

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I & II

INTERMEDIARY [] AUDITED DATE RECEIVED _____ [] INITIAL [] RE-OPENING
USE ONLY: [] DESK REVIEWED INTERMEDIARY NO. _____ [] FINAL [] MCR CODE

PART I - CERTIFICATION

CHECK _____ ELECTRONICALLY FILED COST REPORT DATE: _____
APPLICABLE BOX _____ MANUALLY SUBMITTED COST REPORT TIME: _____

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ALEXIAN BROTHERS BEHAVIORAL HEALTH (14-4031) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2009 AND ENDING 12/31/2009, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX
		PART A	PART B	
	1	2	3	4
1	HOSPITAL			1
2	SUBPROVIDER I	287544	40244	2
3	SWING BED - SNF			3
4	SWING BED - NF			4
5	SKILLED NURSING FACILITY			5
6	NURSING FACILITY			6
7	HOME HEALTH AGENCY			7
8	OUTPATIENT REHABILITATION PROVIDER			8
9	HEALTH CLINIC			9
100	TOTAL	287544	40244	100

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 THIS INFORMATION COLLECTION IS ESTIMATED 657 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 THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1650 MOON LAKE BOULEVARD P.O.BOX: 1
 1.01 CITY: HOFFMAN ESTATES STATE: IL ZIP CODE: 60194 COUNTY: COOK 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)			
				V 4	XVIII 5	XIX 6	
2	HOSPITAL	ALEXIAN BROTHERS BEHAVIORAL HEALTH 14-4031	06/28/1990	N	P	O	2
3	SUBPROVIDER I						3
4	SWING BEDS - SNF						4
5	SWING BEDS - NF						5
6	HOSPITAL-BASED SNF						6
7	HOSPITAL-BASED NF						7
8	HOSPITAL-BASED OLTC						8
9	HOSPITAL-BASED HHA						9
11	SEPARATELY CERTIFIED ASC						11
12	HOSPITAL-BASED HOSPICE						12
14	HOSP-BASED RHC						14
15	OUTPATIENT REHABILITATION PROVID						15
16	RENAL DIALYSIS						16
17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2009	TO: 12/31/2009	1	2		17
18	TYPE OF CONTROL			1			18
TYPE OF HOSPITAL/SUBPROVIDER							
19	HOSPITAL		4				19
20	SUBPROVIDER I						20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.						21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO.			NO			21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.						21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.			1	N	Y 16974	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.			1			21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.			1			21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO.			NO			21.06
21.07	DOES THIS HOSPITAL QUALIFY AS AN SCH WITH UNDER 100 BEDS OR FEWER BEDS UNDER MIPPA 147? ENTER 'Y' FOR YES AND 'N' FOR NO (SEE INSTRUCTIONS).			NO			21.07
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO.						21.08
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?			NO			22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW			NO			23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.						23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.						24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.						24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	NO	25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	NO	25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	NO		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.			28.02
	A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)			
28.03	STAFFING	0.00	NO	28.03
28.04	RECRUITMENT	0.00	NO	28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO	28.05
28.06	TRAINING	0.00	NO	28.06
28.07	OTHER (SPECIFY)		NO	28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	NO		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.			30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?			30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)			30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.			30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO			32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO			33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO			34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES			38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO			38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO			38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO			38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO			38.04

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03.	YES	149019		40
40.01	NAME: ENTER NAME IN COLUMN 1	FI/CONTRACTOR'S NAME: WPS		FI/CONTRACTOR'S NUMBER: 52280	40.01
40.02	STREET: 3040 SALT CREEK LANE			P.O.BOX:	40.02
40.03	CITY: ARLINGTON HEIGHTS			STATE: IL ZIP CODE: 60005	40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES			41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO			43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO			44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO			45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?				45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?				45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?				45.03
46	IF YOU ARE PARTICIPATING IN THE NCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.				46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47	HOSPITAL	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N			49
50	HOME HEALTH AGENCY	N	N			50
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?					52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.					52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					53
53.01	MDH PERIOD: BEGINNING: ENDING:					53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 1109210 PAID LOSSES: 635000 AND/OR SELF INSURANCE:					54
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.					54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.					55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

		DATE	Y/N	LIMIT	Y/N	FEE\$
		0	1	2	3	4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO	56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO			57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO			58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)					58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO			59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		YES			60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)		NO	NO		60.01
MULTICAMPUS						
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.		NO			61
	COUNTY:	STATE:	ZIP CODE	CBSA	FTE/ CAMPUS	
	1	2	3	4	5	
SETTLEMENT DATA						
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		YES	05/11/2010		63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

-----DISCHARGES-----						
COMPONENT	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15		
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		1394	366	5926	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		1394	366	5926	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	WORKSHEET S-3 PART II
1	SALARIES	1	2	3	4	5	6	
1	TOTAL SALARIES	29321400			946678.00			1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A	121903			2080.00			4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES	7130330			162298.00			8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS	2865615			62498.00		HOME OFFICE WPS	11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	5492212					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	1183400					CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)						CMS 339	19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	258398			8123.00			21
22	ADMINISTRATIVE & GENERAL	5407572			172199.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	99428			2086.00			24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING	59790						26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	219128	-31593		7614.00			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA		31593		1283.00			28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	891217			27103.00			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	317121			14454.00			33
34	SOCIAL SERVICE							34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	WORKSHEET S-3 PART III
1		1	2	3	4	5	
1	NET SALARIES	29321400		29321400	946678.00	30.97	1
2	EXCLUDED AREA SALARIES	7130330		7130330	162298.00	43.93	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	22191070		22191070	784380.00	28.29	3
4	SUBTOTAL OTHER WAGES & REL COSTS	2865615		2865615	62498.00	45.85	4
5	SUBTOTAL WAGE-RELATED COSTS	5492212		5492212		24.75%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	30548897		30548897	846878.00	36.07	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	7252654		7252654	232862.00	31.15	13

