

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 [ XX ] MCR CODE 1

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 LINDEN OAKS HOSPITAL (14-4035) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2009 AND ENDING 06/30/2010, 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
1	HOSPITAL		
2	SUBPROVIDER I	60824	
3	SWING BED - SNF		
4	SWING BED - NF		
5	SKILLED NURSING FACILITY		
6	NURSING FACILITY		
7	HOME HEALTH AGENCY		
8	OUTPATIENT REHABILITATION PROVIDER		
9	HEALTH CLINIC		
100	TOTAL	60824	

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: 852 WEST STREET P.O.BOX: 1  
 1.01 CITY: NAPERVILLE STATE: IL ZIP CODE: 60540 COUNTY: DUPAGE 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	LINDEN OAKS HOSPITAL	14-4035	06/01/1992	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: 07/01/2009 TO: 06/30/2010 17  
 18 TYPE OF CONTROL 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 N N 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 100 OR FEWER BEDS UNDER MIPPA 147? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). IS THIS AN SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? NO 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 (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35

		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			40
40.01	NAME: EDWARD HEALTH SERVICES CORP FI/CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICEFI/CONTRACTOR'S NUMBER: 00131				40.01
40.02	STREET: 801 SOUTH WASHINGTON STREET P.O.BOX:				40.02
40.03	CITY: NAPERVILLE, ILLINOIS 60540 STATE: ZIP CODE:				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 NHCMQ 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	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: PAID LOSSES: 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.					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			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)		NO			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		489	251	3920	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		489	251	3920	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	2	3	4	5	6	
1	SALARIES							1
	TOTAL SALARIES	14393751						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							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							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							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)						CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS						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)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS							21
22	ADMINISTRATIVE & GENERAL	3252332						22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT							24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING							26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY							27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	689270						30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY	618						32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR							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	2	3	4	5	
1	NET SALARIES	14393751		14393751			1
2	EXCLUDED AREA SALARIES						2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	14393751		14393751			3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS						5
6	TOTAL (SUM OF LINES 3 THRU 5)	14393751		14393751			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	3942220		3942220			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				825310	825310		825310	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				142263	142263		142263	4
5	0500 EMPLOYEE BENEFITS		2290697	2290697	1096773	3387470		3387470	5
6	0600 ADMINISTRATIVE & GENERAL	3252332	7771493	11023825	-1192292	9831533	484342	10315875	6
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT		522596	522596	-22426	500170		500170	8
9	0900 LAUNDRY & LINEN SERVICE						15720	15720	9
10	1000 HOUSEKEEPING						481757	481757	10
11	1100 DIETARY		856168	856168				832743	11
12	1200 CAFETERIA				-207	855961	-23218		12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION	689270	69417	758687	-55081	703606	-78346	625260	14
15	1500 CENTRAL SERVICES & SUPPLY								15
16	1600 PHARMACY	618	877372	877990	-31	877959		877959	16
17	1700 MEDICAL RECORDS & LIBRARY						397607	397607	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								23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	2500 ADULTS & PEDIATRICS	8116338	1213374	9329712	-1314682	8015030	-1752	8013278	25
	ANCILLARY SERVICE COST CENTERS								
41	4100 RADIOLOGY-DIAGNOSTIC	5025	297804	302829	-375	302454		302454	41
44	4400 LABORATORY		179152	179152		179152		179152	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
50	5000 PHYSICAL THERAPY	188316	38092	226408	-13931	212477		212477	50
53	5300 ELECTROCARDIOLOGY		34160	34160		34160		34160	53
54	5400 ELECTROENCEPHALOGRAPHY		5684	5684		5684		5684	54
55.30	5530 IMPL. DEV. CHARGED TO PATIENT								55.30
56	5600 DRUGS CHARGED TO PATIENTS								56
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								
60.01	6001 PARTIAL HOSPITALIZATION	2141852	758145	2899997	534679	3434676	-116542	3318134	60.01
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
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 OPT								69.20
69.30	6930 CMHC								69.30
69.40	6940 OPT								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	14393751	14914154	29307905		29307905	1159568	30467473	95
	NONREIMBURSABLE COST CENTERS								
100	7950 EDWARD ACADEMY								100
101	TOTAL	14393751	14914154	29307905		29307905	1159568	30467473	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 RENT & LEASE EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		54745	1
2	A					2
3	A					3
4	A					4
5	A					5
6	A					6
7	A					7
8	A					8
9						9
10 PROPERTY INSURANCE	B	NEW CAP REL COSTS-BLDG & FIXT	3		15681	10
11						11
12 BENEFIT AND FICA RECLASS	C	EMPLOYEE BENEFITS	5		1096773	12
13	C					13
14	C					14
15	C					15
16	C					16
17	C					17
18	C					18
19	C					19
20						20
21 DEPRECIATION EXPENSE	D	NEW CAP REL COSTS-BLDG & FIXT	3		749688	21
22	D	NEW CAP REL COSTS-MVBLE EQUIP	4		142263	22
23						23
24 REAL ESTATE TAXES	E	NEW CAP REL COSTS-BLDG & FIXT	3		5196	24
25						25
26 PARTIAL HOSPITALIZATION	F	PARTIAL HOSPITALIZATION	60.01	564889	141032	26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				564889	2205378	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 RENT & LEASE EXPENSE	A					9 1
2	A	ADMINISTRATIVE & GENERAL	6		10835	2
3	A	OPERATION OF PLANT	8		22426	3
4	A	DIETARY	11		207	4
5	A	NURSING ADMINISTRATION	14		5511	5
6	A	ADULTS & PEDIATRICS	25		9729	6
7	A	PHYSICAL THERAPY	50		45	7
8	A	PARTIAL HOSPITALIZATION	60.01		5991	8
9						9
10 PROPERTY INSURANCE	B	ADMINISTRATIVE & GENERAL	6		15681	9 10
11						11
12 BENEFIT AND FICA RECLASS	C					12
13	C	ADMINISTRATIVE & GENERAL	6		268630	13
14	C	NURSING ADMINISTRATION	14		49570	14
15	C	PHARMACY	16		31	15
16	C	ADULTS & PEDIATRICS	25		599032	16
17	C	RADIOLOGY-DIAGNOSTIC	41		375	17
18	C	PHYSICAL THERAPY	50		13886	18
19	C	PARTIAL HOSPITALIZATION	60.01		165251	19
20						20
21 DEPRECIATION EXPENSE	D	ADMINISTRATIVE & GENERAL	6		891950	9 21
22	D					9 22
23						23
24 REAL ESTATE TAXES	E	ADMINISTRATIVE & GENERAL	6		5196	9 24
25						25
26 PARTIAL HOSPITALIZATION	F	ADULTS & PEDIATRICS	25	564889	141032	26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				564889	2205378	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								1
2 LAND IMPROVEMENTS	474681					474681		2
3 BUILDINGS AND FIXTURES	8621395					8621395		3
4 BUILDING IMPROVEMENTS	3773091					3773091		4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	1734292					1734292		6
7 SUBTOTAL	14603459					14603459		7
8 RECONCILING ITEMS								8
9 TOTAL	14603459					14603459		9



ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
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					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	-166420			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST				
	A-8-1	2187146			14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS					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
28 UTIL REVIEW-PHYSICIANS' COMPENSATION	A-8-3		UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	WKST A-8-4				35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	WKST A-8-4				36
37 ADDICTION SRVCS	B	-9255	PARTIAL HOSPITALIZATION	60.01	37
38 MED STAFF FEES	B	-6850	ADMINISTRATIVE & GENERAL	6	38
39 DISCOUNT REVENUE	B	-164	ADMINISTRATIVE & GENERAL	6	39
40 RENT REVENUE	B	-14684	PARTIAL HOSPITALIZATION	60.01	40
41 RENT REVENUE	B	-400	ADMINISTRATIVE & GENERAL	6	41
42 OTHER SEMINARS	B	2950	ADMINISTRATIVE & GENERAL	6	42
43 COMMUNITY EDUC SEMINAR REV	B	-78346	NURSING ADMINISTRATION	14	43
43.02 OTHER A&G	B	-126052	ADMINISTRATIVE & GENERAL	6	43.02
43.04 RESOURCE / REFERRAL REVENUE	B	-327240	ADMINISTRATIVE & GENERAL	6	43.04
44 PHP MEALS EXPENSE	A	-23218	DIETARY	11	44
45 GOODWILL AMORTIZATION CREDIT	A	-21987	ADMINISTRATIVE & GENERAL	6	45
46 CONTRIBUTIONS EXPENSE	A	-55469	ADMINISTRATIVE & GENERAL	6	46
47 MARKETING	A	-200443	ADMINISTRATIVE & GENERAL	6	47
48					48
49					49
50 TOTAL		1159568			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	HOME OFFICE COSTS	2692967	1868447	824520	1
2							2
3	6	ADMINISTRATIVE & GENERAL	BILLING	421277		421277	3
4	6	ADMINISTRATIVE & GENERAL	MEDICAL STAFF	36228		36228	4
4.01	9	LAUNDRY & LINEN SERVICE	LAUNDRY	15720		15720	4.01
4.02	10	HOUSEKEEPING	HOUSEKEEPING	481757		481757	4.02
4.03	17	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	397607		397607	4.03
4.04	25	ADULTS & PEDIATRICS	EMT TRAINING	10037		10037	4.04
5		TOTALS		4055593	1868447	2187146	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 (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
1	B EDWARD HEALTH SERVIC				MANAGEMENT	1
2	B EDWARD HOSPITAL				HEALTHCARE	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. 14-4035 LINDEN OAKS HOSPITAL  
 PERIOD FROM 07/01/2009 TO 06/30/2010

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

VERSION: 2010.09  
 11/20/2010 14:53

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
LINE NO.	1	2	3	4	5	6	7	8	9
1	6	ADMINISTRATIVE & GENERAL	216128		216128	154100	2080	154100	7705
2	25	ADULTS & PEDIATRICS	160529	11789	148740	154100	2080	154100	7705
3	60.01	PARTIAL HOSPITALIZATION	92603	92603					
101		TOTAL	469260	104392	364868		4160	308200	15410

PROVIDER NO. 14-4035 LINDEN OAKS HOSPITAL  
 PERIOD FROM 07/01/2009 TO 06/30/2010

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

VERSION: 2010.09  
 11/20/2010 14:53

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
10	11							
1	6 ADMINISTRATIVE & GENERAL	ADMIN AND GENERAL				154100	62028	62028
2	25 ADULTS & PEDIATRICS	PSYCHIATRIC				154100		11789
3	60.01 PARTIAL HOSPITALIZATION	PSYCHIATRIC						92603
101	TOTAL					308200	62028	166420

