

**REPORT  
ON THE  
COST REPORT REVIEW**

**KINDRED HOSPITAL - WESTMINSTER  
WESTMINSTER, CALIFORNIA  
PROVIDER NUMBER: HSC30363H  
NATIONAL PROVIDER IDENTIFIER: 1528143179  
FISCAL PERIOD ENDED  
AUGUST 31, 2008**

**Audits Section – Santa Ana  
Financial Audits Branch  
Audits and Investigations  
Department of Health Care Services**

**Section Chief: Margaret A. Varho  
Audit Supervisor: Lan Nguyen  
Auditor: Lang Doan**



TOBY DOUGLAS  
DIRECTOR

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

Date: September 30, 2011

Stephen M. Smith  
Corporate Manager of Reimbursement  
Kindred Healthcare Inc.  
680 South Fourth Street  
Louisville, Kentucky 40202

PROVIDER: KINDRED HOSPITAL - WESTMINSTER  
PROVIDER NO. HSC30363H  
NATIONAL PROVIDER IDENTIFIER: 1528143179  
FISCAL PERIOD ENDED AUGUST 31, 2008

We have reviewed the provider's Medi-Cal Cost Report for the above-referenced fiscal period. Our review was made under the authority of Section 14170 of the Welfare and Institutions Code and was limited to a review of the cost report and accompanying financial statements.

The data presented in the Summary of Findings represents the reported Medi-Cal program costs for the above fiscal period, which were accepted as filed.

Notwithstanding this audit report, overpayments to the provider are subject to recovery pursuant to Section 51458.1, Article 6 of Division 3, Title 22, California Code of Regulations.

If you have questions regarding this report, you may call the Audits Section—Santa Ana at (714) 558-4434.

***(Original signed by Margaret Varho)***

Margaret A. Varho, Chief  
Audits Section—Santa Ana  
Financial Audits Branch

Certified

**SUMMARY OF FINDINGS**

**Provider Name:**  
**KINDRED HOSPITAL - WESTMINSTER**

**Fiscal Period Ended:**  
**AUGUST 31, 2008**

|  |                                     | SETTLEMENT | COST       |
|--|-------------------------------------|------------|------------|
| <b>1. Medi-Cal Noncontract Settlement (SCHEDULE 1)</b>                         | <b>Provider No.</b>                 |            |            |
|  | Reported                            | \$ 0       |            |
|  | Net Change                          | \$ 0       |            |
|  | Audited Amount Due Provider (State) | \$ 0       |            |
| <b>2. Subprovider I (SCHEDULE 1-1)</b>   | <b>Provider No.</b>                 |            |            |
|  | Reported                            | \$ 0       |            |
|  | Net Change                          | \$ 0       |            |
|  | Audited Amount Due Provider (State) | \$ 0       |            |
| <b>3. Subprovider II (SCHEDULE 1-2)</b>  | <b>Provider No.</b>                 |            |            |
|  | Reported                            | \$ 0       |            |
|  | Net Change                          | \$ 0       |            |
|  | Audited Amount Due Provider (State) | \$ 0       |            |
| <b>4. Medi-Cal Contract Cost (CONTRACT SCH 1)</b>                              | <b>Provider No. HSC30363H</b>       |            |            |
|  | Reported                            |            | \$ 447,728 |
|  | Net Change                          |            | \$ 0       |
|  | Audited Cost                        |            | \$ 447,728 |
|  | Audited Amount Due Provider (State) | \$ 0       |            |
| <b>5. Distinct Part Nursing Facility (DPNF SCH 1)</b>                          | <b>Provider No.</b>                 |            |            |
|  | Reported                            |            | \$ 0.00    |
|  | Net Change                          |            | \$ 0.00    |
|  | Audited Cost Per Day                |            | \$ 0.00    |
|  | Audited Amount Due Provider (State) | \$ 0       |            |
| <b>6. Distinct Part Nursing Facility (DPNF SCH 1-1)</b>                        | <b>Provider No.</b>                 |            |            |
|  | Reported                            |            | \$ 0.00    |
|  | Net Change                          |            | \$ 0.00    |
|  | Audited Cost Per Day                |            | \$ 0.00    |
|  | Audited Amount Due Provider (State) | \$ 0       |            |
| <b>7. Adult Subacute (ADULT SUBACUTE SCH 1)</b>                                | <b>Provider No.</b>                 |            |            |
|  | Reported                            |            | \$ 0.00    |
|  | Net Change                          |            | \$ 0.00    |
|  | Audited Cost Per Day                |            | \$ 0.00    |
|  | Audited Amount Due Provider (State) | \$ 0       |            |
| <b>8. Total Medi-Cal Settlement Due Provider (State) - (Lines 1 through 7)</b> |                                     | \$ 0       |            |
| <b>9. Total Medi-Cal Cost</b>  |                                     |            | \$ 447,728 |