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
	GENERAL SERVICE COST CENTERS								
1	0100 OLD CAP REL COSTS-BLDG & FIXT								1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT		1240425	1240425	276469	1516894	594410	2111304	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP								4
5	0500 EMPLOYEE BENEFITS	258398	4640196	4898594		4898594		4898594	5
6	0600 ADMINISTRATIVE & GENERAL	5407572	15567490	20975062	-747268	20227794	-2836337	17391457	6
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT	99428	1393382	1492810	-121550	1371260	66504	1437764	8
9	0900 LAUNDRY & LINEN SERVICE								9
10	1000 HOUSEKEEPING	59790	838862	898652		898652		898652	10
11	1100 DIETARY	219128	1431703	1650831	-238012	1412819		1412819	11
12	1200 CAFETERIA				238012	238012	-118159	119853	12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION	891217	117175	1008392		1008392		1008392	14
15	1500 CENTRAL SERVICES & SUPPLY								15
16	1600 PHARMACY								16
17	1700 MEDICAL RECORDS & LIBRARY	317121	279092	596213		596213		596213	17
18	1800 SOCIAL SERVICE								18
20	2000 NONPHYSICIAN ANESTHETISTS								20
21	2100 NURSING SCHOOL								21
22	2200 I&R SERVICES-SALARY & FRINGES A								22
23	2300 I&R SERVICES-OTHER PRGM COSTS A	194815	21214	216029	-216029				23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	2500 ADULTS & PEDIATRICS	12145929	1618569	13764498	563200	14327698		14327698	25
	ANCILLARY SERVICE COST CENTERS								
41	4100 RADIOLOGY-DIAGNOSTIC		31633	31633	-19876	11757		11757	41
44	4400 LABORATORY		768186	768186	28039	796225		796225	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
50	5000 PHYSICAL THERAPY	21339	2520	23859	1648	25507		25507	50
54	5400 ELECTROENCEPHALOGRAPHY		2920	2920	-2920				54
56	5600 DRUGS CHARGED TO PATIENTS		1660972	1660972	40851	1701823		1701823	56
59	3550 ADOLESCENT THERAPY								59
59.01	3950 ECT	316945	96096	413041	8794	421835		421835	59.01
59.02	3951 CHEMICAL DEPENDENCY								59.02
59.97	3997 CARDIAC REHABILITATION								59.97
59.98	3998 HYPERBARIC OXYGEN THERAPY								59.98
59.99	3999 LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63	4950 PARTIAL HOSPITALIZATION	2259388	214651	2474039	184800	2658839	-37954	2620885	63
63.50	6310 RHC								63.50
63.60	6320 FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTESTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	22191070	29925086	52116156	-3842	52112314	-2331536	49780778	95
	NONREIMBURSABLE COST CENTERS								
97	9700 RESEARCH	1168779	806224	1975003	3842	1978845	17097	1995942	97
98	9800 PHYSICIANS' PRIVATE OFFICES	5897317	1073521	6970838		6970838	-829142	6141696	98
99	9900 NONPAID WORKERS	64234	6043	70277		70277		70277	99
100	7950 GUEST MEALS								100
100.01	7951 ADOLESCENT SCHOOL								100.01
100.02	7952 MARKETING								100.02
100.03	7953 OTHER NONREIMBURSEABLE								100.03
101	TOTAL	29321400	31810874	61132274		61132274	-3143581	57988693	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
1	1	2	3	4	5	
1 EEG	A	ADULTS & PEDIATRICS	25			2920
2						
3 BUILDING RENT EXPENSE	B	NEW CAP REL COSTS-BLDG & FIXT	3			113263
4	B					
5						
6 RENTAL EXPENSE	C	NEW CAP REL COSTS-BLDG & FIXT	3			190105
7	C					
8	C					
9	C					
10						
11 CAFETERIA	D	CAFETERIA	12		31593	206419
12						
13 PFS	E	ADULTS & PEDIATRICS	25			384348
14	F	RADIOLOGY-DIAGNOSTIC	41			124
15	F	LABORATORY	44			28039
16	F	PHYSICAL THERAPY	50			1648
17	F	DRUGS CHARGED TO PATIENTS	56			40851
18	F	ECT	59.01			15190
19	F	PARTIAL HOSPITALIZATION	63			184800
20	F	RESEARCH	97			3842
21						
22 RADIOLOGY TO RM AND BOARD	G	ADULTS & PEDIATRICS	25			20000
23						
24 RESIDENTS TO RM AND BOARD	H	ADULTS & PEDIATRICS	25		194815	21214
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36 TOTAL RECLASSIFICATIONS					226408	1212763

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 1

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			Wkst A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 EEG	A	ELECTROENCEPHALOGRAPHY	54		2920	1
2						2
3 BUILDING RENT EXPENSE	B	NEW CAP REL COSTS-BLDG & FIXT	3		26899	9 3
4	B	ADMINISTRATIVE & GENERAL	6		86364	4
5						5
6 RENTAL EXPENSE	C	ADMINISTRATIVE & GENERAL	6		2062	9 6
7	C	OPERATION OF PLANT	8		121550	7
8	C	ADULTS & PEDIATRICS	25		60097	8
9	C	ECT	59.01		6396	9
10						10
11 CAFETERIA	D	DIETARY	11	31593	206419	11
12						12
13 PFS	E	ADMINISTRATIVE & GENERAL	6		658842	13
14	F					14
15	F					15
16	F					16
17	F					17
18	F					18
19	F					19
20	F					20
21						21
22 RADIOLOGY TO RM AND BOARD	G	RADIOLOGY-DIAGNOSTIC	41		20000	22
23						23
24 RESIDENTS TO RM AND BOARD	H	I&R SERVICES-OTHER PRGM COSTS	23	194815	21214	24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				226408	1212763	36

