 and 2, resp	ecti vel y.							

Non-CMS HFS Worksheet Health Financial Systems Kindred Hospital Northwest Indiana VOLUNTARY CONTACT INFORMATION Provider CCN: 15-2012 Worksheet S-2 Peri od: From 09/01/2017 To 08/31/2018 Part V Date/Time Prepared: 12/10/2018 3:21 pm 1.00 Cost Report Preparer Contact Information 1.00 DAVI D 1.00 First Name 2.00 Last Name SI MPSON 2.00 REIMBURSEMENT MANAGER 3.00 Ti tl e 3.00 4.00 Employer KINDRED HEALTHCARE OPERATING 4.00 LLC (502)596-7945 5.00 Phone Number 5.00 6.00 E-mail Address KindredReimbursement@kindred 6.00 COM REIMBURSEMENT 7.00 Department 7.00 680 SOUTH FOURTH AVENUE Mailing Address 1 8.00 8.00 9.00 Mailing Address 2 ATTN: REIMBURSEMENT 9.00 10.00 City LOUI SVI LLE 10.00 11.00 11.00 State KΥ 40202 12.00 Zip 12.00 Officer or Administrator of Provider Contact Information **RI CHARD** 13.00 First Name 13.00 Last Name ALGOOD 14.00 14.00 15.00 Title SENIOR VICE PRESIDENT 15.00 **REI MBURSEMENT** KINDRED HEALTHCARE OPERATING 16.00 Employer 16.00 LLC (502)596-7342 17.00 Phone Number 17.00 RI CHARD. ALGOOD@KI NDRED. COM 18.00 E-mail Address 18.00 19.00 Department **REI MBURSEMENT** 19.00 680 SOUTH FOURTH AVENUE 20.00 Mailing Address 1 20.00 ATTN: REIMBURSEMENT 21.00 Mailing Address 2 21.00 22.00 City LOUI SVI LLE 22.00 23.00 State KΥ 23.00 24. 00 | Zi p 40202 24.00

		al Northwest Indiana		Non-CMS HFS Wo	
HFS Su	upplemental Information	Provider CCN: 15-2012	Period: From 09/01/2017	Worksheet S-2 Part IX	2
			To 08/31/2018		epared.
				12/10/2018 3:	
			Title V	Title XIX	
			1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the		Y	Y	1.00
	stepdown adjustments on W/S B, Part I, column 25? Enter				
	and Y/N in column 2 for Title XIX. (see S-2, Part I, li				
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the			Y	2.00
	Part I (e.g. net of Physician's component)? Enter Y/N i				
	in column 2 for Title XIX. (see S-2, Part I, line 98.01				
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the			Y	3.00
	Cost on W/S D-1, Part IV, line 89? Enter Y/N in column	1 for Title V and Y/N in column	1		
	2 for Title XIX. (see S-2, Part I, line 98.02)				
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01
			Inpati ent	Outpatient	
			1.00	2.00	
	CRITICAL ACCESS HOSPITALS		•	••	1
4.00	Does Title V follow Medicare (Title XVIII) for Critical		N	N	4.00
	reimbursed 101% of cost? Enter Y or N in column 1 for i		2		
F 00	for outpatient. (see S-2, Part I, lines 98.03 and 98.04				
5.00	Does Title XIX follow Medicare (Title XVIII) for Critic			N	5.00
	reimbursed 101% of cost? Enter Y or N in column 1 for i		2		
	for outpatient. (see S-2, Part I, lines 98.03 and 98.04	)	Title V	Title XIX	
			1.00		
	RCE DI SALLOWANCE		1.00	2.00	
( 00	Do Title V or XIX follow Medicare and add back the RCE	Disallawara an W/C C Dart I	Y	Y	1 / 00
6.00			Ŷ	Ŷ	6.00
	column 4? Enter Y/N in column 1 for Title V and Y/N in S-2. Part I, line 98.05)	column 2 for fille xix. (see			
	PASS THROUGH COST				-
7.00	Do Title V or XIX follow Medicare when cost reimbursed	(payment system is "0") for	Y	Y	7.00
7.00	worksheets D, parts I through IV? Enter Y/N in column 1			ř	7.00
	2 for Title XIX. (see S-2, Part I, line 98.06)	for fitte v and fin fit corumn			
	RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04	)2 Enter V/N in column 1 for	N	N	8.00
0.00	Title V and Y/N in column 2 for Title XIX.		IN	IN	0.00
	FQHC				1
9.00	For fiscal year beginning on/after 10/01/2014, use M-se	ries for Title V and/or Title	N	N	9.00
			IN IN	IN	7.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	N: 15-2012	Period: From 09/01/2017 To 08/31/2018		pared:
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P <u>Visits / Trips</u> Title V	
		Line Number 1.00	2.00	Avai I abl e	4.00	E 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2.00	3.00	4.00 40 0.00	5.00	1.00
2.00 3.00 4.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	30.00		20, 4			2. 00 3. 00 4. 00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF					0	4.0 5.0
5.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	6.0
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		56	20, 44	40 0.00		7.0
8.00 9.00 10.00 11.00 12.00 13.00	INTENSI VE CARE UNI T CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY	31. 00	O		0 0.00	0	8.0 9.0 10.0 11.0 12.0 13.0
4.00 5.00 6.00 7.00 8.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER		56	20, 44	40 0.00	0 0	13. C 14. C 15. C 16. C 17. C 18. C
9.00 9.00 1.00 2.00 2.00 2.00 2.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE	44.00	O		0	0	19. 0 20. 0 21. 0 22. 0 23. 0 24. 0
4. 10 5. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24. 1 25. 0
6.00 6.25 7.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	56			0	26.0 26.2 27.0
<ol> <li>00</li> <li>8. 00</li> <li>9. 00</li> <li>0. 00</li> <li>1. 00</li> <li>2. 00</li> <li>2. 01</li> </ol>	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		0	0	27.0 28.0 29.0 30.0 31.0 32.0 32.0
3. 00 3. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33. ( 33. (

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-2012	Perio From To	od: 09/01/2017 08/31/2018	Worksheet S-3 Part I Date/Time Pre 12/10/2018 3:	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		tal Interns Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9, 709	47	13, 17	76			1.0
. 00	HMO and other (see instructions)	826	748					2.0
. 00	HMO IPF Subprovider	0	0					3.0
. 00	HMO IRF Subprovider	0	0					4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.0
. 00	Hospital Adults & Peds. Swing Bed NF		0		0			6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	9, 709	47	13, 17	76			7.0
. 00	INTENSIVE CARE UNIT	0	0		0			8.0
. 00	CORONARY CARE UNI T							9.0
0. 00	BURN INTENSIVE CARE UNIT							10. (
1.00	SURGI CAL I NTENSI VE CARE UNI T							11.0
2.00	OTHER SPECIAL CARE (SPECIFY)							12. (
3.00	NURSERY							13.0
4.00	Total (see instructions)	9, 709	47	13, 17	76	0.00	118.80	14.0
5.00	CAH visits	0	0		0			15. (
6.00	SUBPROVIDER - IPF							16.0
7.00	SUBPROVI DER – I RF							17.0
8.00	SUBPROVI DER							18.0
9.00	SKILLED NURSING FACILITY	0	0		0	0.00	0.00	
0.00	NURSING FACILITY							20. (
1. 00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY							22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)							23.0
4.00	HOSPI CE							24.
4. 10	HOSPICE (non-distinct part)	0	0		0			24.
5.00	CMHC - CMHC							25.
6.00	RURAL HEALTH CLINIC							26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
7.00	Total (sum of lines 14-26)					0.00	118.80	
8.00	Observation Bed Days		0		0			28.
9.00	Ambul ance Trips	0						29.0
0.00	Employee discount days (see instruction)				0			30.
1.00	Employee discount days - IRF	_	_		0			31.
2.00	Labor & delivery days (see instructions)	0	0		0			32.
2. 01	Total ancillary labor & delivery room				0			32.
2 00	outpatient days (see instructions)							
3.00	LTCH non-covered days	62						33.0
3. UI	LTCH site neutral days and discharges	1, 487	I					33.

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CO		Period: From 09/01/2017 To 08/31/2018	Worksheet S-3 Part I Date/Time Pre 12/10/2018 3:	pared:
		Full Time Equivalents		Di s	scharges		
	Component	Nonpaid Workers	Title V	Title XVIII		Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 23.00 24.00 24.00 24.00 24.00 25.00 23.00 24.00 23.00 24.00 26.25 27.00 28.00 29.00 30.00 31.00 32.01	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00 0. 00	0		52 1 23 26 0 52 1	471	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 24.00 25.00 24.00 26.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 32.00
33. 00	LTCH site neutral days and discharges				0 57		33. 00 33. 01

	Financial Systems AL WAGE INDEX INFORMATION	Ki ndi	red Hospital N	lorthwest India Provider C	CN: 15-2012 F F	In Lie Period: From 09/01/2017 To 08/31/2018		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	, J	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES			1	1			1
00	Total salaries (see instructions)	200.00	8,054,675	0	8, 054, 675	247, 082. 14	32.60	1. C
00	Non-physician anesthetist Part		0	0	C	0.00	0.00	2.0
00	A Non-physician anesthetist Part		0	0	C	0.00	0.00	3.0
00	B Physician-Part A -		0	0	C	0.00	0.00	4.0
)1	Administrative		O	0	(	0.00	0.00	4.0
00	Physicians - Part A - Teaching Physician and Non		0	-				
00	Physician-Part B Non-physician-Part B for		0	0	(	0.00	0.00	6. (
,0	hospital-based RHC and FQHC		Ū			0.00	0.00	
00	services Interns & residents (in an	21.00	0	0	C	0.00	0.00	7.0
)1	approved program) Contracted interns and		0	0	(	0.00	0.00	7.(
	residents (in an approved		Ū			0.00	0.00	
00	programs) Home office and/or related		C	0	C	0.00	0.00	8.
00	organization personnel SNF	44.00	0			0.00	0.00	9.
00	Excluded area salaries (see	44.00	0	32, 461	32, 461			
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		1, 080, 094	0	1, 080, 094	15, 110. 00	71.48	11.
00	Care Contract Labor: Top Level		C	0	c c	0.00	0.00	12.
	management and other management and administrative services							
00	Contract Labor: Physician-Part		55, 798	0	55, 798	3 335.00	166. 56	13.
00	A - Administrative Home office and/or related		0	0	C	0.00	0.00	14.
	organization salaries and wage-related costs							
01	Home office salaries		987, 851	0	987, 851	21, 013. 64	47.01	14.
02 00	Related organization salaries Home office: Physician Part A		0	0				
	- Administrative							
00	Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0.00	16.
	WAGE-RELATED COSTS Wage-related costs (core) (see		1, 139, 339	0	1, 139, 339		I	17.
	instructions)							
00	Wage-related costs (other) (see instructions)		0	0	C			18.
00	Excluded areas		4,610	0	4, 610			19.
00	Non-physician anesthetist Part A		0					20.
00	Non-physician anesthetist Part B		0	0	C			21.
00	Physician Part A -		0	0	C	þ		22.
01	Administrative Physician Part A - Teaching		0	0	c			22.
00	Physician Part B		0	0	c c			23.
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0					24. 25.
	approved program)		-					
50	Home office wage-related (core)		0	0	C			25.
51	Related organization wage-related (core)		0	0	C	D		25.
52	Home office: Physician Part A - Administrative -		O	0	c			25.
53	wage-related (core) Home office & Contract		0	_	(			25.
	Physicians Part A – Teaching – wage-related (core)		0					23.
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	<u>-</u> 4. 00	87, 623	0	87, 623	1, 151. 22	76. 11	26
	Administrative & General	5.00	1, 222, 704		1, 222, 704			

Heal th	Financial Systems	Ki nd	red Hospital N	orthwest India	na	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO	F	Period: From 09/01/2017 To 08/31/2018	Date/Time Pre 12/10/2018 3:	pared: 21 pm
		Wkst. A Line		Recl assi fi cati	Adj usted		Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col.$	Salaries in	col. 5)	
				A-6)	3)	col. 4		
	1	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		5, 091	0	5, 091	186.00	27.37	28.00
29.00	Maintenance & Repairs	6.00	0	0	(	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	(	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	(	0.00	0.00	31.00
32.00	Housekeepi ng	9.00	0	0	(	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	C	0.00	0.00	33.00
34.00	Dietary	10.00	65, 952	0	65, 952	2, 090. 00	31.56	34.00
35.00	Dietary under contract (see instructions)		0	0	(	0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	0	(	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	(	0.00	0.00	37.00
38.00	Nursing Administration	13.00	548, 497	0	548, 497	14, 417. 00	38.05	38.00
39.00	Central Services and Supply	14.00	70, 584	0	70, 584	4, 133. 00	17.08	39.00
40.00	Pharmacy	15.00	553, 801	0	553, 801			
41.00	Medi cal Records & Medi cal Records Library	16.00	408, 969	0	408, 969			
42.00	Soci al Servi ce	17.00	274,077	-32, 461	241, 616	4, 846.00	49.86	42.00
43.00	Other General Service	18.00	0		(			43.00

Heal th	Financial Systems	Ki nd	lred Hospital N	lorthwest India	na	In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider CC		Period: From 09/01/2017 To 08/31/2018		
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	,	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-		
1.00	Net salaries (see		8, 059, 766	0	8, 059, 76	6 247, 268. 14	32.60	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		0	32, 461	32, 46	1 651.00	49.86	2.00
3.00	Subtotal salaries (line 1		8, 059, 766	-32, 461	8, 027, 30	5 246, 617. 14	32.55	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2, 123, 743	0	2, 123, 74	3 36, 458. 64	58. 25	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs (see inst.)		1, 139, 339	0	1, 139, 33	9 0.00	14. 19	5.00
6.00	Total (sum of lines 3 thru 5)		11, 322, 848	-32, 461	11, 290, 38	7 283, 075. 78	39.88	6.00
7.00	Total overhead cost (see instructions)		3, 237, 298	-32, 461	3, 204, 83	7 77, 380. 24	41. 42	7.00
		1		1	Į.	ļ.	1	

Heal th	Financial Systems Kindred Hospital Nor	rthwest Indiana	In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS	Provi der CCN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet S-3 Part IV Date/Time Pre 12/10/2018 3:	pared:
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				1
	RETI REMENT COST				
1.00	401K Employer Contributions			8, 143	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)				1
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)			0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administ	rator)		0	
8.02	Heal th Insurance (Self Funded with a Third Party Administrate			431, 356	0.0.
8.03	Heal th Insurance (Purchased)	61)		431, 330	
9.00	Prescription Drug Plan			0	
9.00 10.00	Dental, Hearing and Vision Plan			5, 267	
	Life Insurance (If employee is owner or beneficiary)				
11.00				4, 325	•
12.00	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)	``````````````````````````````````````		36, 113	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary	y)		0	
15.00	'Workers' Compensation Insurance			57, 971	•
16.00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106.	0	16.00
	Non cumulative portion)				
	TAXES				
17.00	FICA-Employers Portion Only			547, 295	
18.00	Medicare Taxes - Employers Portion Only			0	
19.00	Unemployment Insurance			0	
20.00	State or Federal Unemployment Taxes			24, 747	20.00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost I instructions))	Reported on lines 1 throu	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances			0	22.00
23.00	Tuition Reimbursement			24, 122	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			1, 139, 339	
	Part B - Other than Core Related Cost				1
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th	Financial Systems	Kindred Hospital	Northwest Indiana	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-2012	Peri od:	Worksheet S-3	
				From 09/01/2017		
				To 08/31/2018	Date/Time Pre 12/10/2018 3:2	
	Cost Center Description			Contract Labor	Benefit Cost	
	cost center beschiption			1.00	2.00	
	PART V - Contract Labor and Benefit Cos	:†		1.00	2.00	
	Hospital and Hospital-Based Component I					
1.00	Total facility's contract labor and ber			1, 080, 094	1, 139, 339	1.00
2.00	Hospi tal			1, 080, 094	1, 139, 339	2.00
3.00	Subprovider - IPF			.,,	.,,	3.00
4.00	Subprovider - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF			0	0	8.00
9.00	Hospital-Based NF					9.00
10.00	Hospi tal -Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
	Renal Dialysis			0	0	17.00
18.00	Other			0	0	18.00

ECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider C	CN: 15-2012	Period:	Worksheet A	
					From 09/01/2017 To 08/31/2018	Date/Time Pre 12/10/2018 3:	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
. 00	00100 CAP REL COSTS-BLDG & FIXT		1, 571, 266	1, 571, 20	-342,006	1, 229, 260	) 1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP		520, 590	520, 59	20, 529	541, 119	2.0
. 00	00300 OTHER CAP REL COSTS		23, 586	23, 58	-23, 586	0	3.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	87, 623	1, 224, 370	1, 311, 99	93 0	1, 311, 993	4.0
. 00	00500 ADMINI STRATI VE & GENERAL	1, 222, 704	2, 978, 806	4, 201, 5 <sup>.</sup>	10 38, 817	4, 240, 327	5.0
. 00	00700 OPERATION OF PLANT	0	137,020	137, 02	20 212, 248	349, 268	7.0
. 00	00800 LAUNDRY & LINEN SERVICE	0	66, 259			66, 259	8.0
. 00	00900 HOUSEKEEPI NG	0	289		93, 907	94, 196	
0.00	01000 DI ETARY	65, 952	241, 062			307, 118	
1.00	01100 CAFETERI A	0	0		0 0	0	
3.00	01300 NURSI NG ADMI NI STRATI ON	548, 497	6, 296	554, 79	13, 870		
4.00	01400 CENTRAL SERVICES & SUPPLY	70, 584	4, 020			232, 267	
5.00	01500 PHARMACY	553, 801	100, 014				
6.00	01600 MEDI CAL RECORDS & LI BRARY	408, 969	101, 310			510, 279	
7.00	01700 SOCIAL SERVICE	274,077	12, 965			253, 045	
7.00	INPATIENT ROUTINE SERVICE COST CENTERS	274,077	12, 703	207,0	+2 -33, 777	255, 045	<u> </u>
0. 00	03000 ADULTS & PEDIATRICS	3, 797, 000	381, 126	4, 178, 12	26 374, 277	4, 552, 403	30.
1.00	03100 I NTENSI VE CARE UNI T	3, 777, 000	0		0 0		
4.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0		
4.00	ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	44.
0. 00	05000 OPERATING ROOM	110, 833	1, 508, 489	1, 619, 32	22 0	1, 619, 322	50.
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	367, 281				
		-					
0.00		45, 358	858, 242				
5.00		869, 277	40, 970			958, 301	
6.00	06600 PHYSI CAL THERAPY	0	862, 327	862, 32			
7.00	06700 OCCUPATIONAL THERAPY	0	0		0 0		
8.00	06800 SPEECH PATHOLOGY	0	0	010.0	0 0	0	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	818, 090				
3.00	07300 DRUGS CHARGED TO PATIENTS	0	938, 131			938, 131	
4.00	07400 RENAL DI ALYSI S	0	591, 974	591, 9	74 0	591, 974	74.
	OUTPATIENT SERVICE COST CENTERS	-		1		-	1
0.00	09000 CLINIC	0	0		0 0		
1.00	09100 EMERGENCY	0	0		0 0	0	91.
	OTHER REIMBURSABLE COST CENTERS	-		1		-	
5.00	09500 AMBULANCE SERVICES	0	0		0 0		
8.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.
	SPECIAL PURPOSE COST CENTERS						
18.00		8, 054, 675	13, 354, 483	21, 409, 15	-33, 997	21, 375, 161	118.
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.
	07950 NONALLOWABLE CLINICAL LIAISON	0	0		0 33, 997	33, 997	
	07951 I DLE SPACE	0	0		0 0		194.
	07952 REGIONAL OFFICE	0	0		0 0	0	194.
	07953 DISTRICT OFFICE	0	0		0 0		194.
94.04	07954 NON MCR CERTIFIED UNIT	0	0		0 0	0	194.
	07955 REG NURSG OFFICE	o	0		0 0	0	194.
	07956 CONTACT CENTER	o	0		0 0		194.
	07957 CENTRALI ZED ADMI SSI ONS DEPT	o	0		0 0		194.
	07959 OTHER NONREI MBURSABLE - OPEN	Ő	0		0 0		194
	07958 VI SI TOR MEALS	0	0		0 0		194.
	07962 OTHER NONRELMBURSABLE COST CENTERS	0	0		0 0		194.
94.10	The second secon	0	0	1	-		
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	Ω		0 0	∩	194.

