

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
11/17/2013 10:32

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 11/17/2013 TIME: 10:32
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ALEXIAN BROTHERS BEHAVIORAL HEALTH (14-4031) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, AND 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)

David Jones
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)
 CHIEF FINANCIAL OFFICER
 TITLE
 11/19/13
 DATE

ECR Encryption: 11/17/2013 10:32
hnhj1Fnej3154fIC0W8Pe9ADhKc2A0
KDEH20nJ.U8f8qcFfhgDFRk8PuToHD
L46H0OwvtG033HAs

PI Encryption: 11/17/2013 10:32
eQFXH3ALUOQoruIMolYNgG0Kq5d:0
n3X0C0oQvX7dMSZlswOitJUE.d61kj
Mhgi0xN4zF0z5a4t
PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1	HOSPITAL	-11,971	3,741			1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF					5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC					10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	-11,971	3,741			200

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 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

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

 TITLE

 DATE

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	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1	HOSPITAL					1
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	56	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56	
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57	
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58	
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59	
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	Y/N N	IME	DIRECT GME	61	
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01	
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)				61.02	
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03	
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04	
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05	
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
		PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED IME FTE COUNT 3	UNWEIGHTED DIRECT GME FTE COUNT 4	61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					61.20
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)						
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62	
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01	
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS						
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63	

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

UNWEIGHTED FTES UNWEIGHTED FTES RATIO
 NONPROVIDER IN (COL.1/
 SITE HOSPITAL (COL.1+COL.2))

64 ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED
 RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY
 CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL
 NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED
 NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN
 COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE
 INSTRUCTIONS)

64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF
 UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS
 OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER
 OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL.
 ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)).
 (SEE INSTRUCTIONS)

PROGRAM NAME PROGRAM CODE UNWEIGHTED FTES UNWEIGHTED FTES RATIO
 1 2 3 4 5
 (COL.3+COL.4)

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

UNWEIGHTED FTES UNWEIGHTED FTES RATIO
 NONPROVIDER IN (COL.1/
 SITE HOSPITAL (COL.1+COL.2))

66 ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT
 FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS.
 ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT
 FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF
 (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)

66

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2
 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY
 CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-
 PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED
 PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER
 IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)).
 (SEE INSTRUCTIONS)

PROGRAM NAME PROGRAM CODE UNWEIGHTED FTES UNWEIGHTED FTES RATIO
 1 2 3 4 5
 (COL.3+COL.4)

INPATIENT PSYCHIATRIC FACILITY PPS

70 IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?
 ENTER 'Y' FOR YES OR 'N' FOR NO.
 71 IF LINE 70 YES:
 COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR
 BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO.
 COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH
 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO.
 COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING
 PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT
 ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.

Y 70
 N 71

INPATIENT REHABILITATION FACILITY PPS

75 IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?
 ENTER 'Y' FOR YES OR 'N' FOR NO.
 76 IF LINE 75 YES:
 COLUMN 1: DID 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.
 COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH
 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO.
 COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING
 PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT
 ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.

N 75
 76

LONG TERM CARE HOSPITAL PPS

80 IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.

N 80

TEFRA PROVIDERS

85 IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.
 86 DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)?
 ENTER 'Y' FOR YES, OR 'N' FOR NO.

N 85
 N 86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

		V	XIX	
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	1	2	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N	2	105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: 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 IN COLUMN 1. 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, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	109
MISCELLANEOUS COST REPORTING INFORMATION				
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 865,931 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121
TRANSPLANT CENTER INFORMATION				
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ALL PROVIDERS

140 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1,
 CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS
 ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER. 1
Y 149019 140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND
 ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141 NAME: ALEXIAN BROTHERS HOSPITAL NETW CONTRACTOR'S NAME: WPS CONTRACTOR'S NUMBER: 05901 141
 142 STREET: 3040 SALT CREEK LANE P.O. BOX: 142
 143 CITY: ARLINGTON HEIGHTS STATE: IL ZIP CODE: 60005 143
 144 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y 144
 145 IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT
 SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO. N 145
 146 HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y'
 FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE
 APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2. N 146
 147 WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO. N 147
 148 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO. N 148
 149 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO. N 149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE
 APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO
 FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
	1	2	3	4
155 HOSPITAL	N	N		N 155
156 SUBPROVIDER - IPF	N	N		156
157 SUBPROVIDER - IRF	N	N		157
158 SUBPROVIDER - (OTHER)	N	N		158
159 SNF	N	N		159
160 HHA	N	N		160
161 CMHC		N		161
161.10 CORF				161.10