ANALYSIS OF CHANGES DURING COST REPORTING
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	1400000					1400000		1
2 LAND IMPROVEMENTS	624000	36000		36000		660000		2
3 BUILDINGS AND FIXTURES	25701000	293000		293000		25994000		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	877000	4000		4000		881000		5
6 MOVABLE EQUIPMENT	4767000	218000		218000	157000	4828000		6
7 SUBTOTAL	33369000	551000		551000	157000	33763000		7
8 RECONCILING ITEMS								8
9 TOTAL	33369000	551000		551000	157000	33763000		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF		OTHER CAPITAL	TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	RELATED COSTS	
	1	2	3	4	5	6	7	
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT				.000000				3
4 NEW CAP REL COSTS-MVBLE EQUIP				.000000				4
5 TOTAL				.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS		
	9	10	11	12	13	14		
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT		2111304						3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 TOTAL		2111304						5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS		
	9	10	11	12	13	14		
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT		1240425						3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 TOTAL		1240425						5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER					5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES	B	-7127	ADMINISTRATIVE & GENERAL	6	7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)					9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2				12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST				
	A-8-1	277939			14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-118159	CAFETERIA	12	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS					20
21 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		HOME HEALTH AGENCY	71	27
	A-8-3		UTILIZATION REVIEW-SNF	89	28
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			OLD CAP REL COSTS-BLDG & FIXT	1	29
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-MVBLE EQUIP	2	30
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			NEW CAP REL COSTS-BLDG & FIXT	3	31
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-MVBLE EQUIP	4	32
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NONPHYSICIAN ANESTHETISTS	20	33
33 NON-PHYSICIAN ANESTHETIST					34
34 PHYSICIANS' ASSISTANT					
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				35
	WKST A-8-4				
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	WKST A-8-4				36
37 OTHER INCOME	B	-10210	ADMINISTRATIVE & GENERAL	6	37
37.01 BAD DEBTS	A	-1543514	ADMINISTRATIVE & GENERAL	6	37.01
37.02 RESEARCH HBP	A	-150422	PHYSICIANS' PRIVATE OFFICES	98	37.02
37.03 GROUP PRACTICE HBP	A	-768110	PHYSICIANS' PRIVATE OFFICES	98	37.03
38 BUSINESS DEVELOPMENT/MARKETING	A	-270619	ADMINISTRATIVE & GENERAL	6	38
39 PHYSICIAN GUARANTEE FORGIVENESS	A	-134056	ADMINISTRATIVE & GENERAL	6	39
40					40
41 SCHOOL REIMBURSEMENT	A	-376849	ADMINISTRATIVE & GENERAL	6	41
42 PARTIAL HOSPITALIZATION	B	-37954	PARTIAL HOSPITALIZATION	63	42
43 REAL ESTATE TAXES	A	-2000	ADMINISTRATIVE & GENERAL	6	43
44 CONTRIBUTIONS	A	-2500	ADMINISTRATIVE & GENERAL	6	44
45					45
46					46
47					47
48					48
49					49
50 TOTAL		-3143581			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ- USTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1	6	ADMINISTRATIVE & GENERAL	4348205	4837667	-489462	1
2	3	NEW CAP REL COSTS-BLDG & FIXT	641954	641954	641954	9 2
3	6	ADMINISTRATIVE & GENERAL	603441	603441		3
4	3	NEW CAP REL COSTS-BLDG & FIXT	45034	86364	-41330	9 4
4.01	8	OPERATION OF PLANT	57043		57043	4.01
4.02	5	EMPLOYEE BENEFITS	115093	115093		4.02
4.03	8	OPERATION OF PLANT	9461		9461	4.03
4.04	97	RESEARCH	158759	141662	17097	4.04
4.05	98	PHYSICIANS' PRIVATE OFFICES	371012	281622	89390	4.05
4.06	3	NEW CAP REL COSTS-BLDG & FIXT	20685	26899	-6214	9 4.06
5		TOTALS	6370687	6092748	277939	5

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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 REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----						
SYMBOL	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
(1)	2	3	4	5	6	
1	B ALEXIAN BROS HEALTH	100.00				1
2						2
3						3
4						4
5						5

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE 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.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER NO. 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 01/01/2009 TO 12/31/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2010.02
 06/22/2010 15:05

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
2	6 ADMINISTRATIVE & GENERAL ADMINISTRATION	121903		121903	154100	2080	154100	7705
101	TOTAL	121903		121903		2080	154100	7705

PROVIDER NO. 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
PERIOD FROM 01/01/2009 TO 12/31/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2010.02
06/22/2010 15:05

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.		12	13	14	15	16	17	18
2	6	ADMINISTRATIVE & GENERAL ADMINISTRATION				154100		
101		TOTAL				154100		

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS- TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	2111304	2111304							3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS	4898594		4898594						5
6 ADMINISTRATIVE & GENERAL	17391457	650495	911452	18953404	18953404				6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	1437764	9904	16759	1464427	711045	2175472			8
9 LAUNDRY & LINEN SERVICE		4396		4396	2134	6592	13122		9
10 HOUSEKEEPING	898652	2472	10078	911202	442430	3706		1357338	10
11 DIETARY	1412819	27737	31609	1472165	714802	41589		26072	11
12 CAFETERIA	119853	44841	5325	170019	82552	67233		42148	12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	1008392		150216	1158608	562556				14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY									16
17 MEDICAL RECORDS & LIBRARY	596213	17684	53451	667348	324027	26515		16622	17
18 SOCIAL SERVICE									18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	14327698	990373	2080039	17398110	8447580	1484956	13122	930913	25
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC	11757			11757	5709				41
44 LABORATORY	796225			796225	386603				44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
50 PHYSICAL THERAPY	25507		3597	29104	14131				50
54 ELECTROENCEPHALOGRAPHY									54
56 DRUGS CHARGED TO PATIENTS	1701823	7548		1709371	829977	11317		7095	56
59 ADOLSCENT THERAPY									59
59.01 ECT	421835	10219	53421	485475	235720	15322		9605	59.01
59.02 CHEMICAL DEPENDENCY									59.02
59.97 CARDIAC REHABILITATION									59.97
59.98 HYPERBARIC OXYGEN THERAPY									59.98
59.99 LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS									
62 OBSERVATION BEDS (NON-DISTINCT									62
63 PARTIAL HOSPITALIZATION	2620885	92037	380822	3093744	1502152	137999		86511	63
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	49780778	1857706	3696769	48325355	14261418	1795229	13122	1118966	95
NONREIMBURSABLE COST CENTERS									
97 RESEARCH	1995942	3417	196999	2196358	1066431	5124		3212	97
98 PHYSICIANS' PRIVATE OFFICES	6141696	250181	993999	7385876	3586175	375119		235160	98
99 NONPAID WORKERS	70277		10827	81104	39380				99
100 GUEST MEALS									100
100.01ADOLESCENT SCHOOL									100.01
100.02MARKETING									100.02
100.03OTHER NONREIMBURSEABLE									100.03
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	57988693	2111304	4898594	57988693	18953404	2175472	13122	1357338	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING	MEDICAL	SUBTOTAL	I&R COST &	TOTAL
	11	12	ADMINIS- TRATION 14	RECORDS & LIBRARY 17		POST STEP- DOWN ADJS 26	
GENERAL SERVICE COST CENTERS							
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT							3
4 NEW CAP REL COSTS-MVBLE EQUIP							4
5 EMPLOYEE BENEFITS							5
6 ADMINISTRATIVE & GENERAL							6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT							8
9 LAUNDRY & LINEN SERVICE							9
10 HOUSEKEEPING							10
11 DIETARY	2254628						11
12 CAFETERIA		361952					12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION			1721164				14
15 CENTRAL SERVICES & SUPPLY							15
16 PHARMACY							16
17 MEDICAL RECORDS & LIBRARY		7322		1041834			17
18 SOCIAL SERVICE							18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES A							22
23 I&R SERVICES-OTHER PRGM COSTS A							23
24 PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS							
25 ADULTS & PEDIATRICS	2254628	221652	1428577	611357	32790895		32790895
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC				197	17663		17663
44 LABORATORY				44597	1227425		1227425
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
50 PHYSICAL THERAPY		442		2620	46297		46297
54 ELECTROENCEPHALOGRAPHY							54
56 DRUGS CHARGED TO PATIENTS				64975	2622735		2622735
59 ADOLSCENT THERAPY							59
59.01 ECT		4931		24160	775213		775213
59.02 CHEMICAL DEPENDENCY							59.02
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINCT							62
63 PARTIAL HOSPITALIZATION		45397	292587	293928	5452318		5452318
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
69.10 CMHC							69.10
69.20 OUTPATIENT PHYSICAL THERAPY							69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
95 SUBTOTALS	2254628	279744	1721164	1041834	42932546		42932546
NONREIMBURSABLE COST CENTERS							
97 RESEARCH		10620			3281745		3281745
98 PHYSICIANS' PRIVATE OFFICES		70334			11652664		11652664
99 NONPAID WORKERS		1254			121738		121738
100 GUEST MEALS							100
100.01ADOLESCENT SCHOOL							100.01
100.02MARKETING							100.02
100.03OTHER NONREIMBURSEABLE							100.03
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	2254628	361952	1721164	1041834	57988693		57988693