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION	NEW CAP BLDGS & FIXTURES	NEW CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	0	3	4	5	5A	6	8	9	
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	825310	825310							3
4 NEW CAP REL COSTS-MVBLE EQUIP	142263		142263						4
5 EMPLOYEE BENEFITS	3387470			3387470					5
6 ADMINISTRATIVE & GENERAL	10315875	227812	39269	765414	11348370	11348370			6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	500170	183286	31594		715050	424427	1139477		8
9 LAUNDRY & LINEN SERVICE	15720				15720	9331		25051	9
10 HOUSEKEEPING	481757				481757	285953		3268	10
11 DIETARY	832743	41401	7136		881280	523094	113892	4792	11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	625260			162215	787475	467415			14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY	877959	3554	613	145	882271	523683	9776		16
17 MEDICAL RECORDS & LIBRARY	397607				397607	236004			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	8013278	283533	48874	1777181	10122866	6008545	779987	16991	25
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC	302454			1183	303637	180227			41
44 LABORATORY	179152	2569	443		182164	108126	7067		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
50 PHYSICAL THERAPY	212477			44319	256796	152424			50
53 ELECTROCARDIOLOGY	34160				34160	20276			53
54 ELECTROENCEPHALOGRAPHY	5684				5684	3374			54
55.30 IMPL. DEV. CHARGED TO PATIENT									55.30
56 DRUGS CHARGED TO PATIENTS									56
59.97 CARDIAC REHABILITATION									59.97
59.98 HYPERBARIC OXYGEN THERAPY									59.98
59.99 LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS									
60.01 PARTIAL HOSPITALIZATION	3318134	83155	14334	637013	4052636	2405491	228755		60.01
62 OBSERVATION BEDS (NON-DISTINCT)									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OPT									69.20
69.30 CMHC									69.30
69.40 OPT									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	30467473	825310	142263	3387470	30467473	11348370	1139477	25051	95
NONREIMBURSABLE COST CENTERS									
100 EDWARD ACADEMY									100
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	30467473	825310	142263	3387470	30467473	11348370	1139477	25051	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	10	11	14	16	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	770978							10
11 DIETARY	77060	1600118						11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION			1254890					14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY	6614			1422344				16
17 MEDICAL RECORDS & LIBRARY					633611			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	527746	1600118	1076302		316805	20449360		20449360 25
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC						483864		483864 41
44 LABORATORY	4781					302138		302138 44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
50 PHYSICAL THERAPY						409220		409220 50
53 ELECTROCARDIOLOGY						54436		54436 53
54 ELECTROENCEPHALOGRAPHY						9058		9058 54
55.30 IMPL. DEV. CHARGED TO PATIENT								55.30
56 DRUGS CHARGED TO PATIENTS				1422344		1422344		1422344 56
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
60.01 PARTIAL HOSPITALIZATION	154777		178588		316806	7337053		7337053 60.01
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OPT								69.20
69.30 CMHC								69.30
69.40 OPT								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	770978	1600118	1254890	1422344	633611	30467473		30467473 95
NONREIMBURSABLE COST CENTERS								
100 EDWARD ACADEMY								100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	770978	1600118	1254890	1422344	633611	30467473		30467473 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	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									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6 ADMINISTRATIVE & GENERAL		227812	39269	267081	267081				6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT		183286	31594	214880	9989	224869			8
9 LAUNDRY & LINEN SERVICE					220		220		9
10 HOUSEKEEPING					6730		29	6759	10
11 DIETARY	41401		7136	48537	12311	22476	42	676	11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION					11000				14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY		3554	613	4167	12324	1929		58	16
17 MEDICAL RECORDS & LIBRARY					5554				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		283533	48874	332407	141412	153926	149	4626	25
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC					4242				41
44 LABORATORY		2569	443	3012	2545	1395		42	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
50 PHYSICAL THERAPY					3587				50
53 ELECTROCARDIOLOGY					477				53
54 ELECTROENCEPHALOGRAPHY					79				54
55.30 IMPL. DEV. CHARGED TO PATIENT									55.30
56 DRUGS CHARGED TO PATIENTS									56
59.97 CARDIAC REHABILITATION									59.97
59.98 HYPERBARIC OXYGEN THERAPY									59.98
59.99 LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS									
60.01 PARTIAL HOSPITALIZATION		83155	14334	97489	56611	45143		1357	60.01
62 OBSERVATION BEDS (NON-DISTINCT)									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OPT									69.20
69.30 CMHC									69.30
69.40 OPT									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		825310	142263	967573	267081	224869	220	6759	95
NONREIMBURSABLE COST CENTERS									
100 EDWARD ACADEMY									100
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL		825310	142263	967573	267081	224869	220	6759	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIETARY 11	NURSING ADMINIS- TRATION 14	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 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	84042							11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION		11000						14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY			18478					16
17 MEDICAL RECORDS & LIBRARY				5554				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	84042	9435		2777	728774		728774	25
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC					4242		4242	41
44 LABORATORY					6994		6994	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
50 PHYSICAL THERAPY					3587		3587	50
53 ELECTROCARDIOLOGY					477		477	53
54 ELECTROENCEPHALOGRAPHY					79		79	54
55.30 IMPL. DEV. CHARGED TO PATIENT								55.30
56 DRUGS CHARGED TO PATIENTS			18478		18478		18478	56
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
60.01 PARTIAL HOSPITALIZATION		1565		2777	204942		204942	60.01
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OPT								69.20
69.30 CMHC								69.30
69.40 OPT								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	84042	11000	18478	5554	967573		967573	95
NONREIMBURSABLE COST CENTERS								