**SUMMARY OF FINDINGS**

**Provider Name:**  
**KINDRED HOSPITAL - WESTMINSTER**

**Fiscal Period Ended:**  
**AUGUST 31, 2008**

|   |                                     | SETTLEMENT | COST    |
|---|-------------------------------------|------------|---------|
| <b>10. Subacute (SUBACUTE SCH 1-1)<br/>Provider No.</b>   | Reported                            |            | \$ 0.00 |
|   | Net Change                          |            | \$ 0.00 |
|   | Audited Cost Per Day                |            | \$ 0.00 |
|   | Audited Amount Due Provider (State) | \$ 0       |         |
|   |                                     |            |         |
| <b>11. Rural Health Clinic (RHC SCH 1)<br/>Provider No.</b>   | Reported                            | \$ 0       |         |
|   | Net Change                          | \$ 0       |         |
|   | Audited Amount Due Provider (State) | \$ 0       |         |
|   |                                     |            |         |
| <b>12. Rural Health Clinic (RHC 95-210 SCH 1)<br/>Provider No.</b>                                  | Reported                            | \$ 0       |         |
|   | Net Change                          | \$ 0       |         |
|   | Audited Amount Due Provider (State) | \$ 0       |         |
|   |                                     |            |         |
| <b>13. Rural Health Clinic (RHC 95-210 SCH 1-1)<br/>Provider No.</b>                                | Reported                            | \$ 0       |         |
|   | Net Change                          | \$ 0       |         |
|   | Audited Amount Due Provider (State) | \$ 0       |         |
|   |                                     |            |         |
| <b>14. County Medical Services Program (CMSP SCH 1)<br/>Provider No.</b>                            | Reported                            | \$ 0       |         |
|   | Net Change                          | \$ 0       |         |
|   | Audited Amount Due Provider (State) | \$ 0       |         |
|   |                                     |            |         |
| <b>15. Transitional Care (TC SCH 1)<br/>Provider No.</b>  | Reported                            |            | \$ 0.00 |
|   | Net Change                          |            | \$ 0.00 |
|   | Audited Cost Per Day                |            | \$ 0.00 |
|   | Audited Amount Due Provider (State) | \$ 0       |         |
|   |                                     |            |         |
| <b>16. Total Other Settlement<br/>Due Provider - (Lines 10 through 15)</b>                          |                                     | \$ 0       |         |
| <b>17. Total Combined Audited Settlement Due<br/>Provider (State/CMSP/RHC) - (Line 8 + Line 16)</b> |                                     | \$ 0       |         |

## COMPUTATION OF MEDI-CAL CONTRACT COST

Provider Name:  
KINDRED HOSPITAL - WESTMINSTER

Fiscal Period Ended:  
AUGUST 31, 2008

Provider No:  
HSC30363H

|   | REPORTED                 | AUDITED                  |
|---|--------------------------|--------------------------|
| 1. Net Cost of Covered Services Rendered to<br>Medi-Cal Patients (Contract Sch 3) | \$ <u>447,728</u>        | \$ <u>447,728</u>        |
| 2. Excess Reasonable Cost Over Charges (Contract Sch 2)                           | \$ <u>0</u>              | \$ <u>0</u>              |
| 3. Medi-Cal Inpatient Hospital Based Physician Services                           | \$ <u>0</u>              | \$ <u>N/A</u>            |
| 4.  | \$ <u>0</u>              | \$ <u>0</u>              |
| 5. Subtotal (Sum of Lines 1 through 4)  | \$ <u>447,728</u>        | \$ <u>447,728</u>        |
| 6.  | \$ <u>0</u>              | \$ <u>0</u>              |
| 7.  | \$ <u>0</u>              | \$ <u>0</u>              |
| 8. Total Medi-Cal Cost (Sum of Lines 5 through 7)                                 | \$ <u><u>447,728</u></u> | \$ <u><u>447,728</u></u> |
|   | (To Summary of Findings) |                          |
| 9. Medi-Cal Overpayments (Adj )   | \$ <u>0</u>              | \$ <u>0</u>              |
| 10. Medi-Cal Credit Balances (Adj )   | \$ <u>0</u>              | \$ <u>0</u>              |
| 11.   | \$ <u>0</u>              | \$ <u>0</u>              |
| 12.   | \$ <u>0</u>              | \$ <u>0</u>              |
| 13. TOTAL MEDI-CAL SETTLEMENT Due Provider (State)                                | \$ <u><u>0</u></u>       | \$ <u><u>0</u></u>       |
|   | (To Summary of Findings) |                          |