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	CAP REL COST TO BE ALLOC 4A	ADMINIS- TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL		650495	650495	650495				6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT		9904	9904	24403	34307			8
9 LAUNDRY & LINEN SERVICE		4396	4396	73	104	4573		9
10 HOUSEKEEPING		2472	2472	15184	58		17714	10
11 DIETARY		27737	27737	24532	656		340	53265
12 CAFETERIA		44841	44841	2833	1060		550	12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION				19307				14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY		17684	17684	11121	418		217	17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS		990373	990373	289934	23418	4573	12149	53265
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC				196				41
44 LABORATORY				13268				44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
50 PHYSICAL THERAPY				485				50
54 ELECTROENCEPHALOGRAPHY								54
56 DRUGS CHARGED TO PATIENTS		7548	7548	28485	178		93	56
59 ADOLSCENT THERAPY								59
59.01 ECT		10219	10219	8090	242		125	59.01
59.02 CHEMICAL DEPENDENCY								59.02
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINCT								62
63 PARTIAL HOSPITALIZATION		92037	92037	51554	2176		1129	63
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS		1857706	1857706	489465	28310	4573	14603	53265
NONREIMBURSABLE COST CENTERS								
97 RESEARCH		3417	3417	36600	81		42	97
98 PHYSICIANS' PRIVATE OFFICES		250181	250181	123078	5916		3069	98
99 NONPAID WORKERS				1352				99
100 GUEST MEALS								100
100.01ADOLESCENT SCHOOL								100.01
100.02MARKETING								100.02
100.03OTHER NONREIMBURSEABLE								100.03
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL		2111304	2111304	650495	34307	4573	17714	53265

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	12	14	17	25	26	27	
GENERAL SERVICE COST CENTERS							
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT							3
4 NEW CAP REL COSTS-MVBLE EQUIP							4
5 EMPLOYEE BENEFITS							5
6 ADMINISTRATIVE & GENERAL							6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT							8
9 LAUNDRY & LINEN SERVICE							9
10 HOUSEKEEPING							10
11 DIETARY							11
12 CAFETERIA	49284						12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION		19307					14
15 CENTRAL SERVICES & SUPPLY							15
16 PHARMACY							16
17 MEDICAL RECORDS & LIBRARY	997		30437				17
18 SOCIAL SERVICE							18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES A							22
23 I&R SERVICES-OTHER PRGM COSTS A							23
24 PARAMED ED PRGM-(SPECIFY)							24
25 INPATIENT ROUTINE SERV COST CENTERS							
ADULTS & PEDIATRICS	30181	16025	17873	1437791		1437791	25
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC			6	202		202	41
44 LABORATORY			1302	14570		14570	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
50 PHYSICAL THERAPY	60		76	621		621	50
54 ELECTROENCEPHALOGRAPHY							54
56 DRUGS CHARGED TO PATIENTS			1896	38200		38200	56
59 ADOLSCENT THERAPY							59
59.01 ECT	671		705	20052		20052	59.01
59.02 CHEMICAL DEPENDENCY							59.02
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINCT							62
63 PARTIAL HOSPITALIZATION	6181	3282	8579	164938		164938	63
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
69.10 CMHC							69.10
69.20 OUTPATIENT PHYSICAL THERAPY							69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
95 SUBTOTALS	38090	19307	30437	1676374		1676374	95
NONREIMBURSABLE COST CENTERS							
97 RESEARCH	1446			41586		41586	97
98 PHYSICIANS' PRIVATE OFFICES	9577			391821		391821	98
99 NONPAID WORKERS	171			1523		1523	99
100 GUEST MEALS							100
100.01ADOLESCENT SCHOOL							100.01
100.02MARKETING							100.02
100.03OTHER NONREIMBURSEABLE							100.03
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	49284	19307	30437	2111304		2111304	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	NURSING	MEDICAL	
	OF PLANT	& LINEN	KEEPING			ADMINIS-	RECORDS &	
	SQUARE	POUNDS OF	SQUARE	MEALS	FULL TIME	TRATION	LIBRARY	
	FEET	LAUNDRY	FEET	SERVED	EQUIV'S	DIRECT	GROSS	
	8	9	10	11	12	NRSING HRS	REVENUE	17
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	2175472	13122	1357338	2254628	361952	1721164	1041834	103
104 UNIT COST MULT-WS B PT I	24.873624		15.593162		10.535336		.010347	104
104 UNIT COST MULT-WS B PT I		131.220000		16.361715		67.901373		104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III	34307	4573	17714	53265	49284	19307	30437	107
108 UNIT COST MULT-WS B PT III	.392255		.203499		1.434509		.000302	108
108 UNIT COST MULT-WS B PT III		45.730000		.386541		.761677		108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 27)	LIMIT ADJUSTMENT		DISALLOWANCE		
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	32790895		32790895		32790895	25
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	17663		17663		17663	41
44 LABORATORY	1227425		1227425		1227425	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
50 PHYSICAL THERAPY	46297		46297		46297	50
54 ELECTROENCEPHALOGRAPHY						54
56 DRUGS CHARGED TO PATIENTS	2622735		2622735		2622735	56
59 ADOLSCENT THERAPY						59
59.01 ECT	775213		775213		775213	59.01
59.02 CHEMICAL DEPENDENCY						59.02
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTI						62
63 PARTIAL HOSPITALIZATION	5452318		5452318		5452318	63
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	42932546		42932546		42932546	101
102 LESS OBSERVATION BEDS						102
103 TOTAL	42932546		42932546		42932546	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25 INPATIENT ROUTINE SERV COST CENTERS						25
ADULTS & PEDIATRICS	59081318		59081318			
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	17050	2000	19050	.927192	.927192	.927192 41
44 LABORATORY	4011351	298790	4310141	.284776	.284776	.284776 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
50 PHYSICAL THERAPY	253259		253259	.182805	.182805	.182805 50
54 ELECTROENCEPHALOGRAPHY						54
56 DRUGS CHARGED TO PATIENTS	6275598	4000	6279598	.417660	.417660	.417660 56
59 ADOLSCENT THERAPY						59
59.01 ECT	1236894	1098127	2335021	.331994	.331994	.331994 59.01
59.02 CHEMICAL DEPENDENCY						59.02
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTI						62
63 PARTIAL HOSPITALIZATION		28407088	28407088	.191935	.191935	.191935 63
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	70875470	29810005	100685475			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	70875470	29810005	100685475			103