100 EDWARD ACADEMY								100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	84042	11000	18478	5554	967573		967573	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP	NEW CAP	EMPLOYEE	RECON-	ADMINIS-	OPERATION	LAUNDRY
	BLDGS & FIXTURES	MOVABLE EQUIPMENT	BENEFITS		TRATIVE & GENERAL	OF PLANT	& LINEN SERVICE
	SQUARE FEET	SQUARE FEET	GROSS SALARIES	CILIATION	ACCUM COST	SQUARE FEET	POUNDS OF LAUNDRY
	3	4	5	6A	6	8	9
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	77107						3
4 NEW CAP REL COSTS-MVBLE EQUIP		77107					4
5 EMPLOYEE BENEFITS			14393751				5
6 ADMINISTRATIVE & GENERAL	21284	21284	3252332	-11348370	19119103		6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	17124	17124			715050	38699	8
9 LAUNDRY & LINEN SERVICE					15720		575 9
10 HOUSEKEEPING					481757		75 10
11 DIETARY	3868	3868			881280	3868	110 11
12 CAFETERIA							12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION			689270		787475		14
15 CENTRAL SERVICES & SUPPLY							15
16 PHARMACY	332	332	618		882271	332	16
17 MEDICAL RECORDS & LIBRARY					397607		17
18 SOCIAL SERVICE							18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES							22
23 I&R SERVICES-OTHER PRGM COSTS							23
24 PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS							
25 ADULTS & PEDIATRICS	26490	26490	7551449		10122866	26490	390 25
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC			5025		303637		41
44 LABORATORY	240	240			182164	240	44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY			188316		256796		50
53 ELECTROCARDIOLOGY					34160		53
54 ELECTROENCEPHALOGRAPHY					5684		54
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS							56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60.01 PARTIAL HOSPITALIZATION	7769	7769	2706741		4052636	7769	60.01
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
69.10 CMHC							69.10
69.20 OPT							69.20
69.30 CMHC							69.30
69.40 OPT							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	77107	77107	14393751	-11348370	19119103	38699	575 95
NONREIMBURSABLE COST CENTERS							
100 EDWARD ACADEMY							100
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 COST TO BE ALLOC PER B PT I	825310	142263	3387470		11348370	1139477	25051 103
104 UNIT COST MULT-WS B PT I		1.845008				29.444611	104
104 UNIT COST MULT-WS B PT I	10.703438		.235343		.593562		43.566957 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					267081	224869	220 107
108 UNIT COST MULT-WS B PT III						5.810719	108
108 UNIT COST MULT-WS B PT III					.013969		.382609 108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	SQUARE FEET	PATIENT DAYS	FTE'S	DIRECT NRSING HRS	COSTED REQUIS.	TIME SPENT	TIME SPENT	
	10	11	12	14	16	17	18	
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	38699							10
11 DIETARY	3868	26412						11
12 CAFETERIA			1964					12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION				92	343073			14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY	332					100		16
17 MEDICAL RECORDS & LIBRARY							100	17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS							75	20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES								22
23 I&R SERVICES-OTHER PRGM COSTS								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	26490	26412	1431	294249		50	50	25
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC			1					41
44 LABORATORY	240							44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
50 PHYSICAL THERAPY			39					50
53 ELECTROCARDIOLOGY								53
54 ELECTROENCEPHALOGRAPHY								54
55.30 IMPL. DEV. CHARGED TO PATIENT								55.30
56 DRUGS CHARGED TO PATIENTS					100			56
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
60.01 PARTIAL HOSPITALIZATION	7769		401	48824		50	25	60.01
62 OBSERVATION BEDS (NON-DISTINC								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OPT								69.20
69.30 CMHC								69.30
69.40 OPT								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	38699	26412	1964	343073	100	100	75	95
NONREIMBURSABLE COST CENTERS								
100 EDWARD ACADEMY								100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	770978	1600118		1254890	1422344	633611		103
104 UNIT COST MULT-WS B PT I	19.922427				14223.440000			104
104 UNIT COST MULT-WS B PT I		60.582993		3.657793		6336.110000		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	6759	84042		11000	18478	5554		107
108 UNIT COST MULT-WS B PT III	.174656				184.780000			108
108 UNIT COST MULT-WS B PT III		3.181963		.032063		55.540000		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	
25 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	20449360		20449360		20449360	25
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	483864		483864		483864	41
44 LABORATORY	302138		302138		302138	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
50 PHYSICAL THERAPY	409220		409220		409220	50
53 ELECTROCARDIOLOGY	54436		54436		54436	53
54 ELECTROENCEPHALOGRAPHY	9058		9058		9058	54
55.30 IMPL. DEV. CHARGED TO PATIE						55.30
56 DRUGS CHARGED TO PATIENTS	1422344		1422344		1422344	56
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
60.01 PARTIAL HOSPITALIZATION	7337053		7337053		7337053	60.01
62 OBSERVATION BEDS (NON-DISTI						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	30467473		30467473		30467473	101
102 LESS OBSERVATION BEDS						102
103 TOTAL	30467473		30467473		30467473	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						
ADULTS & PEDIATRICS	35400795		35400795			25
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	659563		659563	.733613	.733613	.733613 41
44 LABORATORY	3872585	2685	3875270	.077966	.077966	.077966 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
50 PHYSICAL THERAPY	725943		725943	.563708	.563708	.563708 50
53 ELECTROCARDIOLOGY	319453	454	319907	.170162	.170162	.170162 53
54 ELECTROENCEPHALOGRAPHY	10504		10504	.862338	.862338	.862338 54
55.30 IMPL. DEV. CHARGED TO PATIE						55.30
56 DRUGS CHARGED TO PATIENTS	3898434	86	3898520	.364842	.364842	.364842 56
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
60.01 PARTIAL HOSPITALIZATION	4458289	24443916	28902205	.253858	.253858	.253858 60.01
62 OBSERVATION BEDS (NON-DISTI						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	49345566	24447141	73792707			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	49345566	24447141	73792707			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 1	SWING-BED ADJUSTMENT 2	REDUCED CAPITAL RELATED COST 3	CAPITAL RELATED COST 4	SWING-BED ADJUSTMENT 5	REDUCED CAPITAL RELATED COST 6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				728774		728774
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				728774		728774