	Financial Systems Kind SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Northwest Indian Provider CCI	In Lie Period:	u of Form CMS-2552 Worksheet A	2-10
				From 09/01/2017 To 08/31/2018	Date/Time Prepare	
	Cost Center Description	Adjustments	Net Expenses		12/10/2018 3:21 p	<u>pm</u>
		(See A-8)	For Allocation			
	I	6.00	7.00	 		
	GENERAL SERVICE COST CENTERS	1	1 1			
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 895				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-125, 989				2.00
3.00	00300 OTHER CAP REL COSTS	C				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-46, 157				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	-909, 956				5.00
7.00	00700 OPERATION OF PLANT	-1, 087				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	66, 259			3.00
9.00	00900 HOUSEKEEPI NG	0	94, 196			9.00
10.00	01000 DI ETARY	0	307, 118			0.00
11.00		C	0			1.00
13.00	01300 NURSING ADMINISTRATION	0	568, 663			3.00
14.00	01400 CENTRAL SERVICES & SUPPLY		232, 267			4.00
	01500 PHARMACY	0	0011120			5.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	4, 372				5.00
17.00	01700 SOCIAL SERVICE	C	253, 045		17.	7.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	70 571	4 472 022			
30.00	03000 ADULTS & PEDIATRICS	-78, 571				0.00
31.00	03100 I NTENSI VE CARE UNI T					1.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	L C			44	4.00
F0 00	ANCI LLARY SERVI CE COST CENTERS		1, 619, 322		F0	0.00
50.00 54.00	05400 RADI OLOGY-DI AGNOSTI C					0. 00 4. 00
54.00 60.00	06000 LABORATORY	-				4.00 D.00
65.00	06500 RESPIRATORY THERAPY	-1, 440 11, 897				5.00
66. 00	06600 PHYSI CAL THERAPY	-54, 395				5.00
67.00	06700 OCCUPATI ONAL THERAPY	-04, 390	0			7.00
	06800 SPEECH PATHOLOGY					3.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		190, 520			1.00
73.00	07300 DRUGS CHARGED TO PATIENTS					3.00
	07400 RENAL DIALYSIS	407				4.00
/ 1. 00	OUTPATIENT SERVICE COST CENTERS	107	072,001			1. 00
90.00	09000 CLINIC	C	0		90	D. 00
	09100 EMERGENCY	C				1.00
	OTHER REIMBURSABLE COST CENTERS	-	-			
95.00	09500 AMBULANCE SERVI CES	C	0		95	5.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	C				3. 00
	SPECIAL PURPOSE COST CENTERS		· · · · ·			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 195, 024	20, 180, 137		118	3. 00
	NONREI MBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0 0		190	0. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	C	0		192	2.00
194.OC	07950 NONALLOWABLE CLINICAL LIAISON	C	33, 997		194	4.00
194.01	07951 I DLE SPACE	C	0 0		194	4. 01
	07952 REGIONAL OFFICE	C	0			4. 02
194.03	07953 DISTRICT OFFICE	C				4. 03
194.04	07954 NON MCR CERTIFIED UNIT	C	-			4. 04
	07955 REG NURSG OFFICE	C	0			4. 05
	07956 CONTACT CENTER	C	0			4. 06
	07957 CENTRALIZED ADMISSIONS DEPT	C	0			4. 07
	07959 OTHER NONREI MBURSABLE - OPEN	C	0			4. 08
	07958 VISITOR MEALS	C	0			4. 09
	07962 OTHER NONREI MBURSABLE COST CENTERS	C	0			4. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0				4.11
200.00	TOTAL (SUM OF LINES 118 through 199)	-1, 195, 024	20, 214, 134		200	0. 00

Health Financial Systems

In Lieu of Form CMS-2552-10

Heal th	Financial Systems	Kindred Hospital Nort	hwest Indiana		In Lieu of Form CMS-	-2552-10
COST CE	NTERS USED IN COST REPORT		Provider CCN	: 15-2012	Period: Worksheet No	n-CMS W
					From 09/01/2017 To 08/31/2018 Date/Time Pro	oparod
					12/10/2018 12/10/2018 3	· 21 pm
	Cost Center Description			CMS Code	Standard Label For	
					Non-Standard Codes	
				1.00	2.00	
	GENERAL SERVICE COST CENTERS					
	CAP REL COSTS-BLDG & FIXT			00100		1.00
	CAP REL COSTS-MVBLE EQUIP			00200		2.00
	OTHER CAP REL COSTS EMPLOYEE BENEFITS DEPARTMENT			00300 00400		3.00 4.00
	ADMINISTRATIVE & GENERAL			00400		5.00
	OPERATION OF PLANT			00700		7.00
	LAUNDRY & LINEN SERVICE			00800		8.00
	HOUSEKEEPING			00900		9.00
	DI ETARY			01000		10.00
11.00	CAFETERIA			01100		11.00
13.00	NURSING ADMINISTRATION			01300		13.00
14.00	CENTRAL SERVICES & SUPPLY			01400		14.00
	PHARMACY			01500		15.00
	MEDICAL RECORDS & LIBRARY			01600		16.00
	SOCIAL SERVICE			01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS			03000		30.00
	INTENSIVE CARE UNIT SKILLED NURSING FACILITY			03100 04400		31.00 44.00
-	ANCI LLARY SERVICE COST CENTERS			04400		44.00
	OPERATI NG ROOM			05000		50.00
	RADI OLOGY-DI AGNOSTI C			05400		54.00
	LABORATORY			06000		60.00
	RESPI RATORY THERAPY			06500		65.00
66.00	PHYSI CAL THERAPY			06600		66.00
67.00	OCCUPATIONAL THERAPY			06700		67.00
	SPEECH PATHOLOGY			06800		68.00
1	MEDICAL SUPPLIES CHARGED TO PATIENTS			07100		71.00
1	DRUGS CHARGED TO PATIENTS			07300		73.00
	RENAL DIALYSIS			07400		74.00
	DUTPATIENT SERVICE COST CENTERS			09000		90.00
	EMERGENCY			09000		90.00
-	OTHER REIMBURSABLE COST CENTERS		I	09100		1 71.00
	AMBULANCE SERVICES			09500		95.00
	OTHER REIMBURSABLE COST CENTERS			09850		98.00
	SPECIAL PURPOSE COST CENTERS		· · ·			4
118.00	SUBTOTALS (SUM OF LINES 1 through 117)					118.00
	VONREIMBURSABLE COST CENTERS					-
	GIFT, FLOWER, COFFEE SHOP & CANTEEN			19000		190. 00
	PHYSICIANS' PRIVATE OFFICES			19200		192.00
	NONALLOWABLE CLINICAL LIAISON			07950		194.00
	I DLE SPACE			07951		194.01
	REGIONAL OFFICE			07952		194. 02 194. 03
	DISTRICT OFFICE NON MCR CERTIFIED UNIT			07953 07954		194.03
	REG NURSG OFFICE			07954		194.04
	CONTACT CENTER			07956		194.05
	CENTRALIZED ADMISSIONS DEPT			07957		194.00
	OTHER NONREI MBURSABLE – OPEN			07959		194.08
	VISITOR MEALS			07958		194.09
	OTHER NONREIMBURSABLE COST CENTERS			07962		194.10
	NONREIMB NEW BUSINESS IMPLEMENTATION			07961		194.11
200.00	TOTAL (SUM OF LINES 118 through 199)					200. 00

	Financial Systems SIFICATIONS	KITUI	ed Hospital No		CN: 15-2012	Peri od:	u of Form CMS-2 Worksheet A-6	
ULAS	STITCATIONS			FIOVIDEI C	GN. 15-2012	From 09/01/2017		
						To 08/31/2018	Date/Time Pre 12/10/2018 3::	pared: 21 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A - RECLASS NON ALLOWABLE CAS							
00	NONALLOWABLE CLINICAL	194.00	32, 461	1, 536				1.00
	LI AI SON							
	TOTALS		32, 461	1, 536				
	B - RECLASS OXYGEN							
00	RESPIRATORY_THERAPY		0	<u>3, 1</u> 85				1.00
	TOTALS		0	3, 185				
	C - RECLASS NONCHARGEABLE MED							
00		0.00	0	0				1.0
00	ADMI NI STRATI VE & GENERAL	5.00	0	38, 817				2.0
00	HOUSEKEEPI NG	9.00	0	88				5.0
0C	DI ETARY	10.00	0	104				6.0
00	NURSING ADMINISTRATION	13.00	0	13, 870				7.0
00	CENTRAL SERVICES & SUPPLY	14.00	0	157, 663				8.0
00	PHARMACY	15.00	0	3, 913				9.0
. 00	ADULTS & PEDIATRICS	30.00	0	374, 277				12.0
. 00	LABORATORY	60.00	0	27, 422				17.0
. 00	RESPI RATORY THERAPY	65.00	0	7, 285				18.0
. 00	PHYSI CAL THERAPY	66.00	0	946				19.0
	TOTALS		0	624, 385				
	D - RECLASS JLL EQUIP SVC CON	TRACT						
00	LABORATORY	60.00	0	1, 412				1.0
00	RESPI RATORY THERAPY	65.00	0	36, 524				2.0
	TOTALS		0	37, 936				
	E - RECLASS OXYGEN							
00	RESPI RATORY THERAPY	65.00	0	1, 060				1.0
	TOTALS			1,060				
	F - RECLASS HOUSEKEEPING & MA	I NTENANCE						
00	OPERATION OF PLANT	7.00	0	250, 184				1.0
00	HOUSEKEEPI NG	9.00	0	93, 819				2.0
	TOTALS	+	- — — d	344,003				
0.00	Grand Total: Increases		32, 461	1,012,105				500.0

	SI FI CATI ONS			Provi der	CCN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet A-6 Date/Time Prepar 12/10/2018 3:21
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Re	<u>f.</u>	
	6. 00	7.00	8.00	9.00	10.00		
	A - RECLASS NON ALLOWABLE CAS						
1.00	SOCIAL SERVICE		32, 461	<u>1, 5</u> 36	5	0	
	TOTALS		32, 461	1, 536	5		
	B - RECLASS OXYGEN						
	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	3, 185	ō	0	
	TOTALS	+		3, 185	5	1	
	C - RECLASS NONCHARGEABLE MED	SUPPLIES			_	1	
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	624, 385	ō	0	
2.00		0.00	0	(	n l	0	
5.00		0.00	0	(	5	0	Į.
6.00		0.00	0	(		0	
7.00		0.00	0	(		0	-
8.00		0.00	0	(		0	8
9.00		0.00	0	(		0	
12.00		0.00	0			0	1
17.00		0.00	0	(		0	17
18.00		0.00	0	(		0	18
19.00		0.00	0	(		0	19
19.00	TOTALS			624, 385		<u>u</u>	
	D - RECLASS JLL EQUIP SVC CON		0	024, 303			
1.00	OPERATION OF PLANT	7.00	0	37, 936	5	0	
2.00	OF ERATION OF TEAM	0.00	0	57, 750		0	
2.00	TOTALS				·		4
	E - RECLASS OXYGEN		0	37, 930			
	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 060	- -	10	
1.00							
	TOTALS F - RECLASS HOUSEKEEPING & MA		0	1, 060	J		
1 00	F - RECLASS HOUSEKEEPING & MA		0	250 10	4	10	
1.00		1.00	0	250, 184		10	-
2.00	CAP REL_COSTS-BLDG_&_FIXT		0	93, 819		10	
	TOTALS		0 32, 461	344,003			

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

## Kindred Hospital Northwest Indiana Provider CCN: 15-2012

In Lieu of Form CMS-2552-10Period:Worksheet A-6From 09/01/2017Non-CMS WorksheetTo08/31/2018Date/TimeProperty

31/2018	Date/Time Prepared:
0172010	

						lo	08/31/2018	Date/lime Pre 12/10/2018 3:	21 nm
		Increa	ases			Decrea	ises	12/10/2010 3.	21 pm
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - RECLASS NON ALLOW	ABLE CASE	E MANAGER						
1.00	NONALLOWABLE CLINICAL	194.00	32, 461	1, 536	SOCIAL SERVICE	17.00	32, 461	1, 536	1.00
	LI AI SON								
	TOTALS		32, 461	1, 536	TOTALS		32, 461	1, 536	
	B - RECLASS OXYGEN	- <u> </u>							
1.00	RESPI RATORY THERAPY	65.00	0		MEDICAL SUPPLIES	71.00	0	3, 185	1.00
			+		CHARGED TO PATIENTS				
	TOTALS		0	3, 185	TOTALS		0	3, 185	
4 00	C - RECLASS NONCHARGE		SUPPLIES	0		74.00		(04.005	1 00
1.00		0.00	0		MEDICAL SUPPLIES	71.00	0	624, 385	1.00
2.00	ADMI NI STRATI VE &	5.00	0	38, 817	CHARGED TO PATIENTS	0.00	0	0	2.00
2.00	GENERAL	5.00	0	38, 817		0.00	U	0	2.00
5.00	HOUSEKEEPING	9,00	0	88		0.00	0	0	5.00
6.00	DI ETARY	10.00	0	104		0.00	0	0	6.00
7.00	NURSING	13.00	0	13, 870		0.00	0	0	7.00
7.00	ADMI NI STRATI ON	10.00	Ŭ	10,070		0.00	Ű	Ũ	7.00
8.00	CENTRAL SERVICES &	14.00	0	157, 663		0.00	0	0	8,00
	SUPPLY		-				-		
9.00	PHARMACY	15.00	0	3, 913		0.00	0	0	9.00
12.00	ADULTS & PEDIATRICS	30.00	0	374, 277		0.00	o	0	12.00
17.00	LABORATORY	60.00	0	27, 422		0.00	0	0	17.00
18.00	RESPI RATORY THERAPY	65.00	0	7, 285		0.00	0	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	946		0.00	0	0	19.00
	TOTALS		0	624, 385	TOTALS		0	624, 385	
	D - RECLASS JLL EQUIP		FRACT			_			
1.00	LABORATORY	60.00	0		OPERATION OF PLANT	7.00	0	37, 936	1.00
2.00	RESPIRATORY THERAPY	65.00	0	36, 524		0.00	0	0	2.00
	TOTALS		0	37, 936	TOTALS		0	37, 936	
	E - RECLASS OXYGEN					- <b>-</b>			
1.00	RESPI RATORY THERAPY	65.00	0		CAP REL COSTS-MVBLE	2.00	0	1, 060	1.00
		<u> </u>							
	TOTALS		0	1, 060	TOTALS		0	1, 060	
4 00	F - RECLASS HOUSEKEEP			050 404		1 0 0		050 404	1 00
1.00	OPERATION OF PLANT	7.00	0		CAP REL COSTS-BLDG &	1.00	0	250, 184	1.00
2 00		9,00	0		FLXT CAP REL COSTS-BLDG &	1.00	0	02 010	2 00
2.00	HOUSEKEEPING	9.00	U U		FIXT	1.00	0	93, 819	2.00
	TOTALS	$\vdash$ $+$		344,003		$\vdash$ $+$			
500 00	Grand Total:		32, 461		Grand Total:		32, 461	1, 012, 105	500 00
500.00	Increases		52, 401		Decreases		52, 701	1, 012, 103	555.50
	1110100303	1 1	I	I	2001 04303	1 1	I		

Heal th	Financial Systems Kind	lred Hospital N	orthwest India	na		In Lie	u of Form CMS-:	2552-10
RECONCI	LIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-2012		riod: om 09/01/2017 08/31/2018	Worksheet A-7 Part I Date/Time Pre 12/10/2018 3:	pared:
				Acqui si ti on:	s _			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
-	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
	Land	0	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
	Buildings and Fixtures	0	0		0	0	0	3.00
	Building Improvements	186, 136	0		0	0	0	4.00
	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	2, 069, 844	38, 650		0	38, 650	96, 464	6.00
	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2, 255, 980	38, 650		0	38, 650	96, 464	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	2, 255, 980	38, 650		0	38, 650	96, 464	10.00
		Endi ng Bal ance	Fully					
		-	Depreci ated					
			Assets					
		6.00	7.00					
F	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		-				
	Land	0	0					1.00
	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	186, 136	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	2, 012, 030	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	2, 198, 166	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	2, 198, 166	0					10.00

Heal th	Financial Systems Kind	dred Hospital N	orthwest India	na	In Lie	eu of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-2012	Peri od:	Worksheet A-7	
					From 09/01/2017 To 08/31/2018		pared:
						12/10/2018 3:	
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	· ·	
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 571, 266		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	178, 035			0 0	0	2.00
3.00	Total (sum of lines 1-2)	178, 035			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	<b>,</b>				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 571, 266				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	520, 590				2.00
3.00	Total (sum of lines 1-2)	0	2, 091, 856				3.00

Heal th	n Financial Systems Kin	dred Hospital N	lorthwest India	na	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 09/01/2017 To 08/31/2018		pared: 21 pm
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	186, 136 2, 012, 030 2, 198, 166	0	186, 136 2, 012, 030 2, 198, 166 CAPI TAL	0.915322	1, 568	1.00 2.00 3.00
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT			1, 997		1 007 0/0	1 00
1.00 2.00 3.00	CAP REL COSTS-BLOG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	1, 852 20, 021 21, 873	0	21, 589 23, 586	52, 046	341, 495	1.00 2.00 3.00
				JMMARY OF CAPI		.,,	
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	-	1	1	1		
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0 0 0	1, 568	20, 021	0	1, 235, 155 415, 130 1, 650, 285	1.00 2.00 3.00

12021	MENTS TO EXPENSES				Period: From 09/01/2017	Worksheet A-8	
					To 08/31/2018	Date/Time Pre 12/10/2018 3:	pared 21 pm
				Expense Classification of To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1. (
00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. (
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		C		0.00	0	3.
00	(chapter 2) Trade, quantity, and time	В	-4, 078	ADMI NI STRATI VE & GENERAL	5.00	0	4.
00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.
00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.
00	Suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-11, 992	ADMI NI STRATI VE & GENERAL	5.00	0	7.
00	21) Tel evi si on and radi o servi ce	A	-1.087	OPERATION OF PLANT	7.00	0	8. (
00	(chapter 21) Parking lot (chapter 21)		.,,		0.00	0	9.0
D. 00	Provi der-based physi ci an adj ustment	A-8-2	-63, 335		0.00	0	10. (
1.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.
2. 00	Related organization transactions (chapter 10)	A-8-1	59, 007	,		0	12.
3.00 4.00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0 0	13. 14.
4.00 5.00	Rental of quarters to employee		0		0.00	0	14.
5. 00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16. (
7.00	patients Sale of drugs to other than		C		0.00	0	17.
3. 00	patients Sale of medical records and		0		0.00	0	18.
9. 00	abstracts Nursing and allied health education (tuition, fees,		C		0.00	0	19.
	books, etc.) Vendi ng machi nes		0		0.00	0	
. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		C		0.00	0	21.
2. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		O	5	0.00	0	22.
3. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
1. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	O	PHYSI CAL THERAPY	66.00		24.
5.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.
b. 00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28.
. 00 . 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C C	OCCUPATI ONAL THERAPY	0.00 67.00	0	29. 30.
. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30. 00		30.
. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.
2. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		C		0.00	0	32.

Health Financial Systems ADJUSTMENTS TO EXPENSES	Ki nd	lred Hospital N	lorthwest Indiana Provider CCN: 15-2012	In Lie Period:	u of Form CMS-2 Worksheet A-8	2552-10
ADSUSTMENTS TO EXTENSES				From 09/01/2017 To 08/31/2018	Date/Time Pre	
			Expense Classification To/From Which the Amount i		12/10/2018 3::	
Cost Center Descri	ption Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33.00 OTHER ADJUSTMENTS (SPEC (3)		0		0.00		33.00
33. 01 MI SCELLANEOUS I NCOME 33. 02 OTHER ADJUSTMENTS (SPEC (3)	I FY)	-72, 456 0	ADMI NI STRATI VE & GENERAL	5. 00 0. 00		
33. 03 OTHER ADJUSTMENTS (SPEC (3)	I FY)	0		0.00	0	33. 03
33. 04 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 04
33. 05 (3) (3) (3) (3) (3) (3) (3) (3) (3) (3)	I FY)	0		0.00	0	33. 05
33. 06 (3) OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 06
(3) 33. 07 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 07
(3) 33. 08 MEDICARE BAD DEBT - PAR 33. 09 OTHER ADJUSTMENTS (SPEC	1	-841, 330 0	ADMI NI STRATI VE & GENERAL	5.00 0.00		
(3) 33. 10 OTHER MEDICARE NON ALLO			ADMI NI STRATI VE & GENERAL	5.00		
33. 11 OTHER OPERATING - PATIE RELATIONS			ADMI NI STRATI VE & GENERAL	5.00		
33. 12 OTHER OPERATING - PUBLI RELATIONS			ADMI NI STRATI VE & GENERAL	5.00	0	
33.13 OTHER OPERATING - MARKE 33.14 OTHER OPERATING - INTER	1		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00		33. 13 33. 14
33.15 OTHER ADJUSTMENTS (SPEC (3)	IFY)	0		0.00	0	33. 15
33. 16 OTHER ADJUSTMENTS (SPEC (3)	IFY)	0		0.00	0	33. 16
33. 17 OTHER ADJUSTMENTS (SPEC (3)	IFY)	0		0.00	0	33. 17
33. 18 OTHER ADJUSTMENTS (SPEC (3)	IFY)	0		0.00	0	33. 18
33. 19 OTHER ADJUSTMENTS (SPEC (3)	I FY)	0		0.00	0	33. 19
33. 20 OTHER ADJUSTMENTS (SPEC (3)	I FY)	0		0.00	0	33. 20
33. 21 OTHER ADJUSTMENTS (SPEC (3)	I FY)	0		0.00	0	33. 21
33. 22 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 22
<ul> <li>(3)</li> <li>33. 23</li> <li>CHARI TABLE CONTRI BUTI ON</li> <li>33. 24</li> <li>OTHER ADJUSTMENTS (SPEC</li> <li>(2)</li> </ul>		-3, 525 0	ADMI NI STRATI VE & GENERAL	5.00 0.00		
(3) 33. 25 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 25
33. 26 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 26
(3) 33. 27 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 27
(3) 33. 28 AGGREGATE CAPI TAL EROSI 33. 29 OTHER ADJUSTMENTS (SPEC		-25, 652 0	ADMI NI STRATI VE & GENERAL	5.00 0.00		
33. 30 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 30
(3) 33. 31 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 31
(3) 33. 32 OTHER ADJUSTMENTS (SPEC	I FY)	0		0.00	0	33. 32
(3) 33. 33 OTHER ADJUSTMENTS (SPEC	IFY)	0		0.00	0	33. 33
(3) 33. 34 MALPRACTICE TAIL LIABIL 33. 35 OTHER ADJUSTMENTS (SPEC		-36, 984 0	ADMI NI STRATI VE & GENERAL	5.00 0.00		
(3) 33. 36 OTHER ADJUSTMENTS (SPEC	IFY)	0		0.00	0	33. 36
(3) 33. 37 OTHER ADJUSTMENTS (SPEC	IFY)	0		0.00	0	33. 37
(3) 33. 38 OTHER ADJUSTMENTS (SPEC		0		0.00		
(3)	,	Ū				

ealth Financial Systems ADJUSTMENTS TO EXPENSES				Period: From 09/01/2017	worksheet A-8	
				To 08/31/2018	Date/Time Pre 12/10/2018 3:	
			Expense Classification or To/From Which the Amount is			
Cost Center Description	Basi s/Code (2)	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 Ref. 5.00	
3. 39 OTHER ADJUSTMENTS (SPECIFY) (3)	1.00	0		0.00		33.
3. 40 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
3. 41 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	O	33
3. 42 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	33
3. 43 DI STRI CT OFFI CE SALES AND	A	-23, 797	ADMI NI STRATI VE & GENERAL	5.00	0	33
MARKETING DISTRICT OFC SALES AND MKT	А	-1, 848	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	C	33
BENEFITS BUSINESS INTERRUPTIONS INS	А	-651	CAP REL COSTS-BLDG & FIXT	1.00	12	33
PREMI UM 4. 00 MEDI CARE VS BOOK BLDG	A		CAP REL COSTS-BLDG & FIXT	1.00		
4. 01       MEDI CARE VS BOOK MOV EQUI P         4. 02       OTHER ADJUSTMENTS (SPECI FY)	A	-142, 134 0	CAP REL COSTS-MVBLE EQUIP	2.00 0.00		1 .
(3) 4. 03 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34
4.04 ASSET ADD-ON MOV EQUIP	A	16, 191	CAP REL COSTS-MVBLE EQUIP	2.00		
4.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	C	34
4.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	C	34
4. 07 OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	34
<ul> <li>4. 08 NON ALLOWABLE LOBBYING FEES</li> <li>4. 09 OTHER ADJUSTMENTS (SPECIFY)</li> <li>(3)</li> </ul>	A	-2, 587 0	ADMI NI STRATI VE & GENERAL	5.00 0.00		
4. 10 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	C	34
4. 11 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	C	34
4. 12 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	34
(3) 4.13 PATIENT PHONE - DEPREC EQUIP 4.14 OTHER ADJUSTMENTS (SPECIFY)	A	-46 0	CAP REL COSTS-MVBLE EQUIP	2.00 0.00		
(3) 4.15 OTHER ADJUSTMENTS (SPECIFY)		C		0.00	C	34
(3) 4. 16 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	C	34
(3) 4.17 OTHER ADJUSTMENTS (SPECIFY)		O		0.00	C	34
(3) 4.18 OTHER ADJUSTMENTS (SPECIFY)		O		0.00	C	34
(3) 4.19 OTHER ADJUSTMENTS (SPECIFY)		O		0.00	C	34
(3) 4. 20 OTHER ADJUSTMENTS (SPECIFY)		O		0.00	C	34
(3) 4. 21 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34
(3) 4. 22 OTHER ADJUSTMENTS (SPECIFY)		0		0.00		
(3) 4. 23 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34
(3) 4. 24 OTHER ADJUSTMENTS (SPECIFY)		C		0.00		
(3) I. 25 OTHER ADJUSTMENTS (SPECI FY)		0		0.00		
(3) 1. 26 OTHER ADJUSTMENTS (SPECIFY)		0		0.00		
(3) 4. 27 OTHER ADJUSTMENTS (SPECIFY)		0		0.00		
(3) 4. 28 OTHER ADJUSTMENTS (SPECIFY)		0		0.00		
(3) 5. 00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00		
(3)		~				
5. 01 OTHER ADJUSTMENTS (SPECIFY) (3)		U		0.00	0	35

	Financial Systems MENTS TO EXPENSES	Kind		Provider CCN: 15-2012	Peri od:	worksheet A-8	
					From 09/01/2017 To 08/31/2018	Date/Time Pre 12/10/2018 3:	
			-	Expense Classification To/From Which the Amount i			
					s to be Aujusted		
			Americant	Cost Costor	1		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
35.02	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.02
35. 03	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.03
35. 04	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.04
	(3)		0				
35.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.05
35.06	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.06
35.07	(3) OTHER ADJUSTMENTS (SPECIFY)		О		0.00	0	35.07
35. 08	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.08
35.09	(3) PHYSICIAN FEE ADJUSTMENT	А	7, 310	MEDICAL RECORDS & LIBRARY	16.00	0	35.09
35.10	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.10
35. 11	(3) PHYSICIAN FEE ADJUSTMENT	А	-25, 580	ADULTS & PEDIATRICS	30.00	0	35.11
35.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.12
35. 13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.13
35. 14	OTHER ADJUSTMENTS (SPECIFY)		О		0.00	0	35.14
35. 15	(3) OTHER ADJUSTMENTS (SPECIFY)		О		0.00	0	35.15
35. 16	(3) OTHER ADJUSTMENTS (SPECIFY)		О		0.00	0	35.16
35. 17	(3) PHYSICIAN FEE ADJUSTMENT	А	17 550	RESPI RATORY THERAPY	65.00	0	35.17
35.18	OTHER ADJUSTMENTS (SPECIFY)	-	0		0.00	0	1
35. 19	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 19
35. 20	(3) OTHER ADJUSTMENTS (SPECIFY)		о		0.00	0	35. 20
35. 21	(3) PHYSICIAN FEE ADJUSTMENT	А	720	RENAL DI ALYSI S	74.00	0	35.21
35. 22	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	1
35. 23	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.23
35. 24	(3) OTHER ADJUSTMENTS (SPECIFY)		О		0.00	0	35. 24
35. 25	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.25
	(3)						
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1, 195, 024				50.00

(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.