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs?
 ENTER 'Y' FOR YES OR 'N' FOR NO. N 165

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN
 COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. N 167
 168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),
 ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168
 169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
 (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 169
 170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE
 FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyymm) (SEE INSTRUCTIONS) 170

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	Y/N 1 N	DATE 2	V/I 3
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3

FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 Y	2 A	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5

APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N	2 6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N	7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N	8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N	9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N	11
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y 12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N 14

15	BED COMPLEMENT DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N 15
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	PART A		PART B	
	Y/N	DATE	Y/N	DATE
16	1	2	3	4
16	N		N	16
17	Y	09/28/2012	Y	09/28/2012 17
18	N		N	18
19	N		N	19
20	N		N	20
21	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 35

HOME OFFICE COSTS

- | | Y/N | DATE | |
|---|-----|------|----|
| | 1 | 2 | |
| 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? | | | 36 |
| 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | | 37 |
| 38 IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. | N | | 38 |
| 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. | | | 39 |
| 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | | 40 |

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|---|---|-----------------------------|----|
| 41 FIRST NAME: MARY JO | LAST NAME: MACKNISKAS | TITLE: DIRECTOR OF REIMBURS | 41 |
| 42 EMPLOYER: ALEXIAN BROTHERS HEALTH SYSTEM | | | 42 |
| 43 PHONE NUMBER: 847-818-5067 | E-MAIL ADDRESS: MARY.MACKNISKAS@ALEXIAN.NET | | 43 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	34,992,045		1,185,807.00	1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A ADMINISTRATIVE		195,060		2,080.00	4
4.01	PHYSICIAN-PART A - TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)					7.01
8	HOME OFFICE PERSONNEL		1,096,314		8,343.00	8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		9,741,261		228,984.00	10
	OTHER WAGES & RELATED COSTS					
11	CONTRACT LABOR (SEE INSTRUCTIONS)		898,821		16,551.00	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		2,848,506		34,846.00	14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE					15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING					16
	WAGE-RELATED COSTS					
17	WAGE-RELATED COSTS (CORE)		7,311,664	-981,942		17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS			981,942		19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A - ADMINISTRATIVE					22
22.01	PHYSICIAN PART A - TEACHING					22.01
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
	OVERHEAD COSTS - DIRECT SALARIES					
26	EMPLOYEE BENEFITS DEPARTMENT		-408,016			26
27	ADMINISTRATIVE & GENERAL		6,222,057		235,579.00	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		199,607		8,818.00	30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING		64,896		35,324.00	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)		503,978		31,631.55	33
34	DIETARY		228,010	-45,861	4,438.00	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		866,467		74,991.00	35
36	CAFETERIA			45,861		36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION		1,096,834		14,765.00	38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		406,304		8,451.00	41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	35,266,176		35,266,176	1,284,086.55	27.46	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	9,741,261		9,741,261	228,984.00	42.54	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	25,524,915		25,524,915	1,055,102.55	24.19	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	3,747,327		3,747,327	51,397.00	72.91	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	7,311,664	-981,942	6,329,722		24.80%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	36,583,906	-981,942	35,601,964	1,106,499.55	32.18	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	9,180,137		9,180,137	413,997.55	22.17	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	400,350	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	500,360	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	3,393,218	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	177,390	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	68,960	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	81,194	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	244,195	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	2,332,085	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	69,996	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	43,915	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	7,311,663	24

PART B - OTHER THAN CORE RELATED COST

25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25
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PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
11/17/2013 10:31