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	PER DIEM 9	INPATIENT PROGRAM CAPITAL COST 10	PER DIEM 11	INPATIENT PROGRAM CAPITAL COST 12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	26148	5140			27.87	143252
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	26148	5140				143252

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-4035) [ ] 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		4242	659563	226787			.006432	1459	41
44 LABORATORY		6994	3875270	599318			.001805	1082	44
46.30 BLOOD CLOTTING FACTORS ADMIN									46.30
50 PHYSICAL THERAPY		3587	725943	2229			.004941	11	50
53 ELECTROCARDIOLOGY		477	319907	59648			.001491	89	53
54 ELECTROENCEPHALOGRAPHY		79	10504	6560			.007521	49	54
55.30 IMPL. DEV. CHARGED TO PATIENT									55.30
56 DRUGS CHARGED TO PATIENTS		18478	3898520	1254920			.004740	5948	56
59.97 CARDIAC REHABILITATION									59.97
59.98 HYPERBARIC OXYGEN THERAPY									59.98
59.99 LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS									
60.01 PARTIAL HOSPITALIZATION		204942	28902205	78096			.007091	554	60.01
62 OBSERVATION BEDS (NON-DISTINC									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
101 TOTAL		238799	38391912	2227558				9192	101

PROVIDER NO. 14-4035 LINDEN OAKS HOSPITAL  
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VERSION: 2010.09  
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APPORTIONMENT 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 ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					26148		5140	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					26148		5140	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-4035) [ ] 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	NONPHYSICIAN ANESTHETIST	MEDICAL EDUCATION				
	COST 1	COST 1.01	COST 2				
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC				2.01	2.02	2.03	41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
54 ELECTROENCEPHALOGRAPHY							54
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS							56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60.01 PARTIAL HOSPITALIZATION							60.01
62 OBSERVATION BEDS (NON-DISTINC							62
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 (14-4035) [ ] 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		659563			226787		41
44 LABORATORY		3875270			599318		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY		725943			2229		50
53 ELECTROCARDIOLOGY		319907			59648		53
54 ELECTROENCEPHALOGRAPHY		10504			6560		54
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS		3898520			1254920		56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60.01 PARTIAL HOSPITALIZATION		28902205			78096		60.01
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		38391912			2227558		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-4035)	<input type="checkbox"/>	SUB IV	<input type="checkbox"/>	PPS
APPLICABLE	<input checked="" type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	SUB I	<input type="checkbox"/>	SNF	<input type="checkbox"/>	TEFRA
BOXES	<input type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	SUB II	<input type="checkbox"/>	NF		
			<input type="checkbox"/>	SUB III	<input type="checkbox"/>	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
	8.01	8.02	9	9.01	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
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55.30 IMPL. DEV. CHARGED TO PATIENT					55.30
56 DRUGS CHARGED TO PATIENTS					56
59.97 CARDIAC REHABILITATION					59.97
59.98 HYPERBARIC OXYGEN THERAPY					59.98
59.99 LITHOTRIPSY					59.99
OUTPATIENT SERVICE COST CENTERS					
60.01 PARTIAL HOSPITALIZATION					60.01
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL					101

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				728774		728774
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				728774		728774

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	26148	1866			27.87	52005
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	26148	1866				52005

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-4035) [ ] 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		4242	659563				.006432	41
44 LABORATORY		6994	3875270				.001805	44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
50 PHYSICAL THERAPY		3587	725943				.004941	50
53 ELECTROCARDIOLOGY		477	319907				.001491	53
54 ELECTROENCEPHALOGRAPHY		79	10504				.007521	54
55.30 IMPL. DEV. CHARGED TO PATIENT								55.30
56 DRUGS CHARGED TO PATIENTS		18478	3898520				.004740	56
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
60.01 PARTIAL HOSPITALIZATION		204942	28902205				.007091	60.01
62 OBSERVATION BEDS (NON-DISTINC								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
101 TOTAL		238799	38391912					101