Heal th	Financial Systems	Kindred Hospital	Northwest Indiana	In Lieu of Form CMS-2552-10		2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-2012	Period: From 09/01/2017	Worksheet A-8	8-1
OFFICE	COSTS			To 08/31/2018	Date/Time Pre 12/10/2018 3:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	1, 531, 176	1, 272, 881	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	0	44, 309	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	0	100, 584	4.00
4.01	66.00	PHYSI CAL THERAPY	Therapy Servi ces	807,050	861, 445	4.01
4.22	60.00	LABORATORY	Hospital Related services	319, 171	319, 171	4.22
5.00	0		0	2, 657, 397	2, 598, 390	5.00

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

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

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

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

6.00	В	KHOLLC	100.00 Admin & Gen	100.00	6.00
7.00	В	KHOLLC	100.00Cornerstone	100.00	7.00
8.00	В	KHOLLC	100.00Cornerstone	100.00	8.00
9.00	В	KHOLLC	100.00 RehabCare	100.00	9.00
10.00	В	KHOLLC	100.00 KH - Chicago N.	100.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems Kindred Hospital No	rthwest Indiana	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet A-8-1 Date/Time Prepared:

			12/10/2018 3:	21 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE COS	STS:		
1.00	258, 295	0		1.00
2.00	0	0		2.00
3.00	-44, 309	0		3.00
4.00	-100, 584	0		4.00
4.01	-54, 395	0		4.01
4.22	0	0		4.22
5.00	59, 007			5.00

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

nuo no			
	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	Laboratory	10.00	
100.00		100.00	

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

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

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

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

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

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

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

Heal th	Financial Syste	ems		Ki	ndred Hospital	Nort	thwest India	ina	In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN	ADJU	STMENT	·		Provider C		Period: From 09/01/2017 To 08/31/2018		epared:
	Wkst. A Line #		Cost	Center/Physician	Total	Pro	ofessi onal	Provi der	RCE Amount	Physi ci an/Prov	21 pm
				Identi fi er	Remunerati on	С	Component	Component		ider Component Hours	
	1.00			2.00	3.00		4.00	5.00	6.00	7.00	
1.00	65.00	DR.	Α		7, 050		0	7,050	211, 500	47	1.00
2.00	16.00	DR.	В		7, 310		0	7, 310	211, 500	43	2.00
3.00	74.00				720		0	720	211, 500	4	3.00
4.00	65.00	DR.	D		10, 500		0	10, 500	211, 500	70	4.00
5.00	60.00				4, 318		0	4, 318	260, 300	23	5.00
6.00	30.00				42, 140		42, 140	(	,		6.00
7.00	30.00		G		25, 900		0	25, 900	211, 500	148	7.00
8.00	0.00				0		0	(	-	0	8.00
9.00	0.00				0		0	(	0	0	9.00
10.00	0.00				0		0	(	·  ·	0	10.00
200.00					97, 938		42, 140	55, 798			200.00
	Wkst. A Line #		Cost	Center/Physician	Unadjusted RCE		Percent of	Cost of		Physician Cost	
				ldenti fier	Limit	Unad		Memberships &		of Malpractice	
							Limit	Conti nui ng	Share of col.	Insurance	
	1.00			0.00	0.00		0.00	Education	12	11.00	
1.00	1.00	DD	^	2.00	8.00		9.00 239	12.00	13.00	14.00	1.00
2.00	16. 00				4, 779		239 219	(		-	2.00
2.00	74.00				4, 372		219	(		-	2.00
4.00	65.00				7, 118		356	(		-	4.00
4.00 5.00	60.00				2, 878		144	(	-	0	4.00 5.00
6.00	30.00				2,070		0	(	, s	0	6.00
7.00	30.00				15, 049		752	(	0	0	7.00
8.00	0.00		0		13, 049		, 32	(	0	0	8.00
9.00	0.00				0		0	(	-	°,	9.00
10.00	0.00				0		0	(	-	°	10.00
200.00	0.00				34, 603		1, 730	(	, s	Ű	200.00
	Wkst. A Line #		Cost	Center/Physician	Provi der	Adi	justed RCE	RCE	Adjustment	_	
				Identi fi er	Component	5	Limit	Di sal I owance			
					Share of col.						
					14						
	1.00			2.00	15.00		16.00	17.00	18.00		
1.00	65.00				0		4, 779	2, 271			1.00
2.00	16.00				0		4, 372	2, 938			2.00
3.00	74.00				0		407	313			3.00
4.00	65.00				0		7, 118	3, 382			4.00
5.00	60.00				0		2, 878	1,440			5.00
6.00	30.00				0		0	(	12,110		6.00
7.00	30.00	DR.	G		0		15, 049	10, 851			7.00
8.00	0.00				0		0	(	, s		8.00
9.00	0.00				0		0	(			9.00
10.00	0.00				0		0	(			10.00
200.00	l	I			0		34, 603	21, 195	63, 335		200.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 09/01/2017	Worksheet B Part I	
				T		Date/Time Pre 12/10/2018 3:	pared:
			CAPI TAL REL	ATED COSTS		12/10/2010 3.	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT	1, 235, 155	1, 235, 155				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	415, 130	14 200	415, 130			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 265, 836	14, 309 52, 762			2 509 047	4.00 5.00
5.00 7.00	00700 OPERATION OF PLANT	3, 330, 371 348, 181	52, 762	17, 733	197, 201 0	3, 598, 067 348, 181	5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	66, 259	0	0	0	66, 259	8.00
9.00	00900 HOUSEKEEPI NG	94, 196	0	0	0	94, 196	9.00
	01000 DI ETARY	307, 118	2, 713	912	10, 637	321, 380	10.00
11.00	01100 CAFETERI A	0	0	0	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	568, 663	13, 563	4, 559	88, 463	675, 248	13.00
	01400 CENTRAL SERVICES & SUPPLY	232, 267	26, 991	9, 072	11, 384	279, 714	14.00
	01500 PHARMACY	657, 728	6, 510			755, 745	15.00
	01600 MEDICAL RECORDS & LIBRARY	514, 651	32, 620			624, 194	16.00
17.00	01700 SOCIAL SERVICE	253, 045	18, 311	6, 154	38, 969	316, 479	17.00
30, 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	4, 473, 832	840, 460	282, 475	612, 396	6, 209, 163	30.00
	03100 INTENSIVE CARE UNIT	4, 473, 832	840, 480 0		012, 390	0, 209, 103	30.00
	04400 SKI LLED NURSI NG FACI LI TY	0	0		0	0	44.00
111.00	ANCI LLARY SERVICE COST CENTERS		0				
50.00	05000 OPERATI NG ROOM	1, 619, 322	0	0	17, 875	1, 637, 197	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	367, 281	0	0	0	367, 281	54.00
	06000 LABORATORY	930, 994	46, 116			999, 924	60.00
	06500 RESPI RATORY THERAPY	970, 198	6, 510		140, 200	1, 119, 096	65.00
	06600 PHYSI CAL THERAPY	808, 878	174, 290	58, 578	0	1, 041, 746	66.00
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	190, 520	0	0	0	190, 520	68.00 71.00
	07300 DRUGS CHARGED TO PATTENTS	938, 131	0	0	0	938, 131	73.00
	07400 RENAL DIALYSIS	592, 381	0	0	0	592, 381	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0			0	90.00
	09100 EMERGENCY	0	0	0	0	0	91.00
	OTHER REIMBURSABLE COST CENTERS		0				05 00
	09500 AMBULANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	95.00 98.00
90.00	SPECIAL PURPOSE COST CENTERS	U U	0	0	U	0	90.00
118.00		20, 180, 137	1, 235, 155	415, 130	1, 279, 719	20, 174, 902	118.00
	NONREI MBURSABLE COST CENTERS		, ,				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	-		192.00
	07950 NONALLOWABLE CLINICAL LIAISON	33, 997	0	0	5, 235		194.00
	07951 I DLE SPACE	0	0	0	0		194.01
	07952 REGIONAL OFFICE 07953 DISTRICT OFFICE	0	0	0	0		194. 02 194. 03
	07954 NON MCR CERTIFIED UNIT	0	0		0		194.03
	07955 REG NURSG OFFICE	0	0	0	0		194.04
	07956 CONTACT CENTER	0	0	0	0		194.06
	07957 CENTRALI ZED ADMI SSI ONS DEPT	Ő	0	0	o		194.07
	07959 OTHER NONREIMBURSABLE - OPEN	0	0	0	0		194. 08
	07958 VISITOR MEALS	0	0	0	0		194. 09
	07962 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194. 11
200.00			~	_			200.00
201.00 202.00		20, 214, 134	0 1, 235, 155	415, 130	0 1, 284, 954	0 20, 214, 134	201.00
202.00		20,214,134	1,230,100	415,150	1,204,704	20, 214, 134	202.00

COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 09/01/2017 To 08/31/2018	Worksheet B Part I Date/Time Pre 12/10/2018 3:	pared: 21_pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPING	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	3, 598, 067					5.00
7.00	00700 OPERATION OF PLANT	75, 395	423, 576				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	14, 348	0	80, 60	7		8.00
9.00	00900 HOUSEKEEPI NG	20, 397			0 114, 593		9.00
10.00	01000 DI ETARY	69, 592	984	ŀ	0 266	392, 222	
11.00	01100 CAFETERI A	0	C	D	0 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	146, 219			0 1, 331	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	60, 570			0 2,648	0	14.00
15.00	01500 PHARMACY	163, 650			0 639	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	135, 164			0 3, 200	0	
17.00	01700 SOCIAL SERVICE	68, 531	6, 640	/	0 1, 796	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 344, 545	304, 770	80, 60	7 02 452	392, 222	30.00
30.00	03100 INTENSIVE CARE UNIT	1, 344, 545	304,770		7 82, 452 0 0	392, 222	30.00
44.00	04400 SKILLED NURSING FACILITY	0	-		0 0	0	
44.00	ANCI LLARY SERVICE COST CENTERS	0		1	<u>v</u> v	0	44.00
50.00	05000 OPERATI NG ROOM	354, 520	0		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	79, 531			0 0	0	
60.00	06000 LABORATORY	216, 525			0 4, 524	0	60.00
65.00	06500 RESPI RATORY THERAPY	242, 330			0 639	0	65.00
66.00	06600 PHYSI CAL THERAPY	225, 581			0 17, 098	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	41, 255			0 0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	203, 144			0 0	0	
74.00	07400 RENAL DIALYSIS	128, 275	0	)	0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS	-	-	.1			
90.00	09000 CLINIC	0			0 0	0	
91.00		0	0	)	0 0	0	91.00
95.00	OTHER REI MBURSABLE COST CENTERS	0	C		0 0	0	95.00
93.00 98.00	09500 AMBOLANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	
70.00	SPECIAL PURPOSE COST CENTERS	0		/	<u> </u>	0	70.00
118.00		3, 589, 572	423, 576	80, 60	7 114, 593	392, 222	1118 00
110.0	NONREI MBURSABLE COST CENTERS	0,007,072	120,070	, 00,00	/	072,222	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0		192.00
	07950 NONALLOWABLE CLINICAL LIAISON	8, 495	c		0 0	0	194.00
194.0	07951 I DLE SPACE	0	0		0 0	0	194.01
194.02	2 07952 REGIONAL OFFICE	0	0		0 0	0	194.02
194.03	3 07953 DI STRI CT OFFI CE	0	0		0 0		194.03
194.04	4 07954 NON MCR CERTIFIED UNIT	0	0		0 0	0	194.04
	507955 REG NURSG OFFICE	0	0		0 0		194.05
	507956 CONTACT CENTER	0	0		0 0		194.06
	7 07957 CENTRALIZED ADMISSIONS DEPT	0	0	D	0 0		194.07
	3 07959 OTHER NONREI MBURSABLE - OPEN	0	0	D	0 0		194.08
	07958 VI SI TOR MEALS	0	0		0 0		194.09
	07962 OTHER NONREI MBURSABLE COST CENTERS	0	0		0		194.10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	) I	u 0	0	194.11
200.00	3	-	_			-	200.00
201.00		3, 598, 067	423, 576	80, 60	0 0 7 114, 593	0 392, 222	201.00
							1202 00

OST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet B Part I Date/Time Pre	epare
		0.000000		051175.41		12/10/2018 3:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS				_		
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.
00	00200 CAP REL COSTS-MVBLE EQUIP						2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00	00500 ADMINI STRATI VE & GENERAL						5.
00	00700 OPERATION OF PLANT						7.
00	00800 LAUNDRY & LINEN SERVICE						8.
00	00900 HOUSEKEEPI NG						9.
). 00							10.
1.00		(	D				11.
3.00		(	827, 716				13.
1.00		(	0 0	352, 72			14.
5.00		(	0 0	8, 92			15.
b. 00		(	0	35		774, 746	
. 00		(	0 0		0 0	0	17.
	INPATIENT ROUTINE SERVICE COST CENTERS		045 040	014 7	1 0 0 0	000 544	
0. 00			815, 362	214, 77		299, 544	
. 00			0		0 0	0	
. 00		(	0 0		0 0	0	44
	ANCI LLARY SERVICE COST CENTERS		12 254		0 0	45 544	1 50
0. 00		(	12, 354		0 0	45, 546	
. 00		(	0	45 55	0 0	21, 945	
). 00		(		15, 55		78, 361	
5.00 5.00				4, 13 87		125, 467 33, 727	
7.00				87	0 0	33, 727	
3.00					0 0	0	
. 00 . 00				108, 09	-	9, 751	
B. 00				106, 05	0 929, 503	139, 707	
. 00 . 00		(			0 929, 503		
. 00	OUTPATIENT SERVICE COST CENTERS		<u>ار</u>		0 0	20, 698	3 74
. 00			0		0 0	0	90
. 00					0 0	0	
. 00	OTHER REIMBURSABLE COST CENTERS		<u>v</u> <u>v</u>		<u> </u>	0	4 71
. 00		(	0 0		0 0	0	95
. 00					0 0	0	
. 00	SPECIAL PURPOSE COST CENTERS		<u> </u>		<u> </u>		1 /0
8.0		(	827, 716	352, 72	931, 321	774, 746	1118.
	NONREI MBURSABLE COST CENTERS		· · · · ·	·	·		
0.0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(	0 0		0 0	0	190.
2.0	0 19200 PHYSI CLANS' PRI VATE OFFI CES	(	o o		0 0	0	192.
4.0	0 07950 NONALLOWABLE CLINICAL LIAISON	(	o o		0 0		194
4.0	1 07951 I DLE SPACE	(	0 0		0 0		194
	2 07952 REGIONAL OFFICE	(	0 0		0 0		194
4.0	3 07953 DI STRI CT OFFI CE	(	0 0		0 0	0	194
	4 07954 NON MCR CERTIFIED UNIT	(	0 0		0 0		194
	5 07955 REG NURSG OFFICE	(	0 0		0 0		194
	6 07956 CONTACT CENTER	(	0 0		0 0		194
	7 07957 CENTRALIZED ADMISSIONS DEPT	(	0 0		0 0		194
	8 07959 OTHER NONREIMBURSABLE – OPEN	(	0 0		0 0	0	194
	9 07958 VISITOR MEALS	(	0 0		0 0		194
	0 07962 OTHER NONREI MBURSABLE COST CENTERS	(	0 0		0 0	0	194
4.1	1 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	(	0 0		0 0	0	194
0.0	0 Cross Foot Adjustments						200.
1.0	0 Negative Cost Centers	(	0 0		0 0	0	201
	0 TOTAL (sum lines 118 through 201)	(	827, 716	352, 72	931, 321	774, 746	1

	Financial Systems Kin LLOCATION - GENERAL SERVICE COSTS	dred Hospital No		na CN: 15-2012	Period:	u of Form CMS-2552-1 Worksheet B
					From 09/01/2017 To 08/31/2018	Part I
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		
	Г <u> </u>	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	1		1		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL					5.00
7.00	00700 OPERATI ON OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.00 15.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					16.00
	01700 SOCIAL SERVICE	393, 446				17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	070,110		I		
30.00	03000 ADULTS & PEDIATRICS	393, 446	10, 138, 705	;	0 10, 138, 705	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	C		0 0	31.00
44.00	04400 SKILLED NURSING FACILITY	0	0	)	0 0	44.00
	ANCI LLARY SERVI CE COST CENTERS	1 1		1		
	05000 OPERATING ROOM	0	2,049,617		0 2, 049, 617	50.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	468, 757		0 468, 757 0 1, 331, 615	54.00 60.00
	06500 RESPI RATORY THERAPY	0	1, 331, 615 1, 494, 026		0 1, 331, 615 0 1, 494, 026	65.00
	06600 PHYSI CAL THERAPY	0	1, 382, 228		0 1, 382, 228	66.00
	06700 OCCUPATI ONAL THERAPY	0	(		0 0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	349, 620		0 349, 620	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	2, 210, 485		0 2, 210, 485	73.00
74.00	07400 RENAL DIALYSIS	0	741, 354		0 741, 354	74.00
00 00	OUTPATIENT SERVICE COST CENTERS	0		1	0 0	90.00
	09100 EMERGENCY	0	0		0 0	90.00
71.00	OTHER REIMBURSABLE COST CENTERS	0		<u>′</u>		71.00
95.00	09500 AMBULANCE SERVICES	0	C	)	0 0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0	98.00
	SPECIAL PURPOSE COST CENTERS	1				
118.00		393, 446	20, 166, 407		0 20, 166, 407	118.00
100 00	NONREI MBURSABLE COST CENTERS			J		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	(		0 0	190. 00 192. 00
	07950 NONALLOWABLE CLINICAL LIAISON	0	47, 727		0 47,727	192.00
	07951 I DLE SPACE	0	47,727		0 47,727	194. 0
	07952 REGIONAL OFFICE	0	C		0 0	194. 02
194.03	07953 DI STRI CT OFFI CE	0	C		0 0	194. 03
	07954 NON MCR CERTIFIED UNIT	0	C		0 0	194. 04
	07955 REG NURSG OFFICE	0	C		0 0	194. 0
	07956 CONTACT CENTER	0	C		0 0	194.00
	07957 CENTRALIZED ADMISSIONS DEPT	0	(		0	194.0
	07959 OTHER NONREIMBURSABLE - OPEN 07958 VISITOR MEALS	0				194. 08 194. 09
174.09	07958 VISITOR MEALS 07962 OTHER NONREIMBURSABLE COST CENTERS	0	r c			194. 0
194 10	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	(		0 0	194. 1
				1		1.2.0.1
			C		0 0	200.00
194.11	Cross Foot Adjustments	0	C		0 0 0 0	200. 00 201. 00

Heal th	Financial Systems	Kindred Hospital Nor	thwest Ind	i ana	In Lie	u of Form CMS-	2552-10
COST A	LLOCATION STATISTICS		Provi der	CCN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet Non Date/Time Pre	
						12/10/2018 3:	
	Cost Center Description			Statisti	cs Statistics	Description	
				Code			
				1.00	2.	00	
	GENERAL SERVICE COST CENTERS				1		_
1.00	CAP REL COSTS-BLDG & FIXT			1	SQUARE FEET #1		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			2	SQUARE FEET #2		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT			S	GROSS SALARIES		4.00
5.00	ADMINISTRATIVE & GENERAL			-5	ACCUM. COST		5.00
7.00	OPERATION OF PLANT			7	SQUARE FEET #3		7.00
8.00	LAUNDRY & LINEN SERVICE			Р	PATI ENT DAYS		8.00
9.00	HOUSEKEEPING			9	SQUARE FEET #4		9.00
10.00	DI ETARY			10	MEALS SERVED		10.00
11.00	CAFETERIA			11	CAFETERIA FTES		11.00
13.00	NURSING ADMINISTRATION			13	NURSING FTES		13.00
14.00	CENTRAL SERVICES & SUPPLY			14	COSTED REQUIS.		14.00
15.00	PHARMACY			15	COSTED REQUIS.		15.00
16.00	MEDICAL RECORDS & LIBRARY			С	GROSS REVENUE		16.00
17.00	SOCIAL SERVICE			P	PATI ENT DAYS		17.00

		dred Hospital N				u of Form CMS-	2552-10
ALLOCATI	ON OF CAPITAL RELATED COSTS		Provider CO		Period: From 09/01/2017 To 08/31/2018	Worksheet B Part II Date/Time Pre 12/10/2018 3:	epared: 21 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	ENERAL SERVICE COST CENTERS						1
2.00 00 4.00 00 5.00 00 7.00 00	D100 CAP REL COSTS-BLDG & FIXT D200 CAP REL COSTS-MVBLE EQUIP D400 EMPLOYEE BENEFITS DEPARTMENT D500 ADMINISTRATIVE & GENERAL D700 OPERATION OF PLANT D800 LAUNDRY & LINEN SERVICE	0 139, 837 0	14, 309 52, 762 0			19, 118 2, 934 0 0	5.00 7.00
	0900 HOUSEKEEPING	0	0		0 0	0	
10.00 01	1000 DI ETARY	0	2, 713	91	2 3, 625	158	10.00
		0	0		0 0	0	
	I 300 NURSI NG ADMI NI STRATI ON I 400 CENTRAL SERVI CES & SUPPLY	0	13, 563 26, 991	4, 55 9, 07		1, 316	1
	1400 CENTRAL SERVICES & SUPPLY	0	6, 510			169 1, 329	
	1600 MEDICAL RECORDS & LIBRARY	0	32, 620			982	1
	1700 SOCIAL SERVICE	0	18, 311	6, 15		580	
	IPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
	3000 ADULTS & PEDIATRICS	0	840, 460	282, 47		9, 111	
	3100 INTENSIVE CARE UNIT 1400 SKILLED NURSING FACILITY	0	0		0 0 0 0	0	
	ICI LLARY SERVICE COST CENTERS	0	0		0 0	0	44.00
	5000 OPERATING ROOM	0	0		0 0	266	50.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
	5000 LABORATORY	0	46, 116			109	
	5500 RESPI RATORY THERAPY	0	6, 510	2, 18		2,086	
	5600 PHYSI CAL THERAPY 5700 OCCUPATI ONAL THERAPY	0	174, 290	58, 57	8 232, 868 0 0	0	
	5800 SPEECH PATHOLOGY	0	0			0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	7400 RENAL DIALYSIS	0	0		0 0	0	74.00
	JTPATIENT SERVICE COST CENTERS		-	1	-	-	
		0	0		0 0	0	
	P100 EMERGENCY THER REIMBURSABLE COST CENTERS	0	0		0 0	0	91.00
	2500 AMBULANCE SERVICES	0	0		0 0	0	95.00
	9850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	-	
SP	PECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	139, 837	1, 235, 155	415, 13	0 1, 790, 122	19, 040	118.00
	NREIMBURSABLE COST CENTERS	0	0		0 0	0	100.00
	2000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 2200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				190.00 192.00
	7950 NONALLOWABLE CLINICAL LIAISON	0	0		0 0		194.00
	7951 I DLE SPACE	0	0		0 0		194.01
	7952 REGIONAL OFFICE	0	0		0 0	0	194. 02
	7953 DI STRI CT OFFI CE	0	0		0 0		194. 03
	7954 NON MCR CERTIFIED UNIT	0	0		0 0		194.04
	7955 REG NURSG OFFICE 7956 CONTACT CENTER	0	0				194.05 194.06
	7957 CENTRALI ZED ADMI SSI ONS DEPT	0	0		0 0		194.00
	7959 OTHER NONREI MBURSABLE - OPEN	0	0		0 0		194.08
194.0907	7958 VISITOR MEALS	0	0		0 0	0	194.09
	7962 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194. 10
	7961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		0 0	0	194.11
200.00	Cross Foot Adjustments		~		0	-	200.00 201.00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	139, 837	1, 235, 155	415, 13	0 1, 790, 122		201.00
202.00		1 107,007	1,200,100	1 710,10	, , , , , , , , , , , , , , , , , , ,	17,110	1-02.00