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	----- OLD CAPITAL -----			----- NEW CAPITAL -----		
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST
	1	2	3	4	5	6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				1437791		1437791
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL				1437791		1437791

COST CENTER DESCRIPTION	---- OLD CAPITAL ----			---- NEW CAPITAL ----		
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST
	7	8	9	10	11	12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	46759	18288			30.75	562356
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL	46759	18288				562356

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-4031) [] SUB III [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [] TITLE XIX [] SUB II

COST CENTER DESCRIPTION	OLD	NEW	TOTAL	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----		
	CAPITAL RELATED COST 1	CAPITAL RELATED COST 2			RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC		202	19050	10467			.010604	111	41
44 LABORATORY		14570	4310141	1578182			.003380	5334	44
46.30 BLOOD CLOTTING FACTORS ADMIN									46.30
50 PHYSICAL THERAPY		621	253259	216201			.002452	530	50
54 ELECTROENCEPHALOGRAPHY									54
56 DRUGS CHARGED TO PATIENTS		38200	6279598	3359005			.006083	20433	56
59 ADOLSCENT THERAPY									59
59.01 ECT		20052	2335021	627300			.008588	5387	59.01
59.02 CHEMICAL DEPENDENCY									59.02
59.97 CARDIAC REHABILITATION									59.97
59.98 HYPERBARIC OXYGEN THERAPY									59.98
59.99 LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS									
62 OBSERVATION BEDS (NON-DISTINC									62
63 PARTIAL HOSPITALIZATION		164938	28407088				.005806		63
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
101 TOTAL		238583	41604157	5791155				31795	101

PROVIDER NO. 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 01/01/2009 TO 12/31/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
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VERSION: 2010.02
 06/22/2010 15:05

APPORIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL COSTS	TOTAL	PER DIEM	INPATIENT	INPATIENT
	ANESTHETIST COST	EDUCATION COST	ADJUSTMENT AMOUNT		PATIENT DAYS		PROGRAM DAYS	PROGRAM PASS THRU COSTS
	1	2	3	4	5	6	7	8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					46759		18288	25
26 INTENSIVE CARE UNIT								26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					46759		18288	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-4031) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY							50
54 ELECTROENCEPHALOGRAPHY							54
56 DRUGS CHARGED TO PATIENTS							56
59 ADOLSCENT THERAPY							59
59.01 ECT							59.01
59.02 CHEMICAL DEPENDENCY							59.02
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63 PARTIAL HOSPITALIZATION							63
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-4031) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC		19050			10467		41
44 LABORATORY		4310141			1578182	1078	44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY		253259			216201		50
54 ELECTROENCEPHALOGRAPHY							54
56 DRUGS CHARGED TO PATIENTS		6279598			3359005	2222	56
59 ADOLSCENT THERAPY							59
59.01 ECT		2335021			627300	633300	59.01
59.02 CHEMICAL DEPENDENCY							59.02
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63 PARTIAL HOSPITALIZATION		28407088				1159380	63
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		41604157			5791155	1795980	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-4031) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC						41
44 LABORATORY						44
46.30 BLOOD CLOTTING FACTORS ADMIN						46.30
50 PHYSICAL THERAPY						50
54 ELECTROENCEPHALOGRAPHY						54
56 DRUGS CHARGED TO PATIENTS						56
59 ADOLSCENT THERAPY						59
59.01 ECT						59.01
59.02 CHEMICAL DEPENDENCY						59.02
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTINC						62
63 PARTIAL HOSPITALIZATION						63
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 TOTAL						101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-4031) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4
41 ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	.927192	.927192	.927192			41
44 LABORATORY	.284776	.284776	.284776			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
50 PHYSICAL THERAPY	.182805	.182805	.182805			50
54 ELECTROENCEPHALOGRAPHY						54
56 DRUGS CHARGED TO PATIENTS	.417660	.417660	.417660			56
59 ADOLSCENT THERAPY						59
59.01 ECT	.331994	.331994	.331994			59.01
59.02 CHEMICAL DEPENDENCY						59.02
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTINCT						62
63 PARTIAL HOSPITALIZATION	.191935	.191935	.191935			63
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65.01 AMBULANCE SERVICES (2ND PERIOD)						65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)						65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)						65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.417660	1
2 PROGRAM VACCINE CHARGES		2
2.01 PROGRAM VACCINE CHARGES		2.01
3 PROGRAM COSTS		3
3.01 PROGRAM COSTS		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-4031) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
	ALL OTHER (1)	PPS SER-VICES	ALL OTHER	PPS SER-VICES	PPS SER-VICES	OUTPATIENT SURGICAL CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT OTHER DIAGNOSTIC
	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	6	7	8
41 ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC		1078						41
44 LABORATORY								44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
50 PHYSICAL THERAPY								50
54 ELECTROENCEPHALOGRAPHY								54
56 DRUGS CHARGED TO PATIENTS		2222						56
59 ADOLSCENT THERAPY								59
59.01 ECT		633300						59.01
59.02 CHEMICAL DEPENDENCY								59.02
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINCT								62
63 PARTIAL HOSPITALIZATION		1159380						63
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE SERVICES (2ND PERIOD								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD								65.02
65.03 AMBULANCE SERVICES (4TH PERIOD								65.03
101 SUBTOTAL		1795980						101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES		1795980						104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-4031) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5) 9	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03)	PPS SERVICES (COLUMNS 1.01x5.04)	I/P PART B CHARGES (SEE INSTRU.) 10	I/P PART B COST (COLUMNS 1.02x10) 11
41 ANCILLARY SERVICE COST CENTERS							41
41 RADIOLOGY-DIAGNOSTIC		1000					41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
50 PHYSICAL THERAPY							50
54 ELECTROENCEPHALOGRAPHY							54
56 DRUGS CHARGED TO PATIENTS		928					56
59 ADOLSCENT THERAPY							59
59.01 ECT		210252					59.01
59.02 CHEMICAL DEPENDENCY							59.02
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINCT							62
63 PARTIAL HOSPITALIZATION		222526					63
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL		434706					101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES		434706					104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	----- OLD CAPITAL -----			----- NEW CAPITAL -----		
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST
	1	2	3	4	5	6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				1437791		1437791
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL				1437791		1437791