PROVIDER NO. 14-4035 LINDEN OAKS HOSPITAL  
 PERIOD FROM 07/01/2009 TO 06/30/2010

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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	TOTAL	PER	INPATIENT	INPATIENT
		ANESTHETIST	EDUCATION	ADJUSTMENT					COSTS
		COST	COST	AMOUNT		PATIENT	DIEM	DAYS	COSTS
		1	2	3	4	5	6	7	8
	INPAT ROUTINE SERV COST CTRS								
25	ADULTS & PEDIATRICS					26148		1866	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					26148		1866	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-4035) [ ] 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	NONPHYSICIAN ANESTHETIST	MEDICAL EDUCATION				
	COST 1	COST 1.01	COST 2				
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC				2.01	2.02	2.03	41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
54 ELECTROENCEPHALOGRAPHY							54
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS							56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60.01 PARTIAL HOSPITALIZATION							60.01
62 OBSERVATION BEDS (NON-DISTINC							62
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 (14-4035) [ ] 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 CHARGES	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH COSTS		COST TO CHARGES	RATIO OF COST TO CHARGES	PROGRAM CHARGES	PROGRAM PASS THROUGH COSTS	
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC		659563					41
44 LABORATORY		3875270					44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
50 PHYSICAL THERAPY		725943					50
53 ELECTROCARDIOLOGY		319907					53
54 ELECTROENCEPHALOGRAPHY		10504					54
55.30 IMPL. DEV. CHARGED TO PATIENT							55.30
56 DRUGS CHARGED TO PATIENTS		3898520					56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
60.01 PARTIAL HOSPITALIZATION		28902205					60.01
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		38391912					101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-4035) [ ] 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
53 ELECTROCARDIOLOGY						53
54 ELECTROENCEPHALOGRAPHY						54
55.30 IMPL. DEV. CHARGED TO PATIENT						55.30
56 DRUGS CHARGED TO PATIENTS						56
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
60.01 PARTIAL HOSPITALIZATION						60.01
62 OBSERVATION BEDS (NON-DISTINC						62
63.50 RHC						63.50
63.60 FQHC						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) (14-4035)	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)	26148						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	26148						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	26148						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)	5140						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) (14-4035)	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	20449360						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	20449360						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	49350283						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	49350283						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.414372						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1887.34						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	20449360						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) (14-4035)	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	782.06					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	4019788					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	4019788					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) (14-4035)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	707837					48
49 TOTAL PROGRAM INPATIENT COSTS	4727625					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	143252					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	9192					51
52 TOTAL PROGRAM EXCLUDABLE COST	152444					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	4575181					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) (14-4035)	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 [XX] 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 (PPS) (14-4035)	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	782.06	84
85 OBSERVATION BED COST		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL			TOTAL	
ROUTINE	COST	(FROM LINE 27)	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	20449360		86
87 NEW CAPITAL-RELATED COST	728774	.035638	87
88 NON PHYSICIAN ANESTHETIST	20449360		88
89 MEDICAL EDUCATION	20449360		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) (14-4035)	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)	26148						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	26148						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	26148						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)	1866						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) (14-4035)	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	20449360						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	20449360						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	49350283						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	49350283						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.414372						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1887.34						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	20449360						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) (14-4035)	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	782.06					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1459324					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1459324					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						47
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-4035)	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	1459324					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	52005					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST	52005					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) (14-4035)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	PROGRAM DISCHARGES	1	1	1	1	54
55	TARGET AMOUNT PER DISCHARGE	251				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. 14-4035 LINDEN OAKS HOSPITAL  
PERIOD FROM 07/01/2009 TO 06/30/2010

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

VERSION: 2010.09  
11/20/2010 14:53

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. 14-4035 LINDEN OAKS HOSPITAL  
PERIOD FROM 07/01/2009 TO 06/30/2010

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

VERSION: 2010.09  
11/20/2010 14:53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-4035)	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	782.06	84
85 OBSERVATION BED COST		85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-4035)	<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	
25 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		7891093		25
ANCILLARY SERVICE COST CENTERS				
41 RADIOLOGY-DIAGNOSTIC	.733613	226787	166374	41
44 LABORATORY	.077966	599318	46726	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
50 PHYSICAL THERAPY	.563708	2229	1257	50
53 ELECTROCARDIOLOGY	.170162	59648	10150	53
54 ELECTROENCEPHALOGRAPHY	.862338	6560	5657	54
55.30 IMPL. DEV. CHARGED TO PATIENT				55.30
56 DRUGS CHARGED TO PATIENTS	.364842	1254920	457848	56
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
60.01 PARTIAL HOSPITALIZATION	.253858	78096	19825	60.01
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS				62
63.50 RHC				63.50
63.60 FQHC				63.60
101 TOTAL		2227558	707837	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		2227558		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-4035)	<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
25 INPATIENT ROUTINE SERVICE COST CENTERS			25
ADULTS & PEDIATRICS			
ANCILLARY SERVICE COST CENTERS			
41 RADIOLOGY-DIAGNOSTIC	.733613		41
44 LABORATORY	.077966		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
50 PHYSICAL THERAPY	.563708		50
53 ELECTROCARDIOLOGY	.170162		53
54 ELECTROENCEPHALOGRAPHY	.862338		54
55.30 IMPL. DEV. CHARGED TO PATIENT			55.30
56 DRUGS CHARGED TO PATIENTS	.364842		56
59.97 CARDIAC REHABILITATION			59.97
59.98 HYPERBARIC OXYGEN THERAPY			59.98
59.99 LITHOTRIPSY			59.99
OUTPATIENT SERVICE COST CENTERS			
60.01 PARTIAL HOSPITALIZATION	.253858		60.01
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS			62
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 (14-4035)	HOSPITAL (14-4035)	HOSPITAL (14-4035)	
	1	1.01	1.02	
1 MEDICAL AND OTHER SERVICES				1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				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				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-4035)	HOSPITAL (14-4035)	HOSPITAL (14-4035)
	1	1.01	1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES AND COINSURANCE			18
18.01 DEDUCTIBLES AND COINSURANCE RELATING TO			18.01
LINE 17.01			
19 SUBTOTAL			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			23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL			25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS			27
27.01 REDUCED REIMBURSABLE BAD DEBTS			27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			27.02
28 SUBTOTAL			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			32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS			34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM			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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 HOSPITAL (14-4035)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B	
	PART A			
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3848317		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE	NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	.01			3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02			3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03	NONE	NONE	3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .04			3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.05			3.05
	.50			3.50
	PROVIDER .51			3.51
	TO .52	NONE	NONE	3.52
	PROGRAM .53			3.53
	.54			3.54
SUBTOTAL	.99			3.99
4 TOTAL INTERIM PAYMENTS		3848317		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02	NONE	NONE	5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51	NONE	NONE	5.51
	PROGRAM .52			5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01	60824		6.01
	PROVIDER TO .02 PROGRAM			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		3909141		7