Heal th	Financial Systems Kind	dred Hospital N	orthwest India	na	In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 09/01/2017	Worksheet B Part II	
					08/31/2018	Date/Time Pre	
	Cast Capton Decerintian					12/10/2018 3:	21 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1	Γ	1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	213, 266					5.00
7.00	00700 OPERATI ON OF PLANT	4, 469					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	850	0				8.00
9.00	00900 HOUSEKEEPI NG	1, 209	0				9.00
10.00	01000 DI ETARY	4, 125	10	0	3	7, 921	10.00
11.00	01100 CAFETERI A	0	0	0	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	8, 667	52	0	14	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 590			28	0	14.00
15.00	01500 PHARMACY	9, 700			7	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	8, 012	125		34	0	
17.00	01700 SOCI AL SERVI CE	4, 062	70	0	19	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	70.400	0.01/			7.001	
30.00	03000 ADULTS & PEDIATRICS	79, 693	3, 216			7, 921	
31.00	03100 I NTENSI VE CARE UNI T 04400 SKI LLED NURSI NG FACI LI TY	0	0			0	
44.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	44.00
50.00	05000 OPERATING ROOM	21,013	0	0	o	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 714				0	
60.00	06000 LABORATORY	12, 834			48	0	60.00
65.00	06500 RESPIRATORY THERAPY	14, 364			70	0	65.00
66.00	06600 PHYSI CAL THERAPY	13, 371	667		180	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 445	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 041	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	7,603	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLINIC	0				0	
91.00		0	0	0	0	0	91.00
05 00	OTHER REIMBURSABLE COST CENTERS						05 00
95.00	09500 AMBULANCE SERVICES	0				0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	98.00
118.00		212, 762	4, 469	850	1, 209	7 021	118.00
110.00	NONREI MBURSABLE COST CENTERS	212,702	4,409	030	1,209	1, 721	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	07950 NONALLOWABLE CLINICAL LIAISON	504	0	Ö	0		194.00
	07951 I DLE SPACE	0	0	0	0		194.01
194.02	07952 REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953 DI STRI CT OFFI CE	0	0	0	0	0	194.03
194.04	07954 NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
	07955 REG NURSG OFFICE	0	0	0	0	0	194.05
194.00	07956 CONTACT CENTER	0	0	0	0	0	194.06
	07957 CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194. 07
	07959 OTHER NONREI MBURSABLE - OPEN	0	0	0	0		194.08
	07958 VISITOR MEALS	0	0	0	0		194.09
	07962 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194.10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		_	_	_		-	200.00
201.00		0		0			201.00
202.00	η μιστάς (Sum times της through 201)	213, 266	4, 469	850	1, 209	7, 921	202.00

ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CC	N: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet B Part II Date/Time Pre 12/10/2018 3:	epared: 21 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	-
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	(					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	(	28, 171				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	(		39, 95	53		14.00
15.00	01500 PHARMACY	(		1, 01			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	(			1 0	52, 777	
17.00	01700 SOCI AL SERVI CE	(	o o		0 0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·	-1 -1		-1 -1		1
30.00	03000 ADULTS & PEDI ATRI CS	(	27, 751	24, 32	28 41	20, 383	30.00
31.00	03100 I NTENSI VE CARE UNI T		0 0		0 0	0	1
	04400 SKILLED NURSING FACILITY		0 0		0 0	0	
	ANCILLARY SERVICE COST CENTERS		•				
50.00	05000 OPERATI NG ROOM	(	420		0 0	3, 105	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	(	0 0		0 0	1, 496	54.00
60.00	06000 LABORATORY	(	0 0	1, 76	52 0	5, 342	60.00
65.00	06500 RESPI RATORY THERAPY	(	0 0	46	0 8	8, 553	65.00
66.00	06600 PHYSI CAL THERAPY	(	0 0	ç	99 0	2, 299	66.00
67.00	06700 OCCUPATI ONAL THERAPY	(	0 0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	(	0 0		0 0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	(	0 0	12, 24		665	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	(	0 0		0 20, 729	9, 523	73.00
74.00	07400 RENAL DIALYSIS	(	0 0		0 0	1, 411	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 SERVI CES		0 0		0 0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	(	0 0		0 0	0	98.00
	SPECIAL PURPOSE COST CENTERS						
118.00		(	28, 171	39, 95	53 20, 770	52, 777	118.00
100 00	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES				0 0		192.00
	07950 NONALLOWABLE CLINICAL LIAISON				0 0		194.00
	07951 I DLE SPACE				0 0		194.01
	07952 REGI ONAL OFFI CE 07953 DI STRI CT OFFI CE				0 0		194.02
					0 0		194.03
	07954 NON MCR CERTIFIED UNIT 07955 REG NURSG OFFICE						194.04 194.05
	07955 REG NURSG OFFICE 07956 CONTACT CENTER						194.05
	07950 CONTACT CENTER 07957 CENTRALIZED ADMISSIONS DEPT						194.06
	07957 CENTRALIZED ADMISSIONS DEPT 07959 OTHER NONREIMBURSABLE - OPEN						194.07
	07959 OTHER NONRETMBORSABLE - OPEN 07958 VISITOR MEALS						194.08
	07958 VISITOR MEALS 07962 OTHER NONREIMBURSABLE COST CENTERS						194.09
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION						194.10
194. 11 200. 00						0	200.00
200.00 201.00						0	200.00
201.00 202.00			28, 171	39, 95	53 20, 770		201.00
	INTAL (SUM ITTES ITO UNUUM ZUT)		∠0, ۱/۱	37, 93	20, 770	JZ, 111	1202.00

Heal th Financial Systems	Ki nd	red Hospital No	rthwest India	na	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provider C		Period: From 09/01/2017 To 08/31/2018	Worksheet B Part II Date/Time Pre 12/10/2018 3:	pared: 21 pm
Cost Center Description		SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS		I					
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	- NT						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTM	ENI						4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT							5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8.00
9. 00 00900 HOUSEKEEPI NG							9.00
10. 00 01000 DI ETARY							10.00
11. 00 01100 CAFETERIA							11.00
13.00 01300 NURSING ADMINISTRATION							13.00
14.00 01400 CENTRAL SERVICES & SUPPLY							14.00
15. 00 01500 PHARMACY							15.00
16.00 01600 MEDICAL RECORDS & LIBRARY							16.00
17.00 01700 SOCIAL SERVICE		29, 196					17.00
30.00 03000 ADULTS & PEDIATRICS	CENTERS	20, 104	1 224 204		1 224 204		20.00
31. 00 03100 INTENSIVE CARE UNIT		29, 196 0	1, 326, 294 0		0 1, 326, 294 0 0		30.00 31.00
44. 00 04400 SKILLED NURSING FACILITY		0	0		0 0		44.00
ANCI LLARY SERVICE COST CENTERS							11.00
50.00 05000 OPERATI NG ROOM		0	24, 804	(	0 24, 804		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0	6, 210		0 6, 210		54.00
60. 00 06000 LABORATORY		0	81, 886		0 81, 886		60.00
65. 00 06500 RESPI RATORY THERAPY		0	34, 201		0 34, 201		65.00
66.00 06600 PHYSI CAL THERAPY		0	249, 484		0 249, 484		66.00
67.00 06700 OCCUPATIONAL THERAPY		0	0				67.00
68. 00 06800 SPEECH PATHOLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED		0	15, 354		0 0 0 15,354		68.00 71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	42, 293		0 42, 293		73.00
74. 00 07400 RENAL DI ALYSI S		Ő	9,014		9,014		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 0		91.00
OTHER REI MBURSABLE COST CENTERS		-					
95.00 09500 AMBULANCE SERVICES 98.00 09850 OTHER REIMBURSABLE COST C		0	0		0 0 0 0		95.00
98.00 09850 OTHER REIMBURSABLE COST C SPECIAL PURPOSE COST CENTERS	ENTERS	U	0	1			98.00
118.00 SUBTOTALS (SUM OF LINES 1	through 117)	29, 196	1, 789, 540		0 1, 789, 540		118.00
NONREI MBURSABLE COST CENTERS	thi ough (17)	2,,,,,,,,	1,707,010		1,10,1010		
190.00 19000 GIFT, FLOWER, COFFEE SHOP	& CANTEEN	0	0		0 0		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI C	ES	0	0	(	0 0		192.00
194.0007950 NONALLOWABLE CLINICAL LIA	I SON	0	582		0 582		194.00
194.0107951 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
194.0407954 NON MCR CERTIFIED UNIT 194.0507955 REG NURSG OFFICE		0	0				194.04
194. 06 07956 CONTACT CENTER			0				194.05 194.06
194. 07 07957 CENTRALI ZED ADMI SSI ONS DE	PT	0	0				194.00
194. 08 07959 OTHER NONREI MBURSABLE - 0		o	0		o ol		194.08
194. 09 07958 VI SI TOR MEALS		o	0		0 0		194.09
194. 10 07962 OTHER NONREI MBURSABLE COS		О	0	(	0 0		194.10
194.11 07961 NONREIMB NEW BUSINESS IMP	LEMENTATI ON	0	0		0 0		194. 11
200.00 Cross Foot Adjustments			0	(	0 0		200.00
201.00 Negative Cost Centers	ugh 201)		1 700 100		0 0 0		201.00
202.00  TOTAL (sum lines 118 thro	ugii 201)	29, 196	1, 790, 122	I (	0 1, 790, 122		202.00

In Lieu of Form CMS-2552-10

			dred Hospital N				u of Form CMS-:	
OST .	ALLOCA	TION - STATISTICAL BASIS		Provider CC		eriod:	Worksheet B-1	
						rom 09/01/2017 o 08/31/2018	Date/Time Pre	pare
							12/10/2018 3:	
			CAPI TAL REL	ATED COSTS				
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconci I i ati on		
			(SQUARE FEET #1)	(SQUARE FEET	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	
			#1)	#2)	(GROSS		(ACCOM. COST)	
					SALARI ES)			
			1.00	2.00	4.00	5A	5.00	<u> </u>
	GENEF	RAL SERVICE COST CENTERS						
. 00	00100	CAP REL COSTS-BLDG & FIXT	18, 213					1.
. 00	00200	CAP REL COSTS-MVBLE EQUIP		18, 213				2.
. 00	00400	EMPLOYEE BENEFITS DEPARTMENT	211	211	7, 967, 052			4.
. 00	00500	DADMINISTRATIVE & GENERAL	778	778	1, 222, 704	-3, 598, 067	16, 616, 067	5.
. 00		OPERATION OF PLANT	0	0	0	0	348, 181	7.
. 00		LAUNDRY & LINEN SERVICE	0	0	0	0	66, 259	
. 00		HOUSEKEEPING	0	0	0	-	94, 196	
0. 00		DI ETARY	40	40	65, 952	0	321, 380	
1.00	1	CAFETERIA	0	0	0	Ű	0	
3.00		NURSI NG ADMI NI STRATI ON	200		548, 497		675, 248	
4.00	1	CENTRAL SERVICES & SUPPLY	398		70, 584		279, 714	
5.00		PHARMACY	96	96	553, 801		755, 745	
6.00		MEDICAL RECORDS & LIBRARY	481	481	408, 969		624, 194	
7.00			270	270	241, 616	0	316, 479	17.
0 00		ADULTS & DEDUATED OS	12 202	10,000	2 707 000	0	( 200 1/2	20
D. 00 1. 00		ADULTS & PEDIATRICS	12, 393		3, 797, 000		6, 209, 163	
1.00 4.00	1	SKILLED NURSING FACILITY	0		0		0	
+. 00		LARY SERVICE COST CENTERS	0	0	0	0	0	44.
0. 00		OPERATING ROOM	0	0	110, 833	0	1, 637, 197	50.
1. 00		RADI OLOGY-DI AGNOSTI C	0		033		367, 281	
). 00		LABORATORY	680		45, 358	-	999, 924	
5. 00		RESPIRATORY THERAPY	96		869, 277		1, 119, 096	
5. 00 5. 00		PHYSICAL THERAPY	2, 570		007,277		1, 041, 746	
7. 00		OCCUPATIONAL THERAPY	2,0,0	2, 0, 0	0	-	0	
3. 00		SPEECH PATHOLOGY	0	0	0	-	0	
1.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	-	190, 520	
3.00		DRUGS CHARGED TO PATIENTS	0	-	0	-	938, 131	
4.00		RENAL DI ALYSI S	0		0	-	592, 381	
		ATIENT SERVICE COST CENTERS						
0. 00		D CLINIC	0	0	0	0	0	90.
1.00	09100	EMERGENCY	0	0	0	0	0	91.
	OTHEF	REIMBURSABLE COST CENTERS						
5. 00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.
8. 00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.
	SPECI	AL PURPOSE COST CENTERS						
18.0	0	SUBTOTALS (SUM OF LINES 1 through 117)	18, 213	18, 213	7, 934, 591	-3, 598, 067	16, 576, 835	118.
		IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.
		PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.
		NONALLOWABLE CLINICAL LIAISON	0	0	32, 461	0	39, 232	
		I DLE SPACE	0	0	0	-		194.
		2 REGIONAL OFFICE	0	-	0	-		194.
		B DI STRI CT OFFI CE	0	0	0	-		194
		NON MCR CERTIFIED UNIT	0	-	0	-		194
		REG NURSG OFFICE	0	0	0	-		194
		CONTACT CENTER	0	0	0	-		194
	/07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	-		194
4.0	00-0	OTHER NONREIMBURSABLE – OPEN	I 0I	0	0	-		194
4.0 4.0					0	0		194
4.0 4.0 4.0	9 07958	B VISITOR MEALS	0	0				194
4.0 4.0 4.0 4.1	9 07958 0 07962	3 VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	-		104
4.0 4.0 4.0 4.1 4.1	9 07958 0 07962 1 07961	VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS 1 NONREIMB NEW BUSINESS IMPLEMENTATION	0 0 0	0 0 0		-		
4.0 4.0 4.1 4.1 0.0	9 07958 0 07962 1 07961 0	VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS 1 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments	000000000000000000000000000000000000000	0	0	-		200.
4.0 4.0 4.1 4.1 0.0 1.0	9 07958 0 07962 1 07961 0 0	VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS 1 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers	0000	0	0 0	0	0	200. 201.
4.0 4.0 4.1 4.1 0.0	9 07958 0 07962 1 07961 0 0	VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS 1 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 1, 235, 155	0	0 0	0		200. 201.
94.0 94.0 94.1 94.1 94.1 90.0 91.0	9 07958 0 07962 1 07961 0 0 0	VISITOR MEALS OTHER NONREIMBURSABLE COST CENTERS NOREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)		0 0 415, 130	0 0 1, 284, 954	0	0 3, 598, 067	200. 201. 202.
94.0 94.0 94.1 94.1 94.1 90.0 91.0 92.0	9 07958 0 07962 1 07961 0 0 0 0	VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS 1 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	0 0 1, 235, 155 67. 817218	0 0 415, 130	0 0 1, 284, 954 0. 161283	O	0 3, 598, 067 0. 216541	200. 201. 202. 203.
94.0 94.0 94.1 94.1 94.1 90.0 91.0 92.0	9 07958 0 07962 1 07961 0 0 0 0	VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS 1 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,		0 0 415, 130	0 0 1, 284, 954	O	0 3, 598, 067	200. 201. 202. 203.
94.0 94.0 94.1 94.1 90.0 91.0 92.0 93.0 94.0	9 07958 0 07962 1 07961 0 0 0 0 0	VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS 1 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)		0 0 415, 130	0 0 1, 284, 954 0. 161283 19, 118	0	0 3, 598, 067 0. 216541 213, 266	200. 201. 202. 203. 204.
94.0 94.0 94.1 94.1 90.0 91.0 92.0 93.0 94.0	9 07958 0 07962 1 07961 0 0 0 0 0	VISITOR MEALS 2 OTHER NONREIMBURSABLE COST CENTERS 1 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part		0 0 415, 130	0 0 1, 284, 954 0. 161283	0	0 3, 598, 067 0. 216541	200 201 202 203 203
94.0 94.0 94.1 94.1 94.1 00.0 01.0 02.0 03.0 04.0	9 07958 0 07962 1 07961 0 0 0 0 0 0	VISITOR MEALS OTHER NONREIMBURSABLE COST CENTERS NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)		0 0 415, 130	0 0 1, 284, 954 0. 161283 19, 118	0	0 3, 598, 067 0. 216541 213, 266	200. 201. 202. 203. 204. 205.
94.0 94.0 94.0 94.1	9 07958 0 07962 1 07961 0 0 0 0 0 0	VISITOR MEALS OTHER NONREIMBURSABLE COST CENTERS NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated		0 0 415, 130	0 0 1, 284, 954 0. 161283 19, 118	0	0 3, 598, 067 0. 216541 213, 266	203. 204.
94.0 94.0 94.0 94.1 94.1 00.0 01.0 02.0 03.0 04.0	9 07958 0 07962 1 07961 0 0 0 0 0 0	VISITOR MEALS OTHER NONREIMBURSABLE COST CENTERS NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)		0 0 415, 130	0 0 1, 284, 954 0. 161283 19, 118	0	0 3, 598, 067 0. 216541 213, 266	200. 201. 202. 203. 204. 205.

	Financial Systems Kind LLOCATION - STATISTICAL BASIS	dred Hospital N	lorthwest India Provider CC		In Lie	u of Form CMS-: Worksheet B-1	
CUST A	LLUCATION - STATISTICAL BASIS			F	rom 09/01/2017 o 08/31/2018	Date/Time Pre 12/10/2018 3:	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPI NG (SQUARE FEET #4)	DI ETARY (MEALS SERVED)	CAFETERI A (CAFETERI A FTES)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS		I		· · · · · · · · · · · · · · · · · · ·		
11. 00 13. 00 14. 00 15. 00 16. 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	17, 224 0 40 200 398 96 481 270	13, 176 0 0 0 0 0 0 0 0 0 0 0	17, 224 40 0 200 398 96 481 270	20, 619 0 0 0 0 0	106 7 2 7 5 3	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
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1				
31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	12, 393 0 0	0	12, 393 0 0	0	66 0 0	30.00 31.00 44.00
54.00 60.00 65.00 66.00 67.00 68.00 71.00 73.00	05000 OPERATING ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 680 96 2, 570 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	0 0 680 96 2, 570 0 0 0 0 0 0 0 0 0	0 0 0	1 0 2 13 0 0 0 0 0 0 0 0 0 0 0	50.00 54.00 60.00 65.00 66.00 67.00 68.00 71.00 73.00 74.00
00.00	OUTPATIENT SERVICE COST CENTERS		0	0		0	
	09000 CLINIC 09100 EMERGENCY			0		0	90.00 91.00
/ 11 00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		1
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
	SPECIAL PURPOSE COST CENTERS						
118.00		17, 224	13, 176	17, 224	20, 619	106	118.00
192.00 194.00 194.01	NORREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRIVATE OFFICES 07950 NONALLOWABLE CLINICAL LIAISON 07951 IDLE SPACE 07952 REGIONAL OFFICE		000000000000000000000000000000000000000	0 0 0 0	0 0 0	0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02
	07953 DI STRI CT OFFI CE		0		0		194.02
	07954 NON MCR CERTIFIED UNIT	0	0	0	Ő		194.04
	07955 REG NURSG OFFICE	0	0	0	0		194. 05
	07956 CONTACT CENTER	0	0	0	0		194.06
	07957 CENTRALIZED ADMISSIONS DEPT 07959 OTHER NONREIMBURSABLE - OPEN		0		0		194. 07 194. 08
	07958 VISITOR MEALS	0	0	0	0		194.09
		C C	0	0 0	0		194. 10 194. 11 200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	423, 576	80, 607	114, 593	392, 222	0	202.00
203. 00 204. 00		24. 592197 4, 469		6. 653100 1, 209		0. 000000 0	203. 00 204. 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 259464	0. 064511	0. 070193	0. 384160	0.000000	205.00
206.00							206. 00
207.00							207. 00
	Parts III and IV)		I				

	Financial Systems Kind LLOCATION - STATISTICAL BASIS	dred Hospital No	Provider CC		Period:	wof Form CMS- Worksheet B-1	
J31 A	LLUCATION - STATISTICAL DASIS		Provider CC	N. 15-2012	From 09/01/2017 To 08/31/2018	Date/Time Pre	epare
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	12/10/2018 3: SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		(NURSING FTES)	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	(PATIENT DAYS)	
			REQUIS.)		REVENUE)		
		13.00	14.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS	Т — Т	T				ł.,
. 00	00100 CAP REL COSTS-BLDG & FLXT						1.
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.
00	00500 ADMI NI STRATI VE & GENERAL						5
00	00700 OPERATION OF PLANT						7
00	00800 LAUNDRY & LINEN SERVICE						8
00	00900 HOUSEKEEPI NG						9
. 00	01000 DI ETARY						10
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	67					11
	01400 CENTRAL SERVICES & SUPPLY	07	621, 673				14
	01500 PHARMACY	0	15, 733	939, 96	56		15
. 00	01600 MEDI CAL RECORDS & LI BRARY	0	633		0 85, 455, 815		16
. 00	01700 SOCIAL SERVICE	0	0		0 0	13, 176	17
~~	INPATIENT ROUTINE SERVICE COST CENTERS		070 540			10.17/	
	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	66 0	378, 543 0	1, 83	35 33, 040, 028 0 0	13, 176 0	
	04400 SKILLED NURSING FACILITY	0	0		0 0	0	
. 00	ANCI LLARY SERVICE COST CENTERS	1 9			<u> </u>		1.
. 00	05000 OPERATING ROOM	1	0		0 5, 023, 803	0	50
. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 2, 420, 534	0	-
. 00	06000 LABORATORY	0	27, 422		0 8, 643, 409	0	
. 00		0	7, 285		0 13, 839, 339	0	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 540 0		0 3, 720, 215	0	
	06800 SPEECH PATHOLOGY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	190, 517		0 1, 075, 506	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	938, 13		0	73
. 00	07400 RENAL DIALYSIS	0	0		0 2, 283, 008	0	74
00	OUTPATIENT SERVICE COST CENTERS		0				
	09000 CLINIC 09100 EMERGENCY	0	0		0 0	0	
00	OTHER REIMBURSABLE COST CENTERS	0	U.		0 0	0	7
. 00	09500 AMBULANCE SERVICES	0	0		0 0	0	95
. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98
	SPECIAL PURPOSE COST CENTERS	, ,					
8.00		67	621, 673	939, 96	6 85, 455, 815	13, 176	118
	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	1190
	19200 PHYSI CLANS' PRI VATE OFFICES	0	0				192
	07950 NONALLOWABLE CLINICAL LIAISON	0	0		0 0		194
	07951 I DLE SPACE	0	Ő		0 0		194
	07952 REGIONAL OFFICE	0	0		0 0		194
	07953 DI STRI CT OFFI CE	0	0		0 0		194
	07954 NON MCR CERTIFIED UNIT	0	0		0 0		194
	07955 REG NURSG OFFICE 07956 CONTACT CENTER	0	0		0 0		194 194
	07957 CENTRALIZED ADMISSIONS DEPT	0	0				194
	07959 OTHER NONREI MBURSABLE - OPEN	0	0		0 0		194
	07958 VISITOR MEALS	0	0		0 0		194
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		0 0	0	194
). 00	5						200
1.00 2.00	5	827, 716	352, 720	931, 32	21 774, 746	393, 446	201
∠.∪∪	Part I)	027,710	352,720	731, 32	//4,/40	373, 440	202
3.00		12, 353. 970149	0. 567372	0. 99080	0. 009066	29.860808	203
4.00		28, 171	39, 953	20, 77		29, 196	
	Part II)						
5.00		420. 462687	0. 064267	0. 02209	0. 000618	2. 215847	205
6. 00	NAHE adjustment amount to be allocated						206
0.00	(per Wkst. B-2)						200
							207
7.00							1201