COST CENTER DESCRIPTION	---- OLD CAPITAL ----			---- NEW CAPITAL ----		
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST
	7	8	9	10	11	12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	46759	3753			30.75	115405
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL	46759	3753				115405

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-4031) [] SUB III [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [XX] OTHER

COST CENTER DESCRIPTION	OLD	NEW	TOTAL	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----	
	CAPITAL RELATED COST 1	CAPITAL RELATED COST 2			RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC		202	19050			.010604		41
44 LABORATORY		14570	4310141			.003380		44
46.30 BLOOD CLOTting FACTORS ADMIN								46.30
50 PHYSICAL THERAPY		621	253259			.002452		50
54 ELECTROENCEPHALOGRAPHY								54
56 DRUGS CHARGED TO PATIENTS		38200	6279598			.006083		56
59 ADOLSCENT THERAPY								59
59.01 ECT		20052	2335021			.008588		59.01
59.02 CHEMICAL DEPENDENCY								59.02
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINC								62
63 PARTIAL HOSPITALIZATION		164938	28407088			.005806		63
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
101 TOTAL		238583	41604157					101

PROVIDER NO. 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 01/01/2009 TO 12/31/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.02
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL COSTS	TOTAL	PER DIEM	INPATIENT	INPATIENT
	ANESTHETIST COST	EDUCATION COST	ADJUSTMENT AMOUNT		PATIENT DAYS		PROGRAM DAYS	PROGRAM PASS THRU COSTS
	1	2	3	4	5	6	7	8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					46759		3753	25
26 INTENSIVE CARE UNIT								26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					46759		3753	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-4031) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY							50
54 ELECTROENCEPHALOGRAPHY							54
56 DRUGS CHARGED TO PATIENTS							56
59 ADOLSCENT THERAPY							59
59.01 ECT							59.01
59.02 CHEMICAL DEPENDENCY							59.02
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63 PARTIAL HOSPITALIZATION							63
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-4031)	[]	SUB IV	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	SUB I	[]	SNF	[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	SUB II	[]	NF	[]	OTHER
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC		19050					41
44 LABORATORY		4310141					44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY		253259					50
54 ELECTROENCEPHALOGRAPHY							54
56 DRUGS CHARGED TO PATIENTS		6279598					56
59 ADOLSCENT THERAPY							59
59.01 ECT		2335021					59.01
59.02 CHEMICAL DEPENDENCY							59.02
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63 PARTIAL HOSPITALIZATION		28407088					63
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		41604157					101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-4031) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC						41
44 LABORATORY						44
46.30 BLOOD CLOTTING FACTORS ADMIN						46.30
50 PHYSICAL THERAPY						50
54 ELECTROENCEPHALOGRAPHY						54
56 DRUGS CHARGED TO PATIENTS						56
59 ADOLSCENT THERAPY						59
59.01 ECT						59.01
59.02 CHEMICAL DEPENDENCY						59.02
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTINC						62
63 PARTIAL HOSPITALIZATION						63
63.50 RHC						63.50
63.60 FOHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 TOTAL						101

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	SNF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	46759						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	46759						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	46759						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	18288						9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	32790895						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	32790895						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	17937595						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	17937595						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.828054						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	383.62						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	32790895						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	701.27					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	12824826					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	12824826					41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	2109838					48
49 TOTAL PROGRAM INPATIENT COSTS	14934664					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	562356					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	31795					51
52 TOTAL PROGRAM EXCLUDABLE COST	594151					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	14340513					53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

SNF

1

66 SNF/NF/ICF/MR ROUTINE SERVICE COST	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	67
68 PROGRAM ROUTINE SERVICE COST	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	71
72 PER DIEM CAPITAL RELATED COSTS	72
73 PROGRAM CAPITAL RELATED COSTS	73
74 INPATIENT ROUTINE SERVICE COST	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	77
78 INPATIENT ROUTINE SERVICE COST LIMITATION	78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION	81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

HOSPITAL SUB I SUB II SUB III SUB IV
 (PPS)
 (14-4031)
 1 1 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS 83
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 701.27 84
 85 OBSERVATION BED COST 85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST	HOSPITAL ROUTINE COST (FROM LINE 27)	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST (FROM LINE 85)	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		32790895			86
87 NEW CAPITAL-RELATED COST	1437791	32790895	.043847		87
88 NON PHYSICIAN ANESTHETIST		32790895			88
89 MEDICAL EDUCATION		32790895			89

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	NF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	46759						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	46759						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	46759						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3753						9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	32790895						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	32790895						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	17937595						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	17937595						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.828054						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	383.62						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	32790895						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	701.27					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2631866					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2631866					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49 TOTAL PROGRAM INPATIENT COSTS	2631866					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	115405					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST	115405					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES	366					54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

PROVIDER NO. 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
PERIOD FROM 01/01/2009 TO 12/31/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.02
06/22/2010 15:05

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT [] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY NF

	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68 PROGRAM ROUTINE SERVICE COST		68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72 PER DIEM CAPITAL RELATED COSTS		72
73 PROGRAM CAPITAL RELATED COSTS		73
74 INPATIENT ROUTINE SERVICE COST		74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80 PROGRAM INPATIENT ANCILLARY SERVICES		80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS		82

PROVIDER NO. 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
PERIOD FROM 01/01/2009 TO 12/31/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.02
06/22/2010 15:05