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT	
0		LABOR	COST	
		1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	17,793	3,653,663	1
2	HOSPITAL	17,793	3,653,663	2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		936,818	936,818	963,234	1
2	00200				400,101	2
3	00300					3
4	00400	-408,016	4,534,397	4,126,381	-594	4
5	00500	6,222,057	18,578,665	24,800,722	-1,015,322	5
6	00600					6
7	00700	199,607	1,103,102	1,302,709		7
8	00800				200,000	8
9	00900	64,896	900,992	965,888	-200,000	9
10	01000	228,010	1,705,309	1,933,319	-388,858	10
11	01100				388,858	11
12	01200					12
13	01300	1,096,834	108,603	1,205,437		13
14	01400					14
15	01500					15
16	01600	406,304	358,210	764,514		16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	13,718,701	2,315,988	16,034,689	420,877	30
ANCILLARY SERVICE COST CENTERS						
54	05400		21,597	21,597	53	54
60	06000		747,087	747,087	31,785	60
62,30	06250					62.30
66	06600	115,219	8,694	123,913	3,695	66
69	06900					69
73	07300		1,597,334	1,597,334	48,526	73
74	07400					74
76	03320	317,096	95,475	412,571	17,764	76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
92	09200					92
93	04950	3,290,076	433,827	3,723,903	249,616	93
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
113	11300		1,126,000	1,126,000	-1,126,000	113
118		25,250,784	34,572,098	59,822,882	-6,265	118
NONREIMBURSABLE COST CENTERS						
191	19100	1,466,474	857,564	2,324,038	6,265	191
192	19200	7,525,129	1,188,490	8,713,619		192
194	07950	61,181	6,861	68,042		194
194.01	07951	688,477	94,735	783,212		194.01
200		34,992,045	36,719,748	71,711,793		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,900,052	-803,296	1,096,756	1
2	00200	400,101	1,241,856	1,641,957	2
3	00300				3
4	00400	4,125,787	19,449	4,145,236	4
5	00500	23,785,400	-3,817,260	19,968,140	5
6	00600				6
7	00700	1,302,709	494,764	1,797,473	7
8	00800	200,000		200,000	8
9	00900	765,888		765,888	9
10	01000	1,544,461		1,544,461	10
11	01100	388,858	-181,081	207,777	11
12	01200				12
13	01300	1,205,437		1,205,437	13
14	01400				14
15	01500				15
16	01600	764,514	31,205	795,719	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	16,455,566		16,455,566	30
ANCILLARY SERVICE COST CENTERS					
54	05400	21,650		21,650	54
60	06000	778,872		778,872	60
62.30	06250				62.30
66	06600	127,608		127,608	66
69	06900				69
73	07300	1,645,860		1,645,860	73
74	07400				74
76	03320	430,335	-35,650	394,685	76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
92	09200				92
93	04950	3,973,519	-66,707	3,906,812	93
OTHER REIMBURSABLE COST CENTERS					
94	09400				94
SPECIAL PURPOSE COST CENTERS					
113	11300				113
118		59,816,617	-3,116,720	56,699,897	118
NONREIMBURSABLE COST CENTERS					
191	19100	2,330,303	-192,450	2,137,853	191
192	19200	8,713,619	-1,249,180	7,464,439	192
194	07950	68,042		68,042	194
194.01	07951	783,212		783,212	194.01
200		71,711,793	-4,558,350	67,153,443	200
TOTAL (SUM OF LINES 118-199)					