Heal th	Financial Systems Kin	dred Hospital N	orthwest India	na	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 09/01/2017 To 08/31/2018	Worksheet C Part I Date/Time Pre 12/10/2018 3:	pared: 21 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2.00	3.00	4,00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30, 00	03000 ADULTS & PEDIATRICS	10, 138, 705		10, 138, 705	10, 851	10, 149, 556	30.00
31.00	03100 INTENSIVE CARE UNIT	0		C	0 0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		l c	0 0	0	44.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	2, 049, 617		2, 049, 617	0	2, 049, 617	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	468, 757		468, 757	0	468, 757	54.00
60.00	06000 LABORATORY	1, 331, 615		1, 331, 615	1, 440	1, 333, 055	60.00
65.00	06500 RESPI RATORY THERAPY	1, 494, 026	0	1, 494, 026	5, 653	1, 499, 679	65.00
66.00	06600 PHYSI CAL THERAPY	1, 382, 228	0	1, 382, 228	8 0	1, 382, 228	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	C	0 0	0	67.00
	06800 SPEECH PATHOLOGY	0	0	C	0 0	0	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	349, 620		349, 620		349, 620	
	07300 DRUGS CHARGED TO PATIENTS	2, 210, 485		2, 210, 485		2, 210, 485	
74.00	07400 RENAL DI ALYSI S	741, 354		741, 354	313	741, 667	74.00
	OUTPATIENT SERVICE COST CENTERS	-		-			
	09000 CLINIC	0		C		0	90.00
91.00	09100 EMERGENCY	0		C	0 0	0	91.00
05 00	OTHER REIMBURSABLE COST CENTERS						05 00
	09500 AMBULANCE SERVICES	0			0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0 1// 107	0			0	98.00
200.00		20, 166, 407	0	20, 166, 407	18, 257	20, 184, 664	200.00
201.00		20 166 407	0		10 257		
202.00	Total (see instructions)	20, 166, 407	0	20, 166, 407	18, 257	20, 184, 004	202.00

	Financial Systems	Kindred Hospital No	rthwest India	na	In Lie	u of Form CMS-	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CC	<u> </u>	Period: From 09/01/2017 Fo 08/31/2018	Worksheet C Part I Date/Time Pre 12/10/2018 3:	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	+ col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS	33, 040, 028		33, 040, 02	3		30.00
	D3100 I NTENSI VE CARE UNI T	0		(	D		31.00
	04400 SKILLED NURSING FACILITY	0		(	)		44.00
	ANCI LLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM	5, 019, 667	4, 136			0. 000000	
	D5400 RADI OLOGY-DI AGNOSTI C	2, 396, 855	23, 679			0.000000	
	D6000 LABORATORY	8, 545, 634	97, 775			0. 000000	
	06500 RESPI RATORY THERAPY	13, 802, 964	36, 375			0. 000000	
	06600 PHYSI CAL THERAPY	3, 696, 264	23, 951	3, 720, 21		0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0	(	0. 000000	0.00000	
	06800 SPEECH PATHOLOGY	0	0	(	0. 000000	0.00000	68.00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS 1, 074, 691	815	1, 075, 50	6 0. 325075	0.00000	71.00
73.00 0	07300 DRUGS CHARGED TO PATIENTS	15, 409, 973	0	15, 409, 97	0. 143445	0.00000	73.00
	07400 RENAL DI ALYSI S	2, 205, 222	77, 786	2, 283, 00	0. 324727	0.00000	74.00
	DUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0	(	0. 000000	0.00000	
	09100 EMERGENCY	0	0	(	0. 000000	0.00000	91.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	0	(	0. 000000	0.00000	
	09850 OTHER REI MBURSABLE COST CENTERS	0	0	(	0. 000000	0. 000000	
200.00	Subtotal (see instructions)	85, 191, 298	264, 517	85, 455, 81	5		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	85, 191, 298	264, 517	85, 455, 81	5		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2012	Peri od: From 09/01/2017 To 08/31/2018	12/10/2018 3:	
		Title XVIII	Hospi tal	PPS	_
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 O5000 OPERATING ROOM	0. 407981				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 193659				54.00
60. 00 06000 LABORATORY	0. 154228				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 108363				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 371545				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. 325075				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 143445				73.00
74.00 07400 RENAL DIALYSIS	0. 324864				74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	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

Heal th	Financial Systems Kin	dred Hospital N	orthwest India	na	In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 09/01/2017 Fo 08/31/2018	12/10/2018 3:	
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	40,400,705		40.400.70	- 10.054	40.440.554	
30.00	03000 ADULTS & PEDIATRICS	10, 138, 705		10, 138, 705	5 10, 851	10, 149, 556	
	03100 I NTENSI VE CARE UNI T	0		(	0	0	31.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0		[(	ט ט	0	44.00
50.00	ANCI LLARY SERVICE COST CENTERS	0.040.447		0.040.44		0.040.747	50.00
	05000 OPERATING ROOM	2,049,617		2, 049, 61		2, 049, 617	
	05400 RADI OLOGY-DI AGNOSTI C	468, 757		468, 75		468, 757	54.00
		1, 331, 615	0	1, 331, 615		1, 333, 055	
65.00		1, 494, 026	0	1, 494, 026		1, 499, 679	65.00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 382, 228	0	1, 382, 228		1, 382, 228	
67.00 68.00	06800 SPEECH PATHOLOGY	0	0			0	67.00 68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	349, 620	0	349, 620		349, 620	
	07300 DRUGS CHARGED TO PATIENTS	2, 210, 485		2, 210, 485		2, 210, 485	
	07400 RENAL DIALYSIS	741, 354		741, 354		2, 210, 485	
74.00	OUTPATIENT SERVICE COST CENTERS	741, 354		741, 354	+ 313	741,007	74.00
90, 00	09000 CLINIC	0		(	o l	0	90.00
	09100 EMERGENCY	0				0	91.00
71.00	OTHER REIMBURSABLE COST CENTERS	0		· · · · · ·	۹ <u></u>	0	71.00
95.00	09500 AMBULANCE SERVICES	0		(	0 0	0	95.00
	09850 OTHER REIMBURSABLE COST CENTERS	0				0	98.00
200.00		20, 166, 407	0	20, 166, 40	18, 257	20, 184, 664	
201.00		0	0	(	, 20,		201.00
202.00		20, 166, 407	0	20, 166, 40	18, 257		

Health Financial Systems	Kindred Hospital No	orthwest India	na	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	· · ·	Provider CO		Period:	Worksheet C	
				rom 09/01/2017 o 08/31/2018	Part I Date/Time Pre	narod
			'	0 00/31/2010	12/10/2018 3:	
		Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			00.040.000			1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS	33, 040, 028		33, 040, 028	3		30.00
31.00 03100 I NTENSI VE CARE UNI T	0		(	)		31.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0		(	)		44.00
ANCI LLARY SERVI CE COST CENTERS	<b>E</b> 010 (/7	4 404	5 000 000	0 407004	0.00000	1 50 00
50. 00 05000 OPERATING ROOM	5, 019, 667	4, 136			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 396, 855	23, 679			0.00000	
	8, 545, 634	97, 775			0.00000	
65. 00 06500 RESPI RATORY THERAPY	13, 802, 964	36, 375			0.00000	
66. 00 06600 PHYSI CAL THERAPY	3, 696, 264	23, 951	3, 720, 215		0.00000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	0.00000	0.00000	
68. 00 06800 SPEECH PATHOLOGY		0	1 075 500	0.000000	0.00000	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI EN		815			0.00000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	15, 409, 973	0	15, 409, 973		0.00000	
74.00 07400 RENAL DIALYSIS	2, 205, 222	77, 786	2, 283, 008	0. 324727	0. 000000	74.00
90. 00 09000 CLINIC		0			0,00000	90.00
90. 00 109000 CLINIC 91. 00 109100 EMERGENCY	0	0	0		0.000000	1
OTHER REIMBURSABLE COST CENTERS	0	0	L C	0.00000	0.00000	91.00
95. 00 09500 AMBULANCE SERVICES	0	0	(	0. 000000	0. 000000	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0.000000	
200.00 Subtotal (see instructions)	85, 191, 298	264, 517	85, 455, 815		0.000000	200.00
201.00 Less Observation Beds	00, 191, 298	204, 517	00, 400, 810			200.00
201.00 Total (see instructions)	85, 191, 298	264, 517	85, 455, 815			201.00
202.00 TIOLAI (SEE TISTIUCTIONS)	05, 191, 290	204, 317	00, 400, 610	2		1202.00

	Financial Systems Kin ATION OF RATIO OF COSTS TO CHARGES	dred Hospital Nor	Provider CCN: 15-2012	Peri od:	u of Form CMS- Worksheet C	2002 10
COMPUT	ATTON OF RATIO OF CUSTS TO CHARGES		Provider CCN. 15-2012	From 09/01/2017	Part I	
				To 08/31/2018	Date/Time Pre	epared:
					12/10/2018 3:	21 pm
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT					31.00
44.00	04400 SKILLED NURSING FACILITY					44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 407981				50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 193659				54.00
60.00	06000 LABORATORY	0. 154228				60.00
65.00	06500 RESPI RATORY THERAPY	0. 108363				65.00
66.00	06600 PHYSI CAL THERAPY	0. 371545				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. 325075				71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 143445				73.00
74.00	07400 RENAL DI ALYSI S	0. 324864				74.00
	OUTPATIENT SERVICE COST CENTERS	· ·				
90.00	09000 CLINIC	0.000000				90.00
91.00	09100 EMERGENCY	0. 000000				91.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0.000000				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
202.00		1				202.00

Health Financial Systems Kind	dred Hospital N	orthwest India	na	In Lie	eu of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	TIOS NET OF	Provider C		Period: From 09/01/2017 To 08/31/2018		
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)		I Reduction	Operating Cost Reduction Amount	
	1, COL. 20)	11 COL 20)	col. 2)		Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2,049,617	24, 804	2, 024, 81	3 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	468, 757				0	54.00
60. 00 06000 LABORATORY	1, 331, 615			9 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 494, 026				0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 382, 228	249, 484	1, 132, 74	4 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	349, 620				0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 210, 485				0	73.00
74.00 07400 RENAL DI ALYSI S	741, 354	9, 014	732, 34	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0 0		90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS			1			0.5.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0	0	98.00
200.00 Subtotal (sum of lines 50 thru 199)	10, 027, 702	463, 246	9, 564, 45	6 0		200.00
201.00 Less Observation Beds	0	0		0		201.00
202.00  Total (line 200 minus line 201)	10, 027, 702	463, 246	9, 564, 45	6 0	0	202.00

Health Financial Systems Kin	dred Hospital N	orthwest India	na	In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider C	CN: 15-2012	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 09/01/2017 To 08/31/2018		nored.
				10 06/31/2016	12/10/2018 3:	21 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		(Worksheet C,				
	Operating Cost	Part I, column	Ratio (col.	6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 049, 617					50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	468, 757	1				54.00
60. 00 06000 LABORATORY	1, 331, 615	8, 643, 409				60.00
65. 00 06500 RESPI RATORY THERAPY	1, 494, 026	13, 839, 339	0. 1079	55		65.00
66. 00 06600 PHYSI CAL THERAPY	1, 382, 228	3, 720, 215				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.0000	00		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	00		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	349, 620	1, 075, 506	0. 3250	75		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 210, 485	15, 409, 973	0. 14344	45		73.00
74.00 07400 RENAL DIALYSIS	741, 354	2, 283, 008	0. 32472	27		74.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLI NI C	0	0	0.0000	00		90.00
91.00 09100 EMERGENCY	0	0	0.0000	00		91.00
OTHER REIMBURSABLE COST CENTERS			_			
95. 00 09500 AMBULANCE SERVICES	0	0	0.0000	00		95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000	00		98.00
200.00 Subtotal (sum of lines 50 thru 199)	10, 027, 702	52, 415, 787				200.00
201.00 Less Observation Beds	0	0				201.00
202.00 Total (line 200 minus line 201)	10, 027, 702	52, 415, 787				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	PITAL COSTS	Provider CC		Period:	Worksheet D	
				From 09/01/2017		
			T	To 08/31/2018		
					12/10/2018 3:2	21 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	1
	(from Wkst. B,		Related Cost	/	()	1
	Part II, col.	/	(col. 1 - col.	/	(	1
	26)	/	2)	//	()	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 ADULTS & PEDIATRICS	1, 326, 294	0	1, 326, 294	4 13, 176	100.66	30.00
1.00 INTENSIVE CARE UNIT	0	,	l (	اں ا	0.00	31.00
4.00 SKILLED NURSING FACILITY	0	,	l (	ן כ	0.00	44.00
00.00 Total (lines 30 through 199)	1, 326, 294	1	1, 326, 294	4 13, 176	d I	200.00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				1
		Capital Cost				1
		(col. 5 x col.				1
		6)				1
	6.00	7.00				1
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	9, 709	977, 308				30.00
31.00 INTENSIVE CARE UNIT	0	0'			1	31.00
44.00 SKILLED NURSING FACILITY	o	0'	l l		I	44.00
200.00 Total (lines 30 through 199)	9, 709	977, 308	4		1	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS         Provider CCN:         15-2012         Period: From 09/01/2017         Worksheet D Date/Time Propract           Image: Cost Center Description         Capital Related Cost (from Wkst. B, Part II, col. 26)         Title XVIII         Hospital         PPS           MCILLARY SERVICE COST CENTERS         Ratio of Cost (from Wkst. B, Part II, col. 26)         Total Charges (col. 1 + col. 26)         Inpatient Program         Capital Column 3 x column 4)         Capital PPS           50.00         05000         OPERATING ROOM         24,804         5,023,803         0.004937         2,615,953         12,915         50.00           54.00         05400         RADIOLOGY-DI AGNOSTIC         6,210         2,420,534         0.002566         1,677,487         4,304         54.00           65.00         06500         RESPIRATORY         84,201         13,839,339         0.002471         10,119,500         25,005         65.00           66.00         06600         PHYSICAL THERAPY         249,484         3,720,215         0.002471         10,119,500         25,005         65.00           68.00         06800         SPEECH PATHOLOGY         0         0         0.000000         0         0         0         0         0         0.00000         0	Health Financial Systems Kin	dred Hospital N	lorthwest India	na	In Lie	u of Form CMS-2	2552-10
Cost Center Description         Capital Related Cost (from Wkst. B, Part II, col. 26)         Total Charges (rom Wkst. C, 20)         Ratio of Cost to Charges (col. 1 + col. 2)         Inpatient Program (col umn 3 x col umn 4)         Capital Costs (col umn 3 x col umn 4)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           05000         0PERATING ROOM         24,804         5,023,803         0.004937         2,615,953         12,915         50.00           60.00         06000         LABORATORY         6,210         2,420,534         0.002471         10,119,500         25,005         66.00           66.00         06500         RESPI RATORY THERAPY         34,201         13,839,339         0.002471         10,119,500         25,005         65.00           66.00         06700         000000         0         0         0.000000         0         0         64.00           67.00         06700         000000         0         0         0.000000         0         0         64.00           67.00         06700         0000000         0         0         0.000000         0         0         66.00           67.00         06700         000000000         0         0         0.0000000 <td>APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA</td> <td>AL COSTS</td> <td>Provider C</td> <td></td> <td>From 09/01/2017 To 08/31/2018</td> <td>Part II Date/Time Pre</td> <td></td>	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		From 09/01/2017 To 08/31/2018	Part II Date/Time Pre	
Related Cost         (from Wkst. C, Part I, col. 26)         to Charges         Program Column 3 x column 4)           26)         20         300         4.00         5.00           50.00         05000         OPERATING ROM         24,804         5,023,803         0.004937         2,615,953         12,915         50.00           54.00         05000         DPERATING ROM         24,804         5,023,803         0.004937         2,615,953         12,915         50.00           54.00         05000         DARDI LLARY SERVICE COST CENTERS         6,210         2,420,534         0.002566         1,677,487         4,304         54.00           65.00         06500         RADI LLARY THERAPY         81,886         8,643,409         0.009474         6,404,100         60,672         60.00           66.00         06500         RESPIRATORY THERAPY         34,201         13,839,339         0.002471         10,119,500         25,005         65.00           67.00         06700         0CUPATIONAL THERAPY         249,484         3,720,215         0.067062         2,714,148         182,016         66.00           68.00         08000         SPECH PATHOLOGY         0         0         0.000000         0         68.00           71							
ANCI LLARY SERVICE COST CENTERS         (from Wkst. B, Part I, col. 20)         (col. 1 + col. 2)         Charges         col umn 4)           ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           S0.00         05000 OPERATI NG ROOM         24,804         5,023,803         0.004937         2,615,953         12,915           54.00         05000 ADERATI NG ROOM         24,804         5,023,803         0.002566         1,677,487         4,304         54.00           60.00         06000 LABORATORY         81,886         8,643,409         0.009474         6,404,100         60,672         60.00           65.00         06500 RESPI RATORY THERAPY         34,201         13,839,339         0.002471         10,119,500         25,005         65.00           67.00         06700 OCCUPATI ONAL THERAPY         249,484         3,720,215         0.067062         2,714,148         182,016         66.00           68.00         08800 SPEECH PATHOLOGY         0         0         0.000000         0         68.00         67.00         60.014276         740,786         10,575         71.00           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         15,354         1,075,506         0.014276         740,786         <	Cost Center Description						
Part II, col. 26)         8)         2)         1         4           20         1.00         2.00         3.00         4.00         5.00           50.00         05000         OPERATING ROOM         24,804         5,023,803         0.004937         2,615,953         12,915         50.00           54.00         05000         DARNOLLLARY SERVICE COST CENTERS         6,210         2,420,534         0.002566         1,677,487         4,304         54.00           60.00         L0600         LABORATORY         81,886         8,643,409         0.009474         6,404,100         60.672         60.00           66.00         06500         RESPI RATORY THERAPY         34,201         13,839,339         0.002471         10,119,500         25,005         65.00           66.00         06600         PHYSI CAL THERAPY         249,484         3,720,215         0.067062         2,714,148         182,016         66.00           67.00         06700         0         0         0         0         0         0         66.00         66.00         68.00         0.6800         9FEECH PATHOLOGY         0         0         68.00         0.6800         9FECH PATHOLOGY         0         0         0.002745         11,059,0							
26)         1         0         4         0					. Charges	column 4)	
I.00         2.00         3.00         4.00         5.00           ANCI LLARY SERVICE COST CENTERS		Part II, col.	8)	2)			
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROM         24, 804         5, 023, 803         0.004937         2, 615, 953         12, 915         50.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         6, 210         2, 420, 534         0.002566         1, 677, 487         4, 304         54.00           60.00         LABORATORY         81, 886         8, 643, 409         0.002566         1, 677, 487         4, 304         54.00           65.00         O6500         RESPI RATORY THERAPY         81, 886         8, 643, 409         0.009474         6, 404, 100         60, 672         60.00           66.00         06600         PHYSI CAL THERAPY         249, 484         3, 720, 215         0.067062         2, 714, 148         182, 016         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0         0         0.000000         0         68.00           71.00         07100         MEUGS CHARGED TO PATI ENTS         15, 354         1, 075, 506         0.014276         740, 786         10, 575         71.00           73.00         07400         REAL SUPPLI ES CHARGED TO PATI ENTS         42, 293         15, 409, 973         0.002745         11, 059, 079         30, 357							
50.00       05000       0PERATI NG ROOM       24, 804       5, 023, 803       0.004937       2, 615, 953       12, 915       50.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       6, 210       2, 420, 534       0.002566       1, 677, 487       4, 304       54.00         60.00       06000       LABORATORY       81, 886       8, 643, 409       0.009474       6, 404, 100       60, 672       60.00         65.00       06500       RESPI RATORY THERAPY       34, 201       13, 839, 339       0.002471       10, 119, 500       25, 005       65.00         66.00       06600       PHYSI CAL       THERAPY       249, 484       3, 720, 215       0.067062       2, 714, 148       182, 016       66.00         67.00       06700       0CUPATI ONAL THERAPY       0       0       0.000000       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0       68.00         71.00       MCDI AL SUPPLI ES CHARGED TO PATI ENTS       15, 354       1, 075, 506       0.014276       740, 786       10, 575       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       15, 354       1, 075, 506       0.003948       1, 406, 092		1.00	2.00	3.00	4.00	5.00	
54.00       05400       RADI OLOGY-DI AGNOSTI C       6, 210       2, 420, 534       0.002566       1, 677, 487       4, 304       54.00         60.00       06000       LABORATORY       81, 886       8, 643, 409       0.009474       6, 404, 100       60, 672       60.00         65.00       06500       RESPI RATORY THERAPY       34, 201       13, 839, 339       0.002471       10, 119, 500       25, 005       65.00         66.00       06600       PHYSI CAL THERAPY       249, 484       3, 720, 215       0.067062       2, 714, 148       182, 016       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       0.000000       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       15, 354       1, 075, 506       0.014276       740, 786       10, 575       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       42, 293       15, 409, 973       0.002745       11, 059, 079       30, 357       73.00         74.00       0       0       0       0.000000       0       0       0       0       0		1	r	1	1		
60.00       06000       LABORATORY       81,886       8,643,409       0.009474       6,404,100       60,672       60.00         65.00       06500       RESPI RATORY THERAPY       34,201       13,839,339       0.002471       10,119,500       25,005       65.00         66.00       06600       PHYSI CAL THERAPY       249,484       3,720,215       0.067062       2,714,148       182,016       66.00         67.00       06700       0CUPATI ONAL THERAPY       0       0       0.000000       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       15,354       1,075,506       0.014276       740,786       10,575       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       42,293       15,409,973       0.002745       11,059,079       30,357       73.00         74.00       07400       RENAL DI ALYSI S       9,014       2,283,008       0.003948       1,406,092       5,551       74.00         09100       EMERGENCY       0       0       0.000000       0       0       0       0       0       0       0<							
65.00       06500       RESPI RATORY THERAPY       34, 201       13, 839, 339       0.002471       10, 119, 500       25, 005       65.00         66.00       06600       PHYSI CAL THERAPY       249, 484       3, 720, 215       0.067062       2, 714, 148       182, 016       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0.000000       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       15, 354       1, 075, 506       0.014276       740, 786       10, 575       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       42, 293       15, 409, 973       0.002745       11, 059, 079       30, 357       73.00         74.00       07400       RENAL DI ALYSIS       9, 014       2, 283, 008       0.003948       1, 406, 092       5, 551       74.00         090.00       090100       EMERGENCY       0       0       0.000000       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>6, 210</td> <td>2, 420, 534</td> <td>0. 00256</td> <td>6 1, 677, 487</td> <td>4, 304</td> <td>54.00</td>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 210	2, 420, 534	0. 00256	6 1, 677, 487	4, 304	54.00
66.00       06600       PHYSI CAL THERAPY       249, 484       3, 720, 215       0.067062       2, 714, 148       182, 016       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       0.000000       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       15, 354       1, 075, 506       0.014276       740, 786       10, 575       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       42, 293       15, 409, 973       0.002745       11, 059, 079       30, 357       73.00         74.00       RENAL DI ALYSI S       9, 014       2, 283, 008       0.003948       1, 406, 092       5, 551       74.00         00.00       CLINIC       0       0       0.000000       0       0       90.00         9100       EMERGENCY       0       0       0.000000       0       91.00       91.00         09100       EMERGENCY       0       0       0.000000       0       91.00       91.00       95.00         98.00       09500       AMBULANCE SERVI CES       0       0 <td< td=""><td></td><td>81, 886</td><td>8, 643, 409</td><td>0. 00947</td><td>6, 404, 100</td><td>60, 672</td><td>60.00</td></td<>		81, 886	8, 643, 409	0. 00947	6, 404, 100	60, 672	60.00
67.00       06700       0CCUPATI 0NAL THERAPY       0       0       0.000000       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       15,354       1,075,506       0.014276       740,786       10,575       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       42,293       15,409,973       0.002745       11,059,079       30,357       73.00         74.00       07400       RENAL DI ALYSIS       9,014       2,283,008       0.003948       1,406,092       5,551       74.00         00.00       0       0       0       0.000000       0       0       90.00         90.00       OPOOO CLI NI C       0       0       0.000000       0       91.00         09100       EMEGENCY       0       0       0.000000       0       0       91.00         09500       AMBULANCE SERVICES       0       0       0.000000       0       95.00       98.00       09850       0THER REI MBURSABLE COST CENTERS       95.00       98.00       98.00       98.00	65. 00 06500 RESPI RATORY THERAPY	34, 201	13, 839, 339	0. 00247	10, 119, 500	25, 005	65.00
68.00       06800       SPECH PATHOLOGY       0       0       0.000000       0       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       15,354       1,075,506       0.014276       740,786       10,575       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       42,293       15,409,973       0.002745       11,059,079       30,357       73.00         74.00       07400       RENAL DI ALYSIS       9,014       2,283,008       0.003948       1,406,092       5,551       74.00         00100       EMERGENCY       0       0       0.000000       0       0       90.00         91.00       O9000       CLINIC       0       0       0.000000       0       90.00         91.00       EMERGENCY       0       0       0.000000       0       0       91.00         91.00       EMERGENCY       0       0       0.000000       0       0       91.00         95.00       09500       AMBULANCE SERVICES       95.00       0       0.000000       0       95.00       98.00       98.00       98.00       98.00       98.00       98.00       98.00       98.00       98.00	66. 00 06600 PHYSI CAL THERAPY	249, 484	3, 720, 215	0. 06706	2, 714, 148	182, 016	66.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       15,354       1,075,506       0.014276       740,786       10,575       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       42,293       15,409,973       0.002745       11,059,079       30,357       73.00         74.00       07400       RENAL DI ALYSIS       9,014       2,283,008       0.003948       1,406,092       5,551       74.00         00       09000       CLI NI C       0       0       0.000000       0       90.00         91.00       09100       EMERGENCY       0       0       0.000000       0       90.00         09100       EMERGENCY       0       0       0.000000       0       90.00         95.00       09500       AMBULANCE SERVICES       95.00       90.00       97.00       97.00         98.00       09850       OTHER REI MBURSABLE COST CENTERS       0       0       0.000000       0       98.00	67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67.00
73.00       07300       DRUGS CHARGED TO PATIENTS       42,293       15,409,973       0.002745       11,059,079       30,357       73.00         74.00       07400       RENAL DIALYSIS       9,014       2,283,008       0.003948       1,406,092       5,551       74.00         00       09000       CLINIC       0       0       0.000000       0       0       90.00         91.00       09100       EMERGENCY       0       0       0.000000       0       90.00         07HER       REIMBURSABLE COST CENTERS       0       0       0.000000       0       90.00         95.00       09500       AMBULANCE SERVICES       95.00       98.00       0.000000       0       98.00	68.00 06800 SPEECH PATHOLOGY	0	0	0. 00000	0 0	0	68.00
74. 00         07400         RENAL DI ALYSI S         9, 014         2, 283, 008         0.003948         1, 406, 092         5, 551         74. 00           0UTPATI ENT SERVICE COST CENTERS         0         0         0.000000         0         0         90. 00           90.00         09000         CLI NI C         0         0         0.000000         0         0         90. 00           91.00         EMERGENCY         0         0         0.000000         0         91. 00           0THER REI MBURSABLE COST CENTERS         0         0         0.000000         0         95. 00           98.00         09850         OTHER REI MBURSABLE COST CENTERS         0         0         0.000000         0         98. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 354	1, 075, 506	0. 01427	740, 786	10, 575	71.00
OUTPATI ENT SERVICE COST CENTERS         0         0         0.00         09000         CLI NI C         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         91.00         91.00         91.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         98.00         0         0         0         0         95.00         98.00	73.00 07300 DRUGS CHARGED TO PATIENTS	42, 293	15, 409, 973	0. 00274	5 11, 059, 079	30, 357	73.00
90.00         09000         CLI NI C         0         0         0.00         0         0         0         0         0         0         90.00         91.00         92.00         93.00         93.00         95.00         98.00         00.000000         0         0         93.00         93.00	74.00 07400 RENAL DIALYSIS	9,014	2, 283, 008	0. 00394	8 1, 406, 092	5, 551	74.00
91.00         09100         EMERGENCY         0         0         0.000000         0         91.00           0THER         REI MBURSABLE         COST         CENTERS         0         0.000000         0         91.00         91.00           95.00         09500         AMBULANCE         SERVICES         95.00         98.00         0         0.000000         0         98.00         98.00	OUTPATIENT SERVICE COST CENTERS			·			1
91.00         09100         EMERGENCY         0         0         0.000000         0         91.00           0THER         REI MBURSABLE         COST         CENTERS         95.00         98.00         09500         AMBULANCE         SERVICES         95.00         98.00         0         0.000000         0         98.00         98.00	90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
95.00         09500         AMBULANCE SERVICES         95.00         98.00         09850         OTHER REI MBURSABLE COST CENTERS         9         0         0         0         98.00         98.00         98.00         95.00         98.00         95.00         98.00         95.00 <t< td=""><td>91. 00 09100 EMERGENCY</td><td>0</td><td>0</td><td></td><td></td><td>0</td><td>91.00</td></t<>	91. 00 09100 EMERGENCY	0	0			0	91.00
95.00         09500         AMBULANCE SERVICES         95.00         98.00         09850         OTHER REI MBURSABLE COST CENTERS         9         0         0         0         98.00         98.00         98.00         95.00         98.00         95.00         98.00         95.00 <t< td=""><td></td><td></td><td></td><td></td><td>-1</td><td></td><td></td></t<>					-1		
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0 98. 00							95.00
		0	l o	0, 00000	0 0	0	
	200.00 Total (lines 50 through 199)	463, 246	52, 415, 787		36, 737, 145	331, 395	