NAME OF INTERMEDIARY: \_\_\_\_\_  
 SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

INTERMEDIARY NUMBER: \_\_\_\_\_  
 DATE (MO/DAY/YR): \_\_\_\_\_

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART I

MEDICARE PART A SERVICES - TEFRA

	HOSPITAL (14-4035)	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	4016493					1.08
1.09	118225					1.09
1.10	30645					1.10
1.11						1.11
1.12						1.12
1.13						1.13
1.14						1.14
1.15						1.15
1.16	71.638356					1.16
1.17						1.17
1.18						1.18
1.19	4165363					1.19
1.20						1.20
1.21						1.21
1.22						1.22
1.23	4165363					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	4165363					4
5	4690					5
6	4160673					6
7	299228					7
8	3861445					8
9	13128					9
10	3848317					10
11	86892					11
11.01	60824					11.01
11.02	86892					11.02
12	3909141					12
13						13

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART I

MEDICARE PART A SERVICES - TEFRA

	HOSPITAL (14-4035)	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	3909141					17
18 SEQUESTRATION ADJUSTMENT						18
19 INTERIM PAYMENTS	3848317					19
19.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)						19.01
20 BALANCE DUE PROVIDER/PROGRAM	60824					20
21 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						21
TO BE COMPLETED BY INTERMEDIARY						
50 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 (14-4035) (OTHER)	SUB I	SUB II	SUB III	
		SUB IV	NF I		
1	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1
2	INPATIENT HOSPITAL/SNF/NF SERVICES	1459324			1
3	MEDICAL AND OTHER SERVICES				2
4	INTERNS AND RESIDENTS				3
5	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O				4
6	COST OF TEACHING PHYSICIANS				5
7	SUBTOTAL	1459324			6
8	INPATIENT PRIMARY PAYER PAYMENTS				7
9	OUTPATIENT PRIMARY PAYER PAYMENTS				8
10	SUBTOTAL	1459324			9
11	COMPUTATION OF LESSER OF COST OR CHARGES				
12	ROUTINE SERVICE CHARGES				10
13	ANCILLARY SERVICE CHARGES				11
14	INTERNS AND RESIDENTS SERVICE CHARGES				12
15	ORGAN ACQUISITION CHARGES, NET OF REVENUE				13
16	TEACHING PHYSICIANS				14
17	INCENTIVE FROM TARGET AMOUNT COMPUTATION				15
18	TOTAL REASONABLE CHARGES				16
19	CUSTOMARY CHARGES				
20	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE				17
21	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM				18
22	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN				
23	ACCORDANCE WITH 42 CFR 413.13(E)				
24	RATIO OF LINE 17 TO LINE 18				19
25	TOTAL CUSTOMARY CHARGES				20
26	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST				21
27	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	1459324			22
28	COST OF COVERED SERVICES	1459324			23
29	PROSPECTIVE PAYMENT AMOUNT				
30	OTHER THAN OUTLIER PAYMENTS				24
31	OUTLIER PAYMENTS				25
32	PROGRAM CAPITAL PAYMENTS				26
33	CAPITAL EXCEPTION PAYMENTS				27
34	ROUTINE SERVICE OTHER PASS THROUGH COSTS				28
35	ANCILLARY SERVICE OTHER PASS THROUGH COSTS				29
36	SUBTOTAL	1459324			30
37	CUSTOMARY CHARGES (TITLE XIX PPS COVERED				31
38	LESSER OF LINES 30 OR 31	1459324			32
39	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 (14-4035) (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	1459324				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 BENEFICIARIES (SEE INSTRUCTIONS)					38.02
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 A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)					44
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 UTILIZATION					49
50	OTHER ADJUSTMENTS					50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS					51
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 SECTION 115.2					59