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER
			LINE #	SALARY	
1	1	2	3	4	5
1 RENTAL EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		5,958
2 RENTAL EXPENSE	A				
3 RENTAL EXPENSE	A				
500 TOTAL RECLASSIFICATIONS					5,958
CODE LETTER - A					500
1					1
2					2
3					3
4 BUILDING RENTAL	B	CAP REL COSTS-BLDG & FIXT	1		119,039
5 BUILDING RENTAL	B				
500 TOTAL RECLASSIFICATIONS					119,039
CODE LETTER -					500
1					1
2					2
3					3
4					4
5					5
6 CAFETERIA RECLASS	C	CAFETERIA	11	45,861	342,997
500 TOTAL RECLASSIFICATIONS				45,861	342,997
CODE LETTER -					500
1					1
2					2
3					3
4					4
5					5
6					6
7 PFS RECLASS	D	ADULTS & PEDIATRICS	30		429,484
8 PFS RECLASS	D	RADIOLOGY-DIAGNOSTIC	54		53
9 PFS RECLASS	D	LABORATORY	60		31,785
10 PFS RECLASS	D	PHYSICAL THERAPY	66		3,695
11 PFS RECLASS	D	ELECTROSHOCK THERAPY	76		2,280
12 PFS RECLASS	D	DRUGS CHARGED TO PATIENTS	73		48,526
13 PFS RECLASS	D	ELECTROSHOCK THERAPY	76		15,520
14 PFS RECLASS	D	PARTIAL HOSPILIZATION	93		256,841
15 PFS RECLASS	D	RESEARCH	191		6,265
500 TOTAL RECLASSIFICATIONS					794,449
CODE LETTER -					500
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15 LAUNDRY	E	LAUNDRY & LINEN SERVICE	8		200,000
500 TOTAL RECLASSIFICATIONS					200,000
CODE LETTER -					500
1 INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		1,126,000
500 TOTAL RECLASSIFICATIONS					1,126,000
CODE LETTER - F					500
1 EQUIPMENT RENTAL	G	CAP REL COSTS-MVBLE EQUIP	2		112,338
2					
3					
500 TOTAL RECLASSIFICATIONS					112,338
CODE LETTER - G					500

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE		SALARY	OTHER
		COST CENTER	LINE #		
	1	2	3	4	5
1 EQUIPMENT DEPRECIATION	H	CAP REL COSTS-MVBLE EQUIP	2		287,763 1
500 TOTAL RECLASSIFICATIONS					287,763 500
CODE LETTER - H					
GRAND TOTAL (INCREASES)				45,861	2,988,544

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 RENTAL EXPENSE	A	ADMINISTRATIVE & GENERAL	5		795	10 1
2 RENTAL EXPENSE	A	ELECTROSHOCK THERAPY	76		36	2
3 RENTAL EXPENSE	A	ADULTS & PEDIATRICS	30		5,127	3
500 TOTAL RECLASSIFICATIONS					5,958	500
CODE LETTER - A						
1						1
2						2
3						3
4 BUILDING RENTAL	B	ADMINISTRATIVE & GENERAL	5		111,814	10 4
5 BUILDING RENTAL	B	PARTIAL HOSPILIZATION	93		7,225	5
500 TOTAL RECLASSIFICATIONS					119,039	500
CODE LETTER -						
1						1
2						2
3						3
4						4
5						5
6 CAFETERIA RECLASS	C	DIETARY	10	45,861	342,997	6
500 TOTAL RECLASSIFICATIONS				45,861	342,997	500
CODE LETTER -						
1						1
2						2
3						3
4						4
5						5
6						6
7 PFS RECLASS	D	ADMINISTRATIVE & GENERAL	5		794,449	7
8 PFS RECLASS	D					8
9 PFS RECLASS	D					9
10 PFS RECLASS	D					10
11 PFS RECLASS	D					11
12 PFS RECLASS	D					12
13 PFS RECLASS	D					13
14 PFS RECLASS	D					14
15 PFS RECLASS	D					15
500 TOTAL RECLASSIFICATIONS					794,449	500
CODE LETTER -						
1						1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15 LAUNDRY	E	HOUSEKEEPING	9		200,000	15
500 TOTAL RECLASSIFICATIONS					200,000	500
CODE LETTER -						
1 INTEREST EXPENSE	F	INTEREST EXPENSE	113		1,126,000	11 1
500 TOTAL RECLASSIFICATIONS					1,126,000	500
CODE LETTER - F						
1 EQUIPMENT RENTAL	G	EMPLOYEE BENEFITS DEPARTMENT	4		594	10 1
2		ADMINISTRATIVE & GENERAL	5		108,264	2
3		ADULTS & PEDIATRICS	30		3,480	3
500 TOTAL RECLASSIFICATIONS					112,338	500
CODE LETTER - G						