Health Financial Systems	Kindred Hospital Nort				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	E OTHER PASS THROUGH COSTS	Provider CC	-	Period: From 09/01/2017 Fo 08/31/2018	Date/Time Pre 12/10/2018 3:	
		Title		Hospi tal	PPS	
Cost Center Description	Nursing School Nur Post-Stepdown Adjustments	-	Post-Stepdown Adjustments	Cost	All Other Medical Education Cost	
		1.00	2A	2.00	3.00	
INPATI ENT ROUTI NE SERVICE COST CENT           30.00         03000 ADULTS & PEDIATRICS           31.00         03100 INTENSIVE CARE UNIT           44.00         04400 SKILLED NURSING FACILITY           200.00         Total (lines 30 through 199)	0 0 0 0	0 0 0 0	(		000000000000000000000000000000000000000	00100
Cost Center Description	Adjustment (su Amount (see 1 instructions) min	um of cols. through 3, nus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENT           30.00         03000         ADULTS & PEDIATRICS           31.00         03100         INTENSIVE CARE UNIT           44.00         04400         SKILLED NURSING FACILITY           200.00         Total (lines 30 through 199)	ERS 0	0 0 0	13, 17( ( ( 13, 17(	0.00 0.00	0	31.00
Cost Center Description	Program Oth	A Adj. All her Medical lcation Cost				
INPATI ENT ROUTI NE SERVI CE COST CENT           30. 00         03000 ADULTS & PEDI ATRI CS           31. 00         03100 I NTENSI VE CARE UNI T           44. 00         04400 SKI LLED NURSI NG FACI LI TY           200. 00         Total (lines 30 through 199)		000000000000000000000000000000000000000				30. 00 31. 00 44. 00 200. 00

	Health Financial Systems Kindred Hospital Northwest Indiana I					2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 09/01/2017		
				To 08/31/2018		pared:
		T: +1 -			12/10/2018 3:	21 pm
			XVIII	Hospi tal	PPS	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	c c		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l a		o o	0	73.00
74.00 07400 RENAL DI ALYSI S	0	l a		o o	0	74.00
OUTPATIENT SERVICE COST CENTERS		1		-		
90. 00 09000 CLI NI C	0	0	)	0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	l o		o o	0	98.00
200.00 Total (lines 50 through 199)	0	c c		0 0	0	200.00
	,		•	,		•

Health Financial Systems Kindred Hospital Northwest Indiana In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C		Period:	Worksheet D		
THROUGH COSTS				From 09/01/2017 To 08/31/2018		narod	
				10 00/31/2010	12/10/2018 3:	21 pm	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
	Medi cal	(sum of col 1		(from Wkst. C,	to Charges		
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.		
		4)	col. 2, 3 an	(8 b	7)		
			4)				
	4.00	5.00	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS				1			
50.00 05000 OPERATI NG ROOM	0	0		0 5, 023, 803			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 2, 420, 534			
60. 00 06000 LABORATORY	0	0		0 8, 643, 409			
65. 00 06500 RESPI RATORY THERAPY	0	0		0 13, 839, 339			
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 720, 215	0.000000	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 075, 506	0.000000	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 15, 409, 973	0.000000	73.00	
74.00 07400 RENAL DIALYSIS	0	0		0 2, 283, 008	0.000000	74.00	
OUTPATIENT SERVICE COST CENTERS			_				
90. 00 09000 CLI NI C	0	0		0 0	0.000000	90.00	
91.00 09100 EMERGENCY	0	0		0 0	0.000000	91.00	
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES						95.00	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0. 000000	98.00	
200.00 Total (lines 50 through 199)	0	0		0 52, 415, 787	1	200. 00	

Health Financial Systems Kindred Hospital Northwest Indiana In Lieu of Form CMS-25						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-2012	Peri od:	Worksheet D	
THROUGH COSTS				From 09/01/2017 To 08/31/2018		narod
				10 00/31/2010	12/10/2018 3:1	21 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	<b>T T</b>			-		
50.00 05000 OPERATI NG ROOM	0. 000000	2, 615, 953		0 0		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 677, 487		0 22, 867		54.00
60. 00 06000 LABORATORY	0. 000000	6, 404, 100		0 2, 222		60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	10, 119, 500		0 36, 375	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 714, 148		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	740, 786		0 815	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	11, 059, 079		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	1, 406, 092		0 76, 095	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0		90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00   Total (lines 50 through 199)		36, 737, 145		0 138, 374	0	200. 00

Health Financial Systems Kind	dred Hospital N	orthwest India	na	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE O		S Provider C	CN: 15-2012	Period: From 09/01/2017	Worksheet D Part IV	
THROUGH COSTS				To 08/31/2018		epared:
					12/10/2018 3:	
			XVIII	Hospi tal	PPS	
Cost Center Description	PSA Adj. Non					
		Other Medical				
		Education Cost				
	Cost					
	21.00	24.00				_
ANCI LLARY SERVICE COST CENTERS	-	-	1			
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				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00 Total (lines 50 through 199)	0	0				200.00
						•

Health Financial Systems Kind	lred Hospital N	orthwest India	na	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 09/01/2017 To 08/31/2018		
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 407981	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 193659			0 0	4, 428	54.00
60. 00 06000 LABORATORY	0. 154061	2, 222		0 0	342	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 107955	36, 375		0 0	3, 927	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 371545	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 325075	815		0 0	265	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 143445	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 324727	76, 095		0 0	24, 710	74.00
OUTPATIENT SERVICE COST CENTERS					•	
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS		•	•	·	•	1
95.00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00 Subtotal (see instructions)		138, 374		0 0	33, 672	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		138, 374		0 0	33, 672	202.00

Heal th	Financial Systems Kind	dred Hospital N	lorthwest India	na	In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Peri od: From 09/01/2017 To 08/31/2018	12/10/2018 3:	
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0				50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	06000 LABORATORY	0	0				60.00
	06500 RESPI RATORY THERAPY	0	0				65.00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00	07400 RENAL DIALYSIS	0	0				74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0				90.00
91.00	09100 EMERGENCY	0	0				91.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0					95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00	Subtotal (see instructions)	0	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00		0	0				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	API TAL COSTS	Provider CC		Period:	Worksheet D	
				From 09/01/2017		
			דן	To 08/31/2018		
					12/10/2018 3:2	<u>21 pm</u>
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	1
	(from Wkst. B,		Related Cost		()	1
	Part II, col.		(col. 1 - col.	4	(	1
	26)	/	2)	/	( /	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						<u> </u>
0. 00 ADULTS & PEDIATRICS	1, 326, 294	0	1, 326, 294	4 13, 176	100.66	30.00
1.00 INTENSIVE CARE UNIT	0	1	۱ r	ا0 (	0.00	31.00
4.00 SKILLED NURSING FACILITY	0	,	۱ r	<sup>ا</sup> ن (	0.00	44.00
00.00 Total (lines 30 through 199)	1, 326, 294	1	1, 326, 294	4 13, 176	1	200.00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				1
		Capital Cost				1
		(col. 5 x col.				1
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	,					1
30. 00 ADULTS & PEDIATRICS	47	4, 731				30. 00
31.00 INTENSIVE CARE UNIT	0	0 <sup>1</sup>	/		I	31.00
4.00 SKILLED NURSING FACILITY	0	0'	,		I	44.00
200.00 Total (lines 30 through 199)	47	4, 731	1		1	200.00

Health Financial Systems Kin	dred Hospital N	lorthwest India	na	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 09/01/2017 To 08/31/2018	Date/Time Pre 12/10/2018 3:	
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	24, 804	5, 023, 803	0.00493	37 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 210	2, 420, 534	0.00256	0 0	0	54.00
60. 00 06000 LABORATORY	81, 886	8, 643, 409	0.00947	74 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	34, 201	13, 839, 339	0.00247	/1 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	249, 484	3, 720, 215	0.06706	02 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.0000	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 354	1, 075, 506	0. 01427	6 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	42, 293	15, 409, 973	0.00274	15 0	0	73.00
74.00 07400 RENAL DIALYSIS	9,014	2, 283, 008	0.00394	8 0	0	74.00
OUTPATIENT SERVICE COST CENTERS			·			1
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
91.00 09100 EMERGENCY	0	0	0.0000	0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	l o	0, 00000	0 0	0	98.00
200.00 Total (lines 50 through 199)	463, 246	52, 415, 787		0	0	200.00

Health Financial Systems	Kindred Hospital Nor				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVIC	CE OTHER PASS THROUGH COSTS	Provider CO	-	Period: From 09/01/2017 Fo 08/31/2018	Date/Time Pre 12/10/2018 3:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments 1A	rsing School	Allied Health Post-Stepdown Adjustments 2A	Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CEN	I	1.00	2A	2.00	3.00	
30. 00         03000         ADULTS & PEDIATRICS           31. 00         03100         INTENSIVE CARE UNIT           44. 00         04400         SKI LLED NURSING FACILITY           200. 00         Total (lines 30 through 199)	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0	00.00
Cost Center Description	Adjustment (s Amount (see 1 instructions) mi	Fotal Costs sum of cols. through 3, nus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTI NE SERVICE COST CEN           30.00         O3000         ADULTS & PEDIATRICS           31.00         O3100         INTENSIVE CARE UNIT           44.00         O4400         SKI LLED NURSING FACILITY           200.00         Total (lines 30 through 199)	0	000000000000000000000000000000000000000	13, 17 13, 17	0.00 0.00	0 0	31.00
Cost Center Description	Program Ot	SA Adj. All ther Medical ucation Cost 13.00				
I NPATI ENT ROUTI NE SERVI CE COST CEN           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         I NTENSI VE CARE UNI T           44. 00         04400         SKI LLED NURSI NG FACI LI TY           200. 00         Total (lines 30 through 199)		000000000000000000000000000000000000000				30. 00 31. 00 44. 00 200. 00

Health Financial Systems Kindred Hospital Northwest Indiana In Lieu of Form (						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				rom 09/01/2017		
				To 08/31/2018		pared:
			<u> </u>		12/10/2018 3:	21 pm
			e XIX	Hospi tal	PPS	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	C		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l c		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l c		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	l c		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS		· · ·				
90. 00 09000 CLINIC	0	C	)	0 0	0	90.00
91.00 09100 EMERGENCY	0	c c		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	l c		0 0	0	98.00
200.00 Total (lines 50 through 199)	0	l c		0 0	0	200.00
	1		1	1		

Health Financial Systems Kindred Hospital Northwest Indiana In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D		
THROUGH COSTS				From 09/01/2017			
				To 08/31/2018	Date/Time Pre 12/10/2018 3::	pared: 21 nm	
		Titl	e XIX	Hospi tal	PPS	<u> </u>	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
	Medi cal	(sum of col 1	Outpatient	(from Wkst. C,			
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.		
		4)	col. 2, 3 and	(8 It	7)		
			4)				
	4.00	5.00	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0	0		0 5, 023, 803			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 2, 420, 534	0.000000	54.00	
60. 00 06000 LABORATORY	0	0		0 8, 643, 409	0.000000	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 13, 839, 339	0.000000	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 720, 215	0.000000	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 075, 506	0.000000	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 15, 409, 973	0.000000	73.00	
74.00 07400 RENAL DIALYSIS	0	0		0 2, 283, 008	0.000000	74.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	0		0 0	0.000000	90.00	
91.00 09100 EMERGENCY	0	0		0 0	0.000000	91.00	
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVI CES						95.00	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.00000	98.00	
200.00 Total (lines 50 through 199)	0	0	1	0 52, 415, 787	1	200. 00	

Health Financial Systems Kin	dred Hospital No	orthwest India	na	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHE THROUGH COSTS		Provider C		Period: From 09/01/2017	Worksheet D Part IV	
THROUGH CUSTS				To 08/31/2018	Date/Time Pre	
					12/10/2018 3: 2	21 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	TT		1			
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0, 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00 Total (lines 50 through 199)	1.000000	0		0 0	-	200.00
	1 1	-	1	-1 -		

Health Financial Systems Kin	dred Hospital N	orthwest India	ina	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS		CN: 15-2012	Peri od: From 09/01/2017 To 08/31/2018	Date/Time Pre 12/10/2018 3:	pared: 21 pm
			e XIX	Hospi tal	PPS	
Cost Center Description		PSA Adj. All Other Medical Education Cost				
	21.00	24.00				
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 OPERATI NG ROOM	0	C				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
60. 00 06000 LABORATORY	0	C				60.00
65. 00 06500 RESPI RATORY THERAPY	0	C				65.00
66. 00 06600 PHYSI CAL THERAPY	0	C	)			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C	0			67.00
68.00 06800 SPEECH PATHOLOGY	0	C	)			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	)			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)			73.00
74.00 07400 RENAL DI ALYSI S	0	0				74.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	C				90.00
91. 00 09100 EMERGENCY	0					91.00
OTHER REIMBURSABLE COST CENTERS	-					
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00  Total (lines 50 through 199)	0	C	)			200.00

Kindred Hospital	Northwest	l ndi ana		
	Drawi	dam CCN.	15 2012	Domi

In Lieu of Form CMS-2552-10

leal th	Financial Systems Kindred Hospital Nort	thwest Indiana	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prep 12/10/2018 3:2	pared:
		Title XVIII	Hospi tal	PPS	21 piii
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		13, 176	1.00
2.00	Inpatient days (including private room days and swing bed days Inpatient days (including private room days, excluding swing-l			13, 176	2.00
3.00	Private room days (excluding swing-bed and observation bed day		rivate room days,	2	3.00
	do not complete this line.		5		
4.00	Semi-private room days (excluding swing-bed and observation be			13, 174	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	er 31 of the cost	0	5.00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6,00
	reporting period (if calendar year, enter 0 on this line)			-	
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7.00
	reporting period		1 .6		0.00
3. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December 3	or the cost	0	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	9, 709	9.00
	newborn days)		, · · · · · · · · · · · · · · · · · · ·		
0.00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10.00
1 00	through December 31 of the cost reporting period (see instruct			0	11 00
1.00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		com days) arter	0	11.00
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period	<u> </u>	5.		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
4.00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter 0 on this lir	ne) davia)	2	14.00
4.00 5.00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	2	14.00
	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17.00
0.00	reporting period			0.00	10.00
8.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18.00
9.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19.00
	reporting period	0			
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
1.00	reporting period Total general inpatient routine service cost (see instructions	e)		10, 149, 556	21.00
22.00	Swing-bed cost applicable to SNF type services through December		ina period (line	0	22.00
	5 x line 17)		511		
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
4 00	x line 18)	r 21 of the east report:	ng portion (line	0	24 00
4.00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	i si di the cost reporti	ng period (inne	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.00
	x line 20)				
6.00	Total swing-bed cost (see instructions)			0	26.00
7.00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		10, 149, 556	27.00
8. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	33, 040, 028	28.00
9.00	Private room charges (excluding swing-bed charges)		lai geo)	5, 998	1
0.00	Semi-private room charges (excluding swing-bed charges)			33, 034, 030	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0. 307190	
2.00 3.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			2, 999. 00 2, 507. 52	
4.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	ctions)	491.48	
5.00	Average per diem private room cost differential (line 34 x lin			150. 98	
6.00	Private room cost differential adjustment (line 3 x line 35)			302	36.00
7.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	10, 149, 254	37.00
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UCTMENTS			
8. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			770. 31	38.00
		instructions)		770. 31 7, 478, 940	
38.00 39.00 40.00 41.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	instructions) 38) am (line 14 x line 35)			39.00 40.00

		dred Hospital N	orthwest Indi	ana	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (		Period:	Worksheet D-1	
					From 09/01/2017 To 08/31/2018	Date/Time Pre	oared:
						12/10/2018 3:	
					Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per sDiem (col. 1	Program Days	Program Cost (col. 3 x col.	
		inpatrent cost	Inpatrent bay	col . 2)		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	0 0	0	43.00
	CORONARY CARE UNIT	0		0.0	0	0	43.00 44.00
	BURN I NTENSI VE CARE UNI T						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	. line 200)			6, 768, 788	48.00
	Total Program inpatient costs (sum of lines			ons)		14, 247, 728	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	977, 308	50.00
51.00	<pre>III) Pass through costs applicable to Program inp red to program inp</pre>	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	331, 395	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				1, 308, 703	52.00
	Total Program inpatient operating cost exclu		lated, non-ph	ysician anesth	etist, and	12, 939, 025	
	medical education costs (line 49 minus line	<u>52)                                      </u>	· · ·				
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	F 4 00
54.00 55.00	Program discharges Target amount per discharge					0 0.00	54.00 55.00
	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (	line 56 minus	line 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the	market basket		0.00	60.00
	If line 53/54 is less than the lower of line				the amount by	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	instructions)				0	62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00
00100	PROGRAM INPATIENT ROUTINE SWING BED COST						00100
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	te after Decomb	or 21 of the	cost roporting	poriod (Soo	0	65.00
03.00	instructions) (title XVIII only)			cost reporting	period (See	0	05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
	(line 13 x line 20)				ring period	-	
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c	-					71.00
72.00	Program routine service cost (line 9 x line						72.00
73.00 74.00	Medically necessary private room cost applic						73.00
75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II column		74.00 75.00
70.00	26, line 45)		00313 (1101	ion Koncet D, T			70.00
76.00	Per diem capital-related costs (line 75 ÷ li	,					76.00
77.00	Program capital -related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider recor	de)			78.00 79.00
80.00	Total Program routine service costs for comp	• •		· · · · · · · · · · · · · · · · · · ·	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi				,		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83.00	Reasonable inpatient routine service costs (		S)				83.00
84.00 85.00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84.00 85.00
	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87.00	Total observation bed days (see instructions		line 2)			0 0.00	87.00 88.00
88.00 89.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se					0.00	88.00 89.00
200						0	