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS

83

84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM

701.27

84

85 OBSERVATION BED COST

85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-4031)	<input type="checkbox"/> SNF	<input checked="" type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		23297455		25
ANCILLARY SERVICE COST CENTERS				
41 RADIOLOGY-DIAGNOSTIC	.927192	10467	9705	41
44 LABORATORY	.284776	1578182	449428	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
50 PHYSICAL THERAPY	.182805	216201	39523	50
54 ELECTROENCEPHALOGRAPHY				54
56 DRUGS CHARGED TO PATIENTS	.417660	3359005	1402922	56
59 ADOLSCENT THERAPY				59
59.01 ECT	.331994	627300	208260	59.01
59.02 CHEMICAL DEPENDENCY				59.02
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)				62
63 PARTIAL HOSPITALIZATION	.191935			63
63.50 RHC				63.50
63.60 FQHC				63.60
101 TOTAL		5791155	2109838	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		5791155		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-4031)	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input checked="" type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	3
INPATIENT ROUTINE SERVICE COST CENTERS			
25 ADULTS & PEDIATRICS			25
ANCILLARY SERVICE COST CENTERS			
41 RADIOLOGY-DIAGNOSTIC	.927192		41
44 LABORATORY	.284776		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
50 PHYSICAL THERAPY	.182805		50
54 ELECTROENCEPHALOGRAPHY			54
56 DRUGS CHARGED TO PATIENTS	.417660		56
59 ADOLSCENT THERAPY			59
59.01 ECT	.331994		59.01
59.02 CHEMICAL DEPENDENCY			59.02
59.97 CARDIAC REHABILITATION			59.97
59.98 HYPERBARIC OXYGEN THERAPY			59.98
59.99 LITHOTRIPSY			59.99
OUTPATIENT SERVICE COST CENTERS			
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)			62
63 PARTIAL HOSPITALIZATION	.191935		63
63.50 RHC			63.50
63.60 FQHC			63.60
101 TOTAL			101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			102
103 NET CHARGES			103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-4031) 1	HOSPITAL (14-4031) 1.01	HOSPITAL (14-4031) 1.02	
1 MEDICAL AND OTHER SERVICES				1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000	434706			1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS	650903			1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST				5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES				10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES				17
17.01 TOTAL PPS PAYMENTS	650903			17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-4031) 1	HOSPITAL (14-4031) 1.01	HOSPITAL (14-4031) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES AND COINSURANCE			18
18.01 DEDUCTIBLES AND COINSURANCE RELATING TO LINE 17.01	133931		18.01
19 SUBTOTAL	516972		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	516972		23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL	516972		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	81066		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	56746		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	67258		27.02
28 SUBTOTAL	573718		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	573718		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	533474		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	40244		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART I

MEDICARE PART A SERVICES - TEFRA

	HOSPITAL (14-4031)	SUB I	SUB II	SUB III	SUB IV	
1						1
1.01						1.01
1.02						1.02
1.03						1.03
1.04						1.04
1.05						1.05
1.06						1.06
1.07						1.07
1.08	14382721					1.08
1.09	49061					1.09
1.10	229375					1.10
1.11						1.11
1.12						1.12
1.13						1.13
1.14						1.14
1.15						1.15
1.16	128.106849					1.16
1.17						1.17
1.18						1.18
1.19	14661157					1.19
1.20						1.20
1.21						1.21
1.22						1.22
1.23	14661157					1.23
1.35						1.35
1.36						1.36
1.37						1.37
1.38						1.38
1.39						1.39
1.40						1.40
1.41						1.41
1.42						1.42
2						2
3						3
4	14661157					4
5	81703					5
6	14579454					6
7	723180					7
8	13856274					8
9	335933					9
10	13520341					10
11	634496					11
11.01	444147					11.01
11.02	518275					11.02
12	13964488					12
13						13

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART I

MEDICARE PART A SERVICES - TEFRA

	HOSPITAL (14-4031)	SUB I	SUB II	SUB III	SUB IV	
13.01 OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)						13.01
14 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION						14
15 OTHER ADJUSTMENTS						15
16 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS						16
17 TOTAL AMOUNT PAYABLE TO THE PROVIDER	13964488					17
18 SEQUESTRATION ADJUSTMENT						18
19 INTERIM PAYMENTS	13676944					19
19.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)						19.01
20 BALANCE DUE PROVIDER/PROGRAM	287544					20
21 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						21
50 TO BE COMPLETED BY INTERMEDIARY ORIGINAL OUTLIER AMOUNT						50
51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)						51
52 THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY						52
53 OPERATING TIME VALUE OF MONEY (SEE INSTRUCTIONS)						53

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (14-4031) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES	2631866					1
2	MEDICAL AND OTHER SERVICES						2
3	INTERNS AND RESIDENTS						3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O						4
5	COST OF TEACHING PHYSICIANS						5
6	SUBTOTAL	2631866					6
7	INPATIENT PRIMARY PAYER PAYMENTS						7
8	OUTPATIENT PRIMARY PAYER PAYMENTS						8
9	SUBTOTAL	2631866					9
	COMPUTATION OF LESSER OF COST OR CHARGES						
10	ROUTINE SERVICE CHARGES						10
11	ANCILLARY SERVICE CHARGES						11
12	INTERNS AND RESIDENTS SERVICE CHARGES						12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE						13
14	TEACHING PHYSICIANS						14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION						15
16	TOTAL REASONABLE CHARGES						16
	CUSTOMARY CHARGES						
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						18
19	RATIO OF LINE 17 TO LINE 18						19
20	TOTAL CUSTOMARY CHARGES						20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	2631866					22
23	COST OF COVERED SERVICES	2631866					23
	PROSPECTIVE PAYMENT AMOUNT						
24	OTHER THAN OUTLIER PAYMENTS						24
25	OUTLIER PAYMENTS						25
26	PROGRAM CAPITAL PAYMENTS						26
27	CAPITAL EXCEPTION PAYMENTS						27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS						28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						29
30	SUBTOTAL	2631866					30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED)						31
32	LESSER OF LINES 30 OR 31	2631866					32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						33

CALCULATION OF REIMBURSEMENT SETTLEMENT
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (14-4031) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
		1	1	1	1	1	1
34	COMPUTATION OF REIMBURSEMENT SETTLEMENT						
35	EXCESS OF REASONABLE COST	2631866					34
36	SUBTOTAL						35
37	COINSURANCE						36
38	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,						37
38	REIMBURSABLE BAD DEBTS						38
38.01	REDUCED REIMBURSABLE BAD DEBTS						38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE						38.02
	BENEFICIARIES (SEE INSTRUCTIONS)						
39	UTILIZATION REVIEW						39
40	SUBTOTAL						40
41	INPATIENT ROUTINE SERVICE COST						41
42	MEDICARE INPATIENT ROUTINE CHARGES						42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM						44
	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN						
	ACCORDANCE WITH 42 CFR 413.13(E)						
45	RATIO OF LINE 43 TO LINE 44						45
46	TOTAL CUSTOMARY CHARGES						46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM						49
	UTILIZATION						
50	OTHER ADJUSTMENTS						50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING						51
	DEPRECIABLE ASSETS						
52	SUBTOTAL						52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT						53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER						55
56	SEQUESTRATION ADJUSTMENT						56
57	INTERIM PAYMENTS						57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						57.01
58	BALANCE DUE PROVIDER/PROGRAM						58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT						59
	SECTION 115.2						