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		WKST A-7	
			LINE #	SALARY	OTHER	REF.
	1	6	7	8	9	10
1 EQUIPMENT DEPRECIATION	H	CAP REL COSTS-BLDG & FIXT	1		287,763	9 1
500 TOTAL RECLASSIFICATIONS					287,763	500
CODE LETTER - H						
GRAND TOTAL (DECREASES)				45,861	2,988,544	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN 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	1,540,000					1,540,000	1
2 LAND IMPROVEMENTS	16,000	17,000		17,000		33,000	2
3 BUILDINGS AND FIXTURES	21,305,000					21,305,000	3
4 BUILDING IMPROVEMENTS	358,000	258,000		258,000		616,000	4
5 FIXED EQUIPMENT	70,000	156,000		156,000	16,000	210,000	5
6 MOVABLE EQUIPMENT	1,179,000	394,000		394,000		1,573,000	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	24,468,000	825,000		825,000	16,000	25,277,000	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	24,468,000	825,000		825,000	16,000	25,277,000	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER	TOTAL(1)
						CAPITAL- RELATED COSTS (SEE INSTR.) 14	(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	936,818						936,818 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	936,818						936,818 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 7	TOTAL (SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	23,288,649		23,288,649	0.951801				1
2 CAP REL COSTS-MVBLE EQUIP	1,179,326		1,179,326	0.048199				2
3 TOTAL (SUM OF LINES 1-2)	24,467,975		24,467,975	1.000000				3

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER	TOTAL(2)
						CAPITAL- RELATED COSTS (SEE INSTR.) 14	(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	863,238	124,997	108,521				1,096,756 1
2 CAP REL COSTS-MVBLE EQUIP	1,529,619	112,338					1,641,957 2
3 TOTAL	2,392,857	237,335	108,521				2,738,713 3

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-BUILDINGS & FIXTURES (CHAPTER 2)	B	-1,017,479	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2 3
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					4
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					5
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					6
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					7
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					8
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					9
9 PARKING LOT (CHAPTER 21)					10
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2				11
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					12
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	828,077			13
13 LAUNDRY AND LINEN SERVICE				11	14
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-180,108	CAFETERIA		15
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					16
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					17
17 SALE OF DRUGS TO OTHER THAN PATIENTS					18
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-1,322	MEDICAL RECORDS & LIBRARY	16	19
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					20
20 VENDING MACHINES	B	-973	CAFETERIA	11	21
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					22
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					23
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	24
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	25
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	26
26 DEPRECIATION--BUILDINGS & FIXTURES	A	-17,848	CAP REL COSTS-BLDG & FIXT	1	9 27
27 DEPRECIATION--MOVABLE EQUIPMENT	A	102,886	CAP REL COSTS-MVBLE EQUIP	2	9 28
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	29
29 PHYSICIANS' ASSISTANT					30
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	31
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	32
32 CAH HIT ADJ FOR DEPRECIATION AND					33
33 MISC INCOME	B	-31,627	ADMINISTRATIVE & GENERAL	5	33.01
33.01 BAD DEBTS	A	-2,060,072	ADMINISTRATIVE & GENERAL	5	33.02
33.02 RESEARCH HBP	A	-150,548	RESEARCH	191	33.03
33.03 GROUP PRACTICE HBP	A	-1,127,772	PHYSICIANS' PRIVATE OFFICES	192	33.05
33.05 PHYSICIAN GUARANTEE	A	-21,241	ADMINISTRATIVE & GENERAL	5	34
34 BUSINESS DEVELOPMENT/MARKETING	A	-313,573	ADMINISTRATIVE & GENERAL	5	35
35 BUSINESS DEVELOPMENT OTHER INCOME	B	-45,700	ADMINISTRATIVE & GENERAL	5	36
36 ECT OTHER INCOME	B	-35,650	ELECTROSHOCK THERAPY	76	37
37 SCHOOL REIMBURSEMENT	A	-404,133	ADMINISTRATIVE & GENERAL	5	38
38 OTHER INCOME - AFTERCARE	B	-58,263	PARTIAL HOSPILIZATION	93	39
39 REAL ESTATE TAXES	A	-8,004	ADMINISTRATIVE & GENERAL	5	40
40 OTHER REVENUE PROFESSIONAL FEES	B	-15,000	ADMINISTRATIVE & GENERAL	5	41
41					42
42					43
43					44
44					45
45					46
46					47
47					48
48					49
49					50
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-4,558,350			