Health Financial Systems Kin	dred Hospital	Nort	hwest Indian	na	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CC		Period: From 09/01/2017	Worksheet D-1	
					To 08/31/2018	Date/Time Pre 12/10/2018 3:	
			Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Ro	outine Cost	column 1 ÷	Total	Observati on	
		(fr	om 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, 326, 29	4	10, 149, 556	0. 1306	5 0	0	90.00
91.00 Nursing School cost		0	10, 149, 556	0.0000	0 0	0	91.00
92.00 Allied health cost		0	10, 149, 556	0.0000	0 0	0	92.00
93.00 All other Medical Education		0	10, 149, 556	0.0000	0 0	0	93.00

Kindred Hospital Nor		
	Descut days CON 15 2012	

In Lieu of Form CMS-2552-10

	Financial Systems Kindred Hospital Nor		In Lie	u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Pre 12/10/2018 3:2	pared
		Title XIX	Hospi tal	PPS	21 pm
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
. 00	Inpatient days (including private room days and swing-bed day	vs excluding newborn)		13, 176	1.0
. 00	Inpatient days (including private room days, excluding swing-			13, 176	
. 00	Private room days (excluding swing-bed and observation bed da		rivate room days,	2	
	do not complete this line.		-		
. 00	Semi-private room days (excluding swing-bed and observation k			13, 174	
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	er 31 of the cost	0	5.0
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after Decomber	21 of the cost	0	6.0
. 00	reporting period (if calendar year, enter 0 on this line)	Join days) arter becember	ST OF THE COST	0	0.0
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.0
	reporting period	· · · · · · · · · · · · · · · · · · ·			
. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 🗧	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	47	9.0
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private)	room days)	0	10.0
0.00	through December 31 of the cost reporting period (see instruc		dage)	0	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.0
	December 31 of the cost reporting period (if calendar year, e				
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12.0
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including prive	to room days)	0	13. (
3.00	after December 31 of the cost reporting period (if calendar y			0	13.0
4.00	Medically necessary private room days applicable to the Progr			2	14.0
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16.
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	17. (
8. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18. (
9. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19. (
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.0
	reporting period				
	Total general inpatient routine service cost (see instruction			10, 149, 556	
2. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22.0
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportio	ng period (line 6	0	23. (
4. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	er 31 of the cost report	ing period (line	0	24.
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.
6.00	Total swing-bed cost (see instructions)			0	26.
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		10, 149, 556	27.
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			00.010.075	
3.00 9.00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	33, 040, 028	1
). 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			5, 998 33, 034, 030	
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 307190	
	Average private room per diem charge (line 29 ÷ line 3)	,		2, 999. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			2, 507. 52	
	Average per diem private room charge differential (line 32 mi		ctions)	491.48	
	Average per diem private room cost differential (line 34 x li	ne 31)		150. 98	
5.00	Private room cost differential adjustment (line 3 x line 35)	and private room cast d	fforontial (line	302 10 140 254	
7.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost d	irrerential (IIne	10, 149, 254	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	UISTMENTS			ł
3. 00	Adjusted general inpatient routine service cost per diem (see			770. 31	38
9.00 9.00	Program general inpatient routine service cost (line 9 x line			36, 205	
/. 00		-			
	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0 36, 205	

COMPLIATION OF TRANSLOAD         Periodic CC 15: 2011         Periodic CC 10: 10: 2012/2018         Description           Cost Conter Description         Title XIX         Intel Title XIX         Description         Description           Cost Conter Description         Title XIX         Intel Title XIX         Periodic XIX         Description           4:00         MORENY CITLE V & X X on Y)         Intel Title XIX         Periodic XIX         Periodic XIX           4:00         MORENY CITLE V & X X on Y)         Intel Title XIX         Periodic XIX         Periodic XIX           4:00         MORENY CITLE V & X X on Y)         Intel Title XIX         Periodic XIX         Periodic XIX           4:00         MORENY CARE MAT         0         0         0         4:00           4:00         MORENY CARE MAT         0         0         0         0         4:00           4:00 <t< th=""><th>Heal th</th><th>Financial Systems Kind</th><th>dred Hospital N</th><th>lorthwest India</th><th>ana</th><th>In Lie</th><th>eu of Form CMS-2</th><th>2552-10</th></t<>	Heal th	Financial Systems Kind	dred Hospital N	lorthwest India	ana	In Lie	eu of Form CMS-2	2552-10
To         ORAL Time Required Install         The NXX         Height into Program Logs         Program Logs         Pr	COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-2012			
Table         Table         Table         Hough Lat         Hough Lat<								pared:
Cost Center Description         Intal Impatient Cost Impatient Description (act 2)         Program Loss (act 2)         Program Loss (act 2)           42.00         INSERV (Litle V & XIX only)         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         4.00         5.00         4.00         4.00         5.00         4.00         5.00         4.00         5.00         4.00         5.00         4.00         5.00         4.00         4.00         5.00         4.00         5.00         4.00         5.00         4.00         5.00         6.00         4.00         5.00         6.00         4.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00         5.00         6.00							12/10/2018 3:	
Industry         Industry         Col. 31         Col. 32			<b>- - - -</b>					
Image: The state of t		Cost Center Description				5		
1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         1.00         2.00         3.00         4.00         5.00           1.00         1.00         0.00         0         4.00         4.00           1.00         1.00         0.00         0         0         4.00           4.00         0.00         0         0         4.00         4.00           4.00         0.00         0         0         4.00         4.00           4.00         0.00         0         0         4.00         4.00           4.00         0.00         0         0         4.00         4.00           4.00         0.00         0         0         4.00         4.00           4.00         0.00         0         0         4.00         4.00           4.00         0.00         0         0         4.00         4.00           4.00         0.00         0         0         4.00         4.00           4.00         0.00         0         0         0         0         0         0         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
Intensive Care Type Inpatient Respital Units         Intensive Care Unit         0 <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td></td> <td>4.00</td> <td></td> <td></td>			1.00	2.00		4.00		
42.00       INTERSIVE CARE UNIT       0       0       0.00       0       0.00       0       44.00         43.00       INTERSIVE CARE UNIT       0       0       0.00       0.00       0       45.00         43.00       INTERSIVE CARE UNIT       0       0       0.00       0.00       0       45.00         45.00       INTERSIVE CARE UNIT       0       0       0.00       0       45.00         45.00       INTERSIVE CARE UNIT       0       0       0.00       0       45.00         45.00       INTERSIVE CARE UNIT       0       0       0.00       0       45.00       47.00         45.00       INTERSIVE CARE UNIT       0       10.00       0       48.00       47.00       47.00       47.00         46.00       Frogram Inpatient costs (unit of ines 40 end 51.00       30.025 f.40       30.025 f.40       50.01       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       51.00       50.00       51.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00	42.00							42.00
44.00       Cookenter CaRE UNIT       44.00         45.00       DRIME INFLICT CARE UNIT       44.00         47.00       STREE CALE Code Control UNIT       44.00         48.00       Program Inpattent costs (sum of lines 51 and 51)       30.000         50.00       Interpret Inpattent costs (sum of lines 51 and 51)       4.731       50.00         50.00       Interpret Inpattent costs (sum of lines 51 and 51)       4.731       50.00         50.00       Torget Inpattent Code Cost and Inpattent S1 and 51)       4.731       50.00         50.00       Torget Inpattent Code Cost and Inpattent Operating cost and target amount (lines 54 and 51)       51.00       54.00         50.00       Torget Inpattent Code Cost and Inpattent S1.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00	12 00		0			0 0	0	1 12 00
45.00       BURN INTENSIVE CARE UNIT       45.00         45.00       SUBRICLALINTENSIVE CARE UNIT       45.00         47.00       OthERS SPECIAL CARE (SPECIFY)       100         41.00       Program Inpatient ancillary service cost (WeSt 10-3, col. 3, line 200)       100         40.00       Program Inpatient ancillary service cost (WeSt 10-3, col. 3, line 200)       36.205         50.00       Program Inpatient ancillary services (from West 0, sum of Parts 1 and 14, 721       56.00         50.00       Pros through costs applicable to Program Inpatient ancillary services (from West 0, sum of Parts 1 and 14, 721       56.00         50.00       Pros through costs applicable to Program Inpatient ancillary services (from West 0, sum of Parts 1 and 14, 731       50.00         50.00       Total Program Inpatient operating cost accluding capital related. non-physician anesthetist, and 13, 474       53.00         50.00       Target amount (ine 54 × 10n 55)       50.00       56.00         50.00       Target amount (ine 54 × 10n 55)       50.00       56.00         50.00       Target amount (ine 54 × 10n 55)       50.00       50.00       56.00         50.00       Target amount (ine 53.40 × 10n cost reporting period ending 1996, updated and compounded by the market basket       0.00       56.00         60.00       Efference betase and seed 57.00       56.00			0		0.0	0	0	
42.00       DTHEE SPECIAL CARE (SPECIFY)       47.00         45.00       Program inpatient ancillary service cast (West: D-3, col. 3, line 200)       0         46.00       Program inpatient motils (sum of lines 41 through 48) (see instructions)       30.25         50.00       Pass through costs applicable to Program inpatient routine services (from West: D, sum of Parts I and IV)       4.73         50.00       Pass through costs applicable to Program inpatient and linery services (from West: D, sum of Parts II and IV)       4.73         50.00       Tast Program inpatient operating cost accolding capital related, non-physician anesthetist, and mal VI       31.47         50.00       Tast Program inpatient operating cost accolding capital related, non-physician anesthetist, and Mita Ander Mot Line Generating cost and target amount (line 56 minus line 53)       55.00         50.00       Target amount per discharge       0.05 40         50.00       Derogram inpatient operating cost and target amount (line 56 minus line 53)       55.00         50.00       Derogram inpatient operating cost and target amount (line 56 minus line 53)       55.00         50.00       Derogram inpatient cost report, updated by the market basket       0.00         50.00       Derogram inpatient cost plus incentive payeent (see instructions)       0.63.00         50.00       Derogram inpatient cost plus incentive payeent (see instructions)       0.60.00								
Cost Contre Description         1.00           46.00         Programe inpatient ancillary service cast (WeSt D-3, col: 3, line 200)         0.0         48.00           47.00         Total Program inpatient costs (aum of lines 41 through 40)(see instructions)         36.202         48.00           50.00         Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts I and III)         47.73         50.00           61.01         pass through costs applicable cost (see of lines 50 and 51)         51.00         61.73         52.00           53.00         Total Program inpatient and line 52)         71.75         52.00         71.75         52.00           54.00         Program of lischargs         50.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         10.00         55.00         0.00         55.00         0.00								46.00
Accord         Trogram         Inpatient ancillary service cost (WkSt D-3, col. 3, line 200)         0         48.00           44:00         Frogram inpatient costs (sum of lines 41 through 48)(see instructions)         50.22         49.00           50.00         MASS. Through costs applicable to Program inpatient routine services (from Wkst. 0, sum of Parts I and 1.73         50.00           10.00         Prost through costs applicable to Program inpatient ancillary services (from Wkst. 0, sum of Parts I and 1.73         51.00           10.00         Total Program excludable cost (sum of lines 50 and 51)         4.731         52.00           10.00         Total Program excludable cost (sum of lines 50 and 51)         4.731         52.00           50.00         Target amount per discharge         0.00         55.00           50.00         Dirget amount per discharge         0.00         56.00           50.01         Dirget amount (line 54 x line 55)         0.00         56.00         56.00           50.01         Dirget amount (cost sharth cost reporting period ending 1996, updated and compounded by the market basket instructions)         0.00         56.00           60.01         If line 50/54 is loss of rom prior year costs intructions)         0.61.00         66.00         66.00           61.01         If line 50/54 is loss of rom prior year costs through backmber 31 of the cost reporting period	47.00							47.00
48:00       Program inpatient ancillary service cost (Wist, D3, col. 3, line 200)       0 </td <td></td> <td>COST CENTER DESCRIPTION</td> <td></td> <td></td> <td></td> <td></td> <td>1 00</td> <td></td>		COST CENTER DESCRIPTION					1 00	
40:00       Total Program inpatient costs (sum of Lines 41 through 48) (see Instructions)       36,205       49,00         ANS. HURSHIELDS       Anstructions       36,205       49,00         ANS. HURSHIELDS       Anstructions       4,731       50,00         100       Program excludable cost (sum of Lines 50 and 51)       4,731       50,00         51.00       Total Program excludable cost (sum of Lines 50 and 51)       4,731       50,00         52.00       Total Program excludable cost (sum of Lines 52)       Total Program excludable cost (sum of Lines 52)       56,00	48.00	Program inpatient ancillary service cost (Wk		3. line 200)				48.00
90.00       Pess through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and H.731 50.00       4,731 50.00         10.00       Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II and M.731 50.00       51.00         10.01       Pass through costs applicable cost (sum of Times 50 and 51)       61.00         10.01       Program inpatient operating cost excluding capital related, non-physician anesthetist, and medication costs (line 40 minus line 52)       61.00         11.02       Target amount (line 54 × line 50)       05.00         10.01       Difference between adjusted inpatient operating cost and target amount (line 53 ± 100.00       05.00         10.01       Difference between adjusted inpatient operating cost and target amount (line 53 ± 54 ± 55 ± 56 mm prior year cost report, updated by the market basket       0.00       00.00         10.01       Difference between adjusted inpatient operating cost and target amount (line 54 ± 100.00       06.00       00.00       06.00					ons)		36, 205	
111)       1111       111       111 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
51.00       Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV)       0       51.00         20.01       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 52)       0       0.54.00         20.01       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 52)       0       0.54.00         20.01       Total Program inpatient costs (line 40 minus line 52)       0       0.54.00         20.01       Total Program inpatient costs (line 55)       0       0.55.00         20.01       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.56.00         20.02       Discover of lines 53/4 or 55 from prior year cost report, updated by the market basket       0.00       0.00         20.01       Discover of lines 53/4 or 55 from prior year cost report, updated by the market basket       0.00       0.00         20.01       Discover of lines 53/4 or 55 from prior year cost report, updated prior to the cost reporting period (See Instructions) (tite VIII only).       0       64.00         20.01       Discover of lines 53/4 or 55 from prior year cost reporting period (See Instructions) (tite VIII only).       0       64.00         20.01       Discovertructos(UIII NE WIN 60 DO COST       0	50.00		atient routine	services (fro	n Wkst. D, sun	of Parts I and	4, 731	50.00
52.00       Total Program excludable cost (sum of lines 50 and 51)       4,731       52.00         50.00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and modical education costs (line 49 minus line 52)       31.474         51.00       Tradet Anount Anb Link T COMPUTATION       55.00         52.00       Target amount per discharges       0         52.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       05.00         50.00       Difference between disusted inpatient operating cost and target amount (line 56 minus line 53)       0.00         50.00       Difference between disusted inpatient operating cost report, updated by the market basket       0.00       60.00         60.01       OI if line 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         61.01       If line bas/54 is 15 stom the cost proving period costs (lines 54 x 60), or 1% of the target amount by which operating costs (line 50, period costs (lines 54 x 60), or 1% of the carget amount by which operating costs (line 50, minut costs 10, minut costs	51.00	Pass through costs applicable to Program inpa	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	0	51.00
53.00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)       31,474       53.00         TARGET AMOUNT AND LIMIT COMPUTATION       Target amount (line 54 x line 55)       0       56.00       57.00       0       0       65.00       55.00       0       56.00       57.00       0       0       65.00       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0 </td <td>52.00</td> <td></td> <td>50 and 51)</td> <td></td> <td></td> <td></td> <td>4, 731</td> <td>52.00</td>	52.00		50 and 51)				4, 731	52.00
TARGET AMOUNT AND LIMIT COMPUTATION       54.00       Forger adjustanges       0       54.00         55.00       Target amount (her 54 x line 55)       0       55.00       0       0       0       55.00       0       0       0       55.00       0       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       56.00       0       0       0       56.00       0       0       0       56.00       0       0       0       0       56.00       0<				elated, non-phy	ysician anesth	etist, and		
54:00       Program discharges       0       54:00       54:00         50:00       Target amount per discharge       0       0       56:00       56:00         50:00       Dirget amount per discharge       0       0       56:00       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       56:00       0       0       56:00       0       0       56:00       0       0       56:00       0       0       0       57:00       0 <t< td=""><td></td><td></td><td>52)</td><td></td><td></td><td></td><td></td><td></td></t<>			52)					
55:00       Target amount (ine 54 x line 55)       0.00       55:00         00       Target amount (line 54 x line 55)       0.00       55:00         00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55:00         00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55:00         00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60:00         01       If lines 53/54 is 15 from prior year cost report, updated by the market basket       0.00       60:00         01       If lines 53/54 or 55 from prior year cost report.       0.01       61:00       62:00         03       Allowable inpatient cost puts incertive payment (see instructions)       0       62:00         04       Market cost puts incertive payment (see instructions)       0       63:00         64:00       Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions)       64:00         65:00       Target Medit MM SWF inpatient routine costs after December 31 of the cost reporting period (See instructions)       65:00         66:00       Title V or XX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       66:00	54 00							54 00
56.00       Target amount (line 54 x line 55)       0       56.00         57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       55.00         58.00       Bonus payment (see instructions)       0       56.00       57.00       0       57.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       50.00       0       60.00       0       60.00       0       60.00       0       60.00       0       61.00       0       66.00       0       66.00       0       66.00       0       66.00       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
58:00       Borus payment (see instructions)       0       58:00       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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       59.00         60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       61.00         61.00       If lines 53/54 is 15 shan 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 for lines for the cost reporting period (See linstructions) (tite XVIII only)       64.00         60.00       Relicer swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See linstructions) (tite XVIII only)       64.00         60.00       Fold care swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)       64.00         60.01       Totil work is mighted NF inpatient routine costs (line 67 + line 68)       0       66.00         60.01       Totil work is mighted NF inpatient routine costs (line 7 + line 68)       0       69.00         70.00       RAILIEL NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY       70.00       71.00         70.00       RAILIEL NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY       72.00       73.00         70.00       RAILI	57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	ine 56 minus	line 53)	0	57.00
market basket       0.00         00.00       tesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00         01.00       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 51) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)       0         02.00       Relice f payment (see instructions)       0         03.00       Allowable (npatient cost plus incentive payment (see instructions)       0         04.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)       0         05.00       Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Cod (kee instructions)       0         06.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       0         07.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         08.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         09.00       Skilled nursing facility/other Nursing faco facility at the								
60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.0	59.00		porting period	ending 1996, i	updated and co	mpounded 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)       61.00         62.00       Relief payment (see instructions)       0         63.00       Allowable Inpatient cost plus incentive payment (see instructions)       0         64.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       0         64.00       Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)       0       65.00         65.00       Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See (line 12 x line 19)       0       67.00         60.00       Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See (line 14 v X line 19)       0       68.00         61.00       Hield vor XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69.00       0         70.00       Title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2)       70.00       71.00         71.00       Adjusted general inpatient routine service costs (line 70 + line 2)       72.00       73.00         71.00       Adjusted general inpatient routine service c	60.00		cost report, up	dated by the i	market basket		0.00	60.00
amount (line 56), otherwise enter zero (see instructions)       0         62:00 Relice f payment (see instructions)       0         63:00 Allowable Inpatient costs plus incentive payment (see instructions)       0         64:00 Instructions)(title XVIII only)       0         64:00 Instructions)(title XVIII only)       0         65:00 Redicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions)(title XVIII only)       0         66:00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)       0       67:00         70:00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See (line 12 x line 19)       0       67:00         80:00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       0       68:00         90:00 Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2)       70:00       70:00         71:00 Adjusted general inpatient routine service costs (line 70 + line 2)       70:00       70:00         72:00 Total Program coutine service cost (line 9 x line 71)       70:00       73:00       74:00       74:00         75:00 Capited real real relatitient routine service costs (from provider records)       79:00       70:00       70:00         70:00 Costal real real related costs (line 7 + line 2)       76:00	61.00						0	61.00
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63:00       Allowable inpatient cost plus incentive payment (see instructions)       0       63:00         PROGRAM INPATIENT ROUTINE SWING BED COST       64.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       64.00         65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       65.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       68.00         68.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       69.00         64.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       69.00         64.00       Title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2)       70.00         70.00       Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 37)       71.00         70.00       Skilled nursing facility/ICF/IID routine service cost (line 37)       71.00         70.00       Title S X Line 20       71.00         70.00       Capital-related costs (line 9 x line 71)       72.00	62 00		Instructions)				0	62 00
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85.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.0087.00Total observation bed days (see instructions)088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)0.00								
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST         87.00         Total observation bed days (see instructions)         0         88.00         Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)         0.00         88.00				ons)				
87.00Total observation bed days (see instructions)087.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)0.0088.00	86.00			nrough 85)				86.00
88.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)0.0088.00	87 00						0	87 00
				line 2)				

Health Financial Systems Kin	dred Hospital	Nort	hwest India	na	In Lie	eu of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CC	CN: 15-2012	Period: From 09/01/2017	Worksheet D-1	
					To 08/31/2018	Date/Time Pre 12/10/2018 3:	
			Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Ro	outine Cost	column 1 ÷	Total	Observation	
		(fr	om 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, 326, 29	4	10, 149, 556	0. 1306	75 0	0	90.00
91.00 Nursing School cost		0	10, 149, 556	0.0000	0 0	0	91.00
92.00 Allied health cost		0	10, 149, 556	0.0000	0 0	0	92.00
93.00 All other Medical Education		0	10, 149, 556	0.0000	00 0	0	93.00

	Financial Systems Kin IONMENT OF COST OF SERVICES RENDERED BY INTER	ndred Hospital No RNS AND RESIDENT		CN: 15-2012 P	eri od:	u of Form CMS-2 Worksheet D-2	
				F	rom 09/01/2017 o 08/31/2018		
						12/10/2018 3: Heal th Care	21
						Program	
						Inpatient Days	
	Cost Center Description	Percent of	Expense	Total	Average Cost	Title V	
		Assigned Time	Allocation	Inpatient Day All Patients	Per Day		
		1.00	2.00	3.00	4.00	5.00	-
	PART I - NOT IN APPROVED TEACHING PROGRAM	1.00	2.00	0.00	1.00	0.00	
0	Total cost of services rendered	0.00	C	)			1 1
	Hospital Inpatient Routine Services:						
0	ADULTS & PEDIATRICS	0.00	C	13, 176	0.00		
)	INTENSIVE CARE UNIT	0.00	C	0 0	0.00	0	
2	CORONARY CARE UNIT						4
) )	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						6
5	OTHER SPECIAL CARE (SPECIFY)						7
5	NURSERY						
5	Subtotal (sum of lines 2 through 8)	0.00	C				9
00	SUBPROVIDER - IPF						10
00	SUBPROVIDER - IRF						11
00	SUBPROVI DER						12
00	SKILLED NURSING FACILITY	0.00	C	0 0	0.00	0	
00	NURSING FACILITY						14
	OTHER LONG TERM CARE HOME HEALTH AGENCY						15
	CMHC						17
	AMBULATORY SURGICAL CENTER (D. P. )						18
	HOSPICE						19
	Subtotal (sum of lines 9 through 19)	0.00	C				20
						Titles V and	
						XIX Outpatient	
						and Title	
						XVIII Part B	
	Cost Center Description			Total Charges	Ratio of Cost	Charges Title V	
	Cost Center Description			(from	to Charges	intro v	
					$(col \cdot 2 \div col \cdot$		
				Part I, column	3		
				8, lines 88			
		1.00		through 93)		5.00	
_	Hospital Outpatient Services:	1.00	2.00	3.00	4.00	5.00	-
	RURAL HEALTH CLINIC						21
	FEDERALLY QUALIFIED HEALTH CENTER						22
	CLINIC	0.00	C	0 0	0.000000	0	
00	EMERGENCY	0.00	C	0 0	0. 000000	0	24
	OBSERVATION BEDS (NON-DISTINCT PART)						25
	OTHER OUTPATIENT SERVICE COST CENTER						26
00	Subtotal (sum of lines 21 through 26)	0.00	0				27
)0	Total (sum of lines 20 and 27)	0.00	Cwing hod	-	Tatal	Average Cost	28
	Cost Center Description	Expenses Allocated To	Swing bed Amount	Net cost (column 1 plus	Total Inpatient Davs	Average Cost Per Day (col	
		cost centers	, anount		- All Patients		
		on Worksheet					
		B, Part I					
		columns 21 and					
		22	2.00	2.00	4.00	F 00	-
	PART II - IN AN APPROVED TEACHING PROGRAM (T	1.00	2.00 T B INPATIENT	3.00 ROUTLINE COSTS (	4.00	5.00	-
	Hospital Inpatient Routine Services:						1
00	ADULTS & PEDIATRICS	0	C	0 0	13, 176	0.00	29
00	Swing Bed - SNF		C	0 0	0		
00	Swing Bed - NF		C	D			31
00	INTENSIVE CARE UNIT	0		0	0	0.00	
00	CORONARY CARE UNIT						33
00	BURN INTENSIVE CARE UNIT						34
	SURGI CAL INTENSIVE CARE UNIT						35
00	OTHER SPECIAL CARE (SPECIFY)						36
00	Subtotal (sum of lines 29, and 32 through 36)	0		0			37
	SUBPROVIDER – IPF						38
)()	SUBPROVIDER - IRF						39
	JUDFROVIDER - IRI						
00	SUBPROVI DER						40
00		0		0	0	0.00	40 41