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	644989			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	4490334			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	96054			7
8	PREPAID EXPENSES	85601			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS	60824			10
11	TOTAL CURRENT ASSETS	5377802			11
FIXED ASSETS					
12	LAND				12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	485306			13
13.01	ACCUMULATED DEPRECIATION	-400662			13.01
14	BUILDINGS	12947430			14
14.01	ACCUMULATED DEPRECIATION	-6253671			14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT				16
16.01	ACCUMULATED DEPRECIATION				16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	1835640			18
18.01	ACCUMULATED DEPRECIATION	-980416			18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	7633627			21
OTHER ASSETS					
22	INVESTMENTS	9610687			22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	242980			25
26	TOTAL OTHER ASSETS	9853667			26
27	TOTAL ASSETS	22865096			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	296284			28
29	SALARIES, WAGES & FEES PAYABLE	2019772			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)				31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS	2354129			34
35	OTHER CURRENT LIABILITIES	471349			35
36	TOTAL CURRENT LIABILITIES	5141534			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				41
42	TOTAL LONG TERM LIABILITIES				42
43	TOTAL LIABILITIES	5141534			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	17723562			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	17723562			51
52	TOTAL LIABILITIES AND FUND BALANCES	22865096			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	14420655			1
2 NET INCOME (LOSS)	3325565			2
3 TOTAL	17746220			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5 CONTRIBUTIONS				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	17746220			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13 CHANGES IN RESTR NET ASSETS OF FOUN	22658			13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS	22658			18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	17723562			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	49350283		49350283	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	49350283		49350283	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				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	49350283		49350283	18
19 ANCILLARY SERVICES				19
20 OUTPATIENT SERVICES		23325014	23325014	20
18.50 RHC				18.50
18.60 FQHC				18.60
21 HOME HEALTH AGENCY				21
22 AMBULANCE				22
23 CORF				23
24 ASC				24
25 HOSPICE				25
26 TOTAL PATIENT REVENUES	49350283	23325014	72675297	26

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		29307905	26
27 ADD (SPECIFY)			27
28 PROVISION FOR BAD DEBT	2211440		28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		2211440	33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		31519345	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	72675297	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	40319551	2
3	NET PATIENT REVENUES	32355746	3
4	LESS - TOTAL OPERATING EXPENSES	31519345	4
5	NET INCOME FROM SERVICE TO PATIENTS	836401	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1400760	6
7	INCOME FROM INVESTMENTS	674402	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		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		21
22	RENTAL OF HOSPITAL SPACE	12850	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.01	EDUCATION REVENUE	2950	24.01
24.02	NURSE TRIAGE SERVICES	327240	24.02
24.03	OTHER MISCELLANEOUS OPERATING REVEN	229801	24.03
25	TOTAL OTHER INCOME	2648003	25
26	TOTAL	3484404	26
27	LOSS ON SALE OF ASSETS	158839	27
28			28
29			29
30	TOTAL OTHER EXPENSES	158839	30
31	NET INCOME (OR LOSS) FOR THE PERIOD	3325565	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	19.66		7.14				26.80 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
41 RADIOLOGY-DIAGNOSTIC	34.38						34.38 41
44 LABORATORY	15.47						15.47 44
50 PHYSICAL THERAPY	0.31						0.31 50
53 ELECTROCARDIOLOGY	18.65						18.65 53
54 ELECTROENCEPHALOGRAPHY	62.45						62.45 54
56 DRUGS CHARGED TO PATIENTS	32.19						32.19 56
60.01 PARTIAL HOSPITALIZATION	0.27						0.27 60.01
101 TOTAL CHARGES	3.02						3.02 101



COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
69.40 OPT							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							
100 EDWARD ACADEMY							100
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	30467473	100.00	0	.00	30467473	100.00	103

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE	
	RELATED		CAPITAL		PROGRAM	INPATIENT
	COSTS	CHARGES	COST TO	CHARGES	PPS CAPITAL	
	1	2	CHARGES	4	COSTS	
			3		5	
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	4242	659563	.006432	226787	1459	41
44 LABORATORY	6994	3875270	.001805	599318	1082	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
50 PHYSICAL THERAPY	3587	725943	.004941	2229	11	50
53 ELECTROCARDIOLOGY	477	319907	.001491	59648	89	53
54 ELECTROENCEPHALOGRAPHY	79	10504	.007521	6560	49	54
55.30 IMPL. DEV. CHARGED TO PATIENT						55.30
56 DRUGS CHARGED TO PATIENTS	18478	3898520	.004740	1254920	5948	56
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
60.01 PARTIAL HOSPITALIZATION	204942	28902205	.007091	78096	554	60.01
62 OBSERVATION BEDS (NON-DISTINCT						62
OTHER REIMBURSABLE COST CENTERS						
63.50 RHC						63.50
63.60 FQHC						63.60
101 TOTAL	238799	38391912		2227558	9192	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	728774		728774	26148	27.87	5140	143252 25
101	TOTAL	728774		728774			5140	143252 101
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS							143252	
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS							9192	
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS							152444	
MEDICARE DISCHARGES (WORKSHEET S-3, LINE 12, COLUMN 13)							489	
MEDICARE PATIENT DAYS (WORKSHEET S-3, LINE 12, COLUMN 4)							5140	
PER DISCHARGE CAPITAL COSTS							311.75	
PER DIEM CAPITAL COSTS							29.66	

I. COST TO CHARGE RATIO FOR FREESTANDING IPF

1. TOTAL MEDICARE COSTS	4727625
(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	10118651
(WKST D-4 COLUMN 2 LINES 25-30 + LINE 103)	
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.467

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS	152444
(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)	.015

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS.	
(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.	
(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)	.000