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	213000			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	7218000			4
5	OTHER RECEIVABLES	100000			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	143000			7
8	PREPAID EXPENSES	158000			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	7832000			11
FIXED ASSETS					
12	LAND	1400000			12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	660000			13
13.01	ACCUMULATED DEPRECIATION	-368000			13.01
14	BUILDINGS	25992000			14
14.01	ACCUMULATED DEPRECIATION	-4249000			14.01
15	LEASEHOLD IMPROVEMENTS	187000			15
15.01	ACCUMULATED AMORTIZATION	-129000			15.01
16	FIXED EQUIPMENT	881000			16
16.01	ACCUMULATED DEPRECIATION	-564000			16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	4831000			18
18.01	ACCUMULATED DEPRECIATION	-3611000			18.01
19	MINOR EQUIPMENT DEPRECIABLE	54000			19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	25084000			21
OTHER ASSETS					
22	INVESTMENTS	5000000			22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	31000			25
26	TOTAL OTHER ASSETS	5031000			26
27	TOTAL ASSETS	37947000			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	738000			28
29	SALARIES, WAGES & FEES PAYABLE				29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)				31
32	DEFERRED INCOME	1195000			32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES	4260000			35
36	TOTAL CURRENT LIABILITIES	6193000			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE				37
38	NOTES PAYABLE				38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES	2837000			41
42	TOTAL LONG TERM LIABILITIES	2837000			42
43	TOTAL LIABILITIES	9030000			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	28917000			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	28917000			51
52	TOTAL LIABILITIES AND FUND BALANCES	37947000			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	33420000			1
2 NET INCOME (LOSS)	-4503000			2
3 TOTAL	28917000			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	28917000			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	28917000			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	59672000		59672000	2
4 SUBPROVIDER I				4
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES	59672000		59672000	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	59672000		59672000	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	11800000		41690000	18
18.50 ANCILLARY SERVICES		29890000		18.50
18.60 OUTPATIENT SERVICES				18.60
19 RHC				19
20 FQHC				20
21 HOME HEALTH AGENCY				21
22 AMBULANCE				22
23 CORF				23
24 ASC				24
25 HOSPICE				25
26 GROUP PRACTICE		10248000	10248000	26
27 TOTAL PATIENT REVENUES	71472000	40138000	111610000	27

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		61132274	26
27 ADD (SPECIFY)			27
28 INTEREST EXPENSE	1330000		28
29 IMMATERIAL VARIANCE			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		1330000	33
34 DEDUCT (SPECIFY)			34
35 IMMATERIAL VARIANCE	-274		35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS	-274		39
40 TOTAL OPERATING EXPENSES		62462000	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	111610000	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	57521000	2
3	NET PATIENT REVENUES	54089000	3
4	LESS - TOTAL OPERATING EXPENSES	62462000	4
5	NET INCOME FROM SERVICE TO PATIENTS	-8373000	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	46000	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	118000	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	7000	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	CAPITATION REVENUE	791000	24
24.01	RESEARCH REVENUE	1971000	24.01
24.02	SCHOOL REVENUE	437000	24.02
24.03	ACCESS INTERCO REVENUE	333000	24.03
24.04	ECT PUBLIC AID	57000	24.04
24.05	RESTRICTED FUNDS	12000	24.05
24.06	AFTERCARE	34000	24.06
24.07	OTHER INCOME	64000	24.07
25	TOTAL OTHER INCOME	3870000	25
26	TOTAL	-4503000	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-4503000	31

***** REPORT 97 ***** UTILIZATION STATISTICS *****

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	39.11		8.03				47.14 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
41 RADIOLOGY-DIAGNOSTIC	54.94	5.66					60.60 41
44 LABORATORY	36.62						36.62 44
50 PHYSICAL THERAPY	85.37						85.37 50
56 DRUGS CHARGED TO PATIENTS	53.49	0.04					53.53 56
59.01 ECT	26.86	27.12					53.98 59.01
63 PARTIAL HOSPITALIZATION		4.08					4.08 63
101 TOTAL CHARGES	5.75	1.78					7.53 101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
69.30 OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
NONREIMBURSABLE COST CENTERS							
97 RESEARCH	1995942	3.44	1285803	4.30	3281745	5.66	97
98 PHYSICIANS' PRIVATE OFFICES	6141696	10.59	5510968	18.45	11652664	20.09	98
99 NONPAID WORKERS	70277	.12	51461	.17	121738	.21	99
100 GUEST MEALS							100
100.01 ADOLESCENT SCHOOL							100.01
100.02 MARKETING							100.02
100.03 OTHER NONREIMBURSEABLE							100.03
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	57988693	100.00	0	.00	57988693	100.00	103

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	202	19050	.010604	10467	111	41
44 LABORATORY	14570	4310141	.003380	1578182	5334	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
50 PHYSICAL THERAPY	621	253259	.002452	216201	530	50
54 ELECTROENCEPHALOGRAPHY						54
56 DRUGS CHARGED TO PATIENTS	38200	6279598	.006083	3359005	20433	56
59 ADOLSCENT THERAPY						59
59.01 ECT	20052	2335021	.008588	627300	5387	59.01
59.02 CHEMICAL DEPENDENCY						59.02
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS						62
63 PARTIAL HOSPITALIZATION	164938	28407088	.005806			63
63.50 RHC						63.50
63.60 FQHC						63.60
101 TOTAL	238583	41604157		5791155	31795	101

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	TOTAL COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
INPATIENT ROUTINE SERVICE COST CENTERS								
25	ADULTS & PEDIATRICS	1437791		1437791	46759	30.75	18288	562356 25
101	TOTAL	1437791		1437791			18288	562356 101
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS							562356	
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS							31795	
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS							594151	
MEDICARE DISCHARGES (WORKSHEET S-3, LINE 12, COLUMN 13)							1394	
MEDICARE PATIENT DAYS (WORKSHEET S-3, LINE 12, COLUMN 4)							18288	
PER DISCHARGE CAPITAL COSTS							426.22	
PER DIEM CAPITAL COSTS							32.49	

I. COST TO CHARGE RATIO FOR FREESTANDING IPF

1. TOTAL MEDICARE COSTS	14934664
(WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 8 LINES 25-30 + WKST D PART IV COL 7 LINE 101))	
2. TOTAL MEDICARE CHARGES	29088610
(WKST D-4 COLUMN 2 LINES 25-30 + LINE 103)	
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.513

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS	594151
(WKST D PART I LINES 25-30, COLS 10 & 12 + WKST D PART II, LINE 101, COLS 6 & 8)	
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	.020

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS.	434706
(WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS.	1795980
(WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.242