Health Financial Systems Kind	dred Hospital Northwest India	ina	In Lieu of	Form CMS-2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	NS AND RESIDENTS Provider C			sheet D-2
			From 09/01/2017 To 08/31/2018 Date 12/1	e/Time Prepared: <u>0/2018 3:21 pm</u>
	Not In Approved Teachin	ig Program	In Approved Teachin	g Program
Cost Center Description	(from Part I:)	Amount	(from Part II, col	. 7, - )
	1.00	2.00	3.00	
PART III - SUMMARY FOR TITLE XVIII (TO BE COM	MPLETED ONLY IF BOTH PARTS I	AND II ARE USI	ED)	
Hospi tal				
43.00  Inpatient	col. 9, line 9.00		0line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF				47.00
48. 00 SUBPROVI DER				48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0col. 9, line 41.00	49.00

ealth Financial Systems k PPORTIONMENT OF COST OF SERVICES RENDERED BY IN	indred Hospital N TERNS AND RESIDENT			In Lie Period:	u of Form CMS-2 Worksheet D-2	
			F	rom 09/01/2017 o 08/31/2018		pared:
	Health Car Inpatie				12/10/2018 3.	
Cost Center Description	Title XVIII, Part B Only less Part A Coverage but no Part B	Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Coverage 6.00	7.00	8.00	9.00	10.00	
PART I - NOT IN APPROVED TEACHING PROGRAM .00 Total cost of services rendered			1			1.0
Hospital Inpatient Routine Services:						1 1.0
.00       ADULTS & PEDIATRICS         .00       INTENSIVE CARE UNIT         .00       CORONARY CARE UNIT	9, 709 0	47 0		-	0	2.0 3.0 4.0
.00 BURN INTENSIVE CARE UNIT .00 SURGICAL INTENSIVE CARE UNIT .00 OTHER SPECIAL CARE (SPECIFY) .00 NURSERY .00 Subtotal (sum of lines 2 through 8)			c	0	0	5. 0 6. 0 7. 0 8. 0 9. 0
0.00 SUBPROVI DER - I PF 1.00 SUBPROVI DER - I RF 2.00 SUBPROVI DER 3.00 SKI LLED NURSI NG FACI LI TY	0	0				10. 0 11. 0 12. 0
4. 00 NURSING FACILITY 5. 00 OTHER LONG TERM CARE 6. 00 HOME HEALTH AGENCY 7. 00 CMHC 8. 00 AMBULATORY SURGICAL CENTER (D. P. ) 9. 00 HOSPICE		J				14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
0.00 Subtotal (sum of lines 9 through 19)						20.0
	Titles V and X and Title X Char	VIII Part B		d XIX Outpatier VIII Part B Cos		
Cost Center Description	Title XVIII Part B 6.00	Title XIX	Title V 8.00	Title XVIII Part B 9.00	Title XIX 10.00	
Hospital Outpatient Services:	0.00	7.00	0.00	7.00	10.00	
<ol> <li>RURAL HEALTH CLINIC</li> <li>OFEDERALLY QUALIFIED HEALTH CENTER</li> <li>OO CLINIC</li> <li>EMERGENCY</li> <li>OBSERVATION BEDS (NON-DISTINCT PART)</li> <li>OTHER OUTPATIENT SERVICE COST CENTER</li> <li>OO Subtotal (sum of lines 21 through 26)</li> <li>OO Total (sum of lines 20 and 27)</li> </ol>	0 0	0 0	c c	0	0	21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0
Cost Center Description	Inpatient Days	(col. 5 x col. 6)	PSA Adj. Interns & Residents			
PART II - IN AN APPROVED TEACHING PROGRAM	6.00 (TITLE XVIII, PAR	7.00 T B INPATIENT	11.00 ROUTINE COSTS	ONLY)		
Hospital Inpatient Routine Services:						
<ul> <li>P. 00 ADULTS &amp; PEDIATRICS</li> <li>D. 00 Swing Bed - SNF</li> <li>I. 00 Swing Bed - NF</li> <li>2. 00 INTENSIVE CARE UNIT</li> <li>3. 00 CORONARY CARE UNIT</li> <li>4. 00 BURN INTENSIVE CARE UNIT</li> <li>5. 00 SURGICAL INTENSIVE CARE UNIT</li> <li>5. 00 OTHER SPECIAL CARE (SPECIFY)</li> <li>7. 00 Subtotal (sum of lines 29, and 32 through 36)</li> </ul>	0 0 0	0 0 0				29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0
8.00 SUBPROVI DER - I PF 9.00 SUBPROVI DER - I RF 0.00 SUBPROVI DER						38. 0 39. 0 40. 0

Health Financial Systems Kin	dred Hospital N	lorthwest Indiana	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	NS AND RESIDEN	TS Provider CCN: 15-2012	Peri od:	Worksheet D-2	
			From 09/01/2017 To 08/31/2018	Date/Time Pre 12/10/2018 3:	
	In Approved	Total Title XVIII	Costs		
	Teachi ng				
	Program				
Cost Center Description	Amount	(to Wkst. E, Part B - )	(col. 2 + col.		
			4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE CO	MPLETED ONLY IF	BOTH PARTS I AND II ARE US	SED)		
Hospi tal					
43.00 Inpatient	0		0		43.00
44.00 Outpatient					44.00
45.00 Total Hospital (sum of lines 43 and 44)	0	line 22	0		45.00
46.00 SUBPROVIDER - IPF					46.00
47.00 SUBPROVIDER - IRF					47.00
48. 00 SUBPROVI DER					48.00
49.00 SKILLED NURSING FACILITY	0	line 22	0		49.00

Health Financial Systems	Kindred Hospital No	rthwest India	ina	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Peri od:	Worksheet D-3	
				From 09/01/2017 To 08/31/2018	Date/Time Pre	pared.
				10 00, 01, 2010	12/10/2018 3:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			1	24, 151, 469		30.00
31. 00 03100 I NTENSI VE CARE UNI T				21,101,107		31.00
ANCI LLARY SERVICE COST CENTERS			1	-		1
50.00 05000 OPERATI NG ROOM			0. 40798	2, 615, 953	1, 067, 259	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 19365	i9 1, 677, 487	324, 860	54.00
60. 00 06000 LABORATORY			0. 15422	6, 404, 100	987, 692	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 10836	3 10, 119, 500	1, 096, 579	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 37154		1, 008, 428	
67.00 06700 OCCUPATI ONAL THERAPY			0.00000		0	07100
68.00 06800 SPEECH PATHOLOGY			0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	TS		0. 32507			•
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 14344			•
74.00 07400 RENAL DI ALYSI S			0. 32486	1, 406, 092	456, 789	74.00
OUTPATIENT SERVICE COST CENTERS			0.0000			00.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY			0.00000		-	
OTHER REIMBURSABLE COST CENTERS			0.0000		0	91.00
95. 00 09500 AMBULANCE SERVICES						95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0. 00000	0	0	
200.00 Total (sum of lines 50 through 94 a	and 96 through 98)		0.00000	36, 737, 145	-	
201.00 Less PBP Clinic Laboratory Services		es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 20				36, 737, 145		202.00

	Financial Systems Kindred Hospital Nor ATION OF REIMBURSEMENT SETTLEMENT	rthwest Indiana Provider CCN: 15-2012	Peri od:	Worksheet E	2002 10
			From 09/01/2017 To 08/31/2018		
		Title XVIII	Hospi tal	12/10/2018 3: PPS	21 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru	ctions)		0 33, 672	
3.00	OPPS payments			37, 989	•
4.00	Outlier payment (see instructions)			0	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0 0. 000	
6.00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV. col. 13. line 200		0	
10.00	Organ acqui si ti ons	,,		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11.00
	Reasonabl e charges				
12.00	Ancillary service charges			0	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Total reasonable charges (sum of lines 12 and 13)	line 69)		0	
14.00	Customary charges			0	1 14.00
15.00	Aggregate amount actually collected from patients liable for			0	
16.00	Amounts that would have been realized from patients liable finad such payment been made in accordance with 42 CFR §413.13	1 5	on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)	nly if line 10 evenede li	no 11) (coo	0	18.00
19.00	Excess of customary charges over reasonable cost (complete or instructions)	niy if line 18 exceeds if	ne II) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete o	nly if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			37, 989	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	
26.00 27.00	Deductibles and Coinsurance relating to amount on line 24 (f Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			7, 598 30, 391	
27.00	instructions)	prus the sum of Trifes 22		50, 571	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,			0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36 Subtotal (sum of lines 27 through 29)	)		0 30, 391	
31.00	Primary payer payments			0	
32.00	Subtotal (line 30 minus line 31)			30, 391	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV Composite rate ESRD (from Wkst. I-5, line 11)	I CES)		0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	
37.00	Subtotal (see instructions)	ti ucti olis)		30, 391	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructio	nc)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration	-		0	39.97
39. 98	Partial or full credits received from manufacturers for repl	aced devices (see instruc	ctions)	0	39.98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 30, 391	
40.00	Sequestration adjustment (see instructions)			608	1
40.02	Demonstration payment adjustment amount after sequestration			0	
41.00 42.00	Interim payments Tentative settlement (for contractors use only)			29, 783 0	1
43.00	Balance due provider/program (see instructions)			0	
44.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
94.00	Total (sum of lines 91 and 93)				94. OC

Health Financial Systems	Kindred Hospital Northwest Indiana	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2012	Peri od:	Worksheet E	
		From 09/01/2017		nored.
		To 08/31/2018	Date/Time Pre 12/10/2018 3:	
	Title XVIII	PPS		
			Overri des	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00 Override of Ancillary service charges (	line 12)		0	112.00
5 5				

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC	CN: 15-2012	Period: From 09/01/2017 To 08/31/2018		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		13, 780, 99	0	29, 783 0	1. 0 2. 0 3. 0
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	ADJUSTMENTS TO PROVIDER	12/01/2017	174, 50	00	0	3. C
02				0	0	3.0
03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
50 51				0	Ő	3.
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		174, 50		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		13, 955, 49	22	29, 783	4.
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)					0.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
	Provider to Program			·		
50	TENTATIVE TO PROGRAM			0	0	5.
51				0	0	5.
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 5.
)0	5. 50-5. 98) Determined net settlement amount (balance due) based on			0	0	5. 6.
)1	the cost report. (1) SETTLEMENT TO PROVIDER		1, 265, 50	)4	0	6.
)2	SETTLEMENT TO PROGRAM		., 200, 00	0	0	6.
00	Total Medicare program liability (see instructions)		15, 220, 99	-	29, 783	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1.00	2.00	

ALCULATION OF REIMBURSEMENT SETTLE	MENT	Provider CCN: 15-2012	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part IV Date/Time Pre 12/10/2018 3:	pare
		Title XVIII	Hospi tal	PPS	<u>z i p</u>
			nooprea		
				1.00	
PART IV - MEDICARE PART A SEI	RVICES - LTCH PPS				
.00 Net Federal PPS Payments (se	e instructions)			15, 688, 619	1.
.01 Full standard payment amount				13, 302, 094	1.
.02 Short stay outlier standard	payment amount			2, 034, 866	1.
.03 Site neutral payment amount	- Cost			34, 781	1.
.04 Site neutral payment amount	- IPPS comparable			316, 878	1.
00 Outlier Payments				716, 437	2.
00 Total PPS Payments (sum of I	nes 1 and 2)			16, 405, 056	3.
00 Nursing and Allied Health Ma	naged Care payments (see ir	istructions)		0	4.
00 Organ acquisition (DO NOT US	E THIS LINE)				5.
00 Cost of physicians' services	in a teaching hospital (se	e instructions)		0	6
00 Subtotal (see instructions)	5 1 3	,		16, 405, 056	7
00 Primary payer payments				0	8
00 Subtotal (line 7 less line 8	).			16, 405, 056	9
. 00 Deducti bl es				15, 864	
.00 Subtotal (line 9 minus line	10)			16, 389, 192	
2.00 Coi nsurance				1, 386, 036	
3.00 Subtotal (line 11 minus line	12)			15,003,156	
.00 Allowable bad debts (exclude		services) (see instructions)		813, 036	
5.00 Adjusted reimbursable bad de				528, 473	
0.00 Allowable bad debts for dual		e instructions)		449, 323	
.00 Subtotal (sum of lines 13 an	<b>a</b>			15, 531, 629	
.00 Direct graduate medical educ	<i>,</i>	F-4 line 49)		0	
0.00 Other pass through costs (se		2 .,		0	
0.00 Outlier payments reconciliat	-			0	
. 00 OTHER ADJUSTMENTS (SEE INSTR				0	
. 50 Pioneer ACO demonstration pa		ructions)		0	
. 99 Demonstration payment adjust				0	
2.00 Total amount payable to the	•			15, 531, 629	
2.01 Sequestration adjustment (se				310, 633	
2.02 Demonstration payment adjust		ation		0,000	
. 00 Interim payments	and another arter sequestre			13, 955, 492	
.00 Tentative settlement (for co	ntractor use only)			0, 100, 172	
. 00 Balance due provi der/program		22 02 23  and  24		1, 265, 504	
		accordance with CMS Pub. 15-2,	chanter 1	18,079	
§115. 2		$10^{-2}$ ,		10, 07 9	
TO BE COMPLETED BY CONTRACTO					
0.00 Original outlier amount from				716, 437	50
00 Outlier reconciliation adjus	tment amount (see instructi	ons)		0	
2.00 The rate used to calculate t	ne Time Value of Money (see	; instructions)		0.00	52
3.00 Time Value of Money (see ins	5 1			0	

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2012	Period: From 09/01/2017	Worksheet E-3 Part VII	
				Date/Time Pre 12/10/2018 3:	pared: 21 pm
		Title XIX	Hospi tal	PPS	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00 3.00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				+
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		0	0	12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for	navment for services o	on O	0	14.00
	a charge basis had such payment been made in accordance with 4.			Ũ	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	•
	Total customary charges (see instructions)		0	0	
17.00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	y IT ITNE 16 exceeds	0	0	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl) (6) (see instructions)	y if line 4 exceeds lir	ne O	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	•
21.00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be a Other than outlier payments	completed for PPS provi	ders.	0	22.00
	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0	_	25.00
26.00 27.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	•
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		0	0	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	•
37.00	OTHER ADJUSTMENTS OTHER ADJUSTMENTS		0	0	•
	Subtotal (line 36 ± line 37)		0	0	•
37.01			0	Ũ	39.00
37. 01 38. 00	Direct graduate medical education payments (from Wkst. E-4)			0	40.00
37.01 38.00 39.00 40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
<ol> <li>37. 01</li> <li>38. 00</li> <li>39. 00</li> <li>40. 00</li> <li>41. 00</li> </ol>	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		0	0	
<ol> <li>37.01</li> <li>38.00</li> <li>39.00</li> <li>40.00</li> <li>41.00</li> <li>42.00</li> </ol>	Total amount payable to the provider (sum of lines 38 and 39) Interim payments Balance due provider/program (line 40 minus line 41)	ce with CMS Dub 15-2	0	0 0	42.00
<ol> <li>37. 01</li> <li>38. 00</li> <li>39. 00</li> <li>40. 00</li> <li>41. 00</li> </ol>	Total amount payable to the provider (sum of lines 38 and 39) Interim payments	ce with CMS Pub 15-2,	0	0	42.00

	Financial Systems Kindred Hospital N E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provi der C	CN: 15-2012 P	Period: Trom 09/01/2017	u of Form CMS-2 Worksheet G	
nly)	ype accounting records, comprete the deneral runa cordinin			08/31/2018	Date/Time Pre 12/10/2018 3:	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	-
	CURRENT ASSETS					
. 00	Cash on hand in banks	-2, 084			0	
. 00	Temporary investments	0	0	-	0	
00	Notes receivable		0	0	0	
	Accounts receivable Other receivable	5, 397, 555		0	0	
		6, 154 -1, 158, 256		0	0	
	Allowances for uncollectible notes and accounts receivable Inventory	258, 668		0	0	
	Prepaid expenses	132, 493		0	0	
	Other current assets	0	0	0	0	
	Due from other funds	C	0	0	0	10
I. 00	Total current assets (sum of lines 1-10)	4, 634, 530	0	0	0	11
	FIXED ASSETS					
	Land	C		-	0	
	Land improvements	0	0	0	0	
	Accumulated depreciation		0	0	0	
	Buildings Accumulated depreciation		0	0	0	
	Leasehold improvements	186, 136			0	
	Accumulated depreciation	-186, 136		0	0	
	Fixed equipment	00,100	0	-	0	
	Accumulated depreciation	C	0	0	0	
1.00	Automobiles and trucks	C	0	0	0	21
2.00	Accumulated depreciation	C	0	0	0	22
	Major movable equipment	2, 012, 030		0	0	
	Accumulated depreciation	-1, 494, 853		0	0	
	Minor equipment depreciable	0	0	0	0	
	Accumulated depreciation	0	0	0	0	1
	HIT designated Assets Accumulated depreciation		0	0	0	
	Mi nor equi pment-nondepreci abl e		0	0	0	
	Total fixed assets (sum of lines 12-29)	517, 177		-	0	
	OTHER ASSETS		-	-1		
	Investments	C	0	0	0	31
2.00	Deposits on Leases	C	0	0	0	32
3.00	Due from owners/officers	0	0	0	0	33
	Other assets	3, 162, 500		0	0	-
	Total other assets (sum of lines 31-34)	3, 162, 500		-	0	
	Total assets (sum of lines 11, 30, and 35)	8, 314, 207	0	0	0	36
	CURRENT LI ABI LI TI ES	454 004	0	ol	0	37
	Accounts payable Salaries, wages, and fees payable	456, 906 314, 402	1		0	
	Payroll taxes payable	46, 049		-	0	
	Notes and Loans payable (short term)	40,047		0	0	
	Deferred income	C C	0	0	0	
	Accelerated payments	C	)			42
3.00	Due to other funds	C	0	0	0	43
	Other current liabilities	194, 789		-	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	1, 012, 146	0	0	0	45
	LONG TERM LIABILITIES					4
	Mortgage payable		0	-	0	
	Notes payable Unsecured Loans		0	0	0	
	Other long term liabilities	98, 692			0	
	Total long term liabilities (sum of lines 46 thru 49)	98, 692		-	0	
	Total liabilities (sum of lines 45 and 50)	1, 110, 838		-	0	
	CAPI TAL ACCOUNTS			·		1
2. 00	General fund balance	7, 203, 369	)			52
3.00	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		5!
	Governing body created - endowment fund balance			0	-	50
	Plant fund balance - invested in plant				0	
8.00	Plant fund balance - reserve for plant improvement,				0	58
9.00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	7, 203, 369	_	0	0	59
	Total liabilities and fund balances (sum of lines 51 and	8, 314, 207			0	
	and runa barances (sum of filles of and	0,014,207		- U	0	1 0

STATEMENT OF CHANGES IN FUND BALANCES		dred Hospital No	Provider CC			In Lie riod: om 09/01/2017 08/31/2018	Worksheet G-7 Date/Time Pre 12/10/2018 3:	epared:
		General	Fund	Speci al	Purp	pose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$	Fund balances at beginning of period Net income (Loss) (from Wkst. G-3, Line 29) Total (sum of Line 1 and Line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of Line 4-9) Subtotal (Line 3 plus Line 10) Deductions (debit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total deductions (sum of Lines 12-17) Fund balance at end of period per balance sheet (Line 11 minus Line 18)	0 0 0 0 0 15, 050, 311 0 0 0 0 0	19, 599, 498 2, 654, 182 22, 253, 680 0 22, 253, 680 15, 050, 311 7, 203, 369		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0		$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund				
1.00		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING	0	0 0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	000	0 0 0 0 0		0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-2012	Period: From 09/01/2017 To 08/31/2018		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		33, 040, 02	28	33, 040, 028	1.0
2.00	SUBPROVIDER - IPF					2.0
3.00	SUBPROVIDER - IRF					3.0
4.00	SUBPROVIDER					4.0
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	
8.00	NURSING FACILITY					8.0
9.00	OTHER LONG TERM CARE					9.0
10.00	Total general inpatient care services (sum of lines 1-9)		33, 040, 02	28	33, 040, 028	10.0
	Intensive Care Type Inpatient Hospital Services				1	
11.00	INTENSIVE CARE UNIT			0	0	•
12.00	CORONARY CARE UNI T					12.0
13.00	BURN INTENSIVE CARE UNIT					13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
16.00	Total intensive care type inpatient hospital services (sum of I	ines		0	0	16.0
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		33, 040, 02		33, 040, 028	
18.00	Ancillary services		52, 151, 2			18.0
19.00	Outpatient services			0 0	-	
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY					22.0
23.00	AMBULANCE SERVICES			0 0	0	
24.00						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.0
26.00	HOSPICE			0		26.0
27.00	OTHER (SPECIFY)	- Witert	05 101 0	0 0	0	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	O WKST.	85, 191, 29	98 264, 517	85, 455, 815	28.0
	G-3, line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			21, 409, 158		29.0
30.00	ADD (SPECIFY)			0		30.0
31.00				0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)			0		36.0
37.00	DEDUCT (SPECIFY)			0		37.0
38.00				0		38.0
39.00				0		39.0
40.00				0		40.0
40.00				0		40.0
41.00	Total deductions (sum of lines 37-41)			0		41.0
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfor		21, 409, 158		42.0
+5.00	to Wkst. G-3, line 4)			21,407,130		+3.0

Heal th	Health Financial Systems         Kindred Hospital Northwest Indiana         In Lieu							
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-2012 Period: W							
	From 09/01/2017 To 08/31/2018							
	To 08/31/2018							
				1.00				
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		85, 455, 815	1.00			
2.00	Less contractual allowances and discounts on patients' accour	its		61, 469, 009	2.00			
3.00	Net patient revenues (line 1 minus line 2)			23, 986, 806	3.00			
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		21, 409, 158	4.00			
5.00	Net income from service to patients (line 3 minus line 4)			2, 577, 648	5.00			
	OTHER INCOME							
6.00	Contributions, donations, bequests, etc			0	6.00			
7.00	Income from investments			0	7.00			
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00			
9.00	Revenue from television and radio service			0	9.00			
10.00	Purchase di scounts			4, 078				
11.00	Rebates and refunds of expenses			0	11.00			
12.00	Parking lot receipts			0	12.00			
13.00				0	13.00			
14.00				0	14.00			
15.00				0	15.00			
16.00		han patients		0	16.00			
17.00				0	17.00			
18.00	Revenue from sale of medical records and abstracts			0	18.00			
19.00				0	19.00			
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00			
21.00	Rental of vending machines			0	21.00			
22.00	Rental of hospital space			0	22.00			
23.00	Governmental appropriations			0	23.00			
24.00	MI SCELLANEOUS I NCOME			72, 456				
25.00	Total other income (sum of lines 6-24)			76, 534				
26.00	Total (line 5 plus line 25)			2, 654, 182				
27.00	OTHER EXPENSES			0	27.00			
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00			
29.00	Net income (or loss) for the period (line 26 minus line 28)		l	2, 654, 182	29.00			