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 (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	5	ADMINISTRATIVE & GENERAL	7,297,520	8,101,389	-803,869	1
2	1	CAP REL COSTS-BLDG & FIXT	226,040		226,040	9 2
3	2	CAP REL COSTS-MVBLE EQUIP	1,138,970		1,138,970	9 3
3.01	5	ADMINISTRATIVE & GENERAL		111,814	-111,814	4.01
3.02	16	MEDICAL RECORDS & LIBRARY	32,527		32,527	4.02
3.03	7	OPERATION OF PLANT	506,572	11,808	494,764	4.03
3.04	5	ADMINISTRATIVE & GENERAL	900,245	900,245		4.04
3.05	4	EMPLOYEE BENEFITS DEPARTMENT	215,518	196,069	19,449	4.05
3.06	1	CAP REL COSTS-BLDG & FIXT	5,991		5,991	9 4.06
3.07	5	ADMINISTRATIVE & GENERAL	975	3,202	-2,227	4.07
3.08	93	PARTIAL HOSPILIZATION	3,699	12,143	-8,444	4.08
3.09	191	RESEARCH	95,512	137,414	-41,902	4.09
3.10	192	PHYSICIANS' PRIVATE OFFICES	276,740	398,148	-121,408	4.10
4						4
5		TOTALS (SUM OF LINES 1-4)	10,700,309	9,872,232	828,077	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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.

SYMBOL (1)	NAME	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6 B	ABHS	100.00			
7					
8					
9					
10					

(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:

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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	5 PERCENT OF UNAD- JUSTED RCE LIMIT		
LINE NO.	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GENERAL DR. A	195,060		195,060	200,000	2,080	200,000	10,000	1
200		TOTAL	195,060		195,060		2,080	200,000	10,000	200

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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. 10	11	12	13	14	15	16	17	18
1	5	ADMINISTRATIVE & GENERAL DR. A				200,000		1
200		TOTAL				200,000		200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVEABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,096,756	1,096,756				1
2 CAP REL COSTS-MVBLE EQUIP	1,641,957		1,641,957			2
4 EMPLOYEE BENEFITS DEPARTMENT	4,145,236			4,145,236		4
5 ADMINISTRATIVE & GENERAL	19,968,140	337,911	505,888	728,584	21,540,523	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,797,473	5,145	7,702	23,373	1,833,693	7
8 LAUNDRY & LINEN SERVICE	200,000	2,284	3,419		205,703	8
9 HOUSEKEEPING	765,888	1,284	1,922	7,599	776,693	9
10 DIETARY	1,544,461	14,409	21,571	21,329	1,601,770	10
11 CAFETERIA	207,777	23,293	34,872	5,370	271,312	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,205,437			128,436	1,333,873	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	795,719	9,186	13,753	47,577	866,235	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	16,455,566	514,469	770,212	1,606,414	19,346,661	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	21,650				21,650	54
60 LABORATORY	778,872				778,872	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66 PHYSICAL THERAPY	127,608			13,492	141,100	66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS	1,645,860	3,921	5,870		1,655,651	73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY	394,685	5,308	7,947	37,131	445,071	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 PARTIAL HOSPILIZATION	3,906,812	47,810	71,577	385,258	4,411,457	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	56,699,897	965,020	1,444,733	3,004,563	55,230,264	118
NONREIMBURSABLE COST CENTERS						
191 RESEARCH	2,137,853	1,775	2,658	171,720	2,314,006	191
192 PHYSICIANS' PRIVATE OFFICES	7,464,439	129,961	194,566	881,170	8,670,136	192
194 DUI PROGRAM	68,042			7,164	75,206	194
194.01 IPPS	783,212			80,619	863,831	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	67,153,443	1,096,756	1,641,957	4,145,236	67,153,443	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	21,540,523					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	865,954	2,699,647				7
8 LAUNDRY & LINEN SERVICE	97,142	8,180	311,025			8
9 HOUSEKEEPING	366,790	4,599		1,148,082		9
10 DIETARY	756,429	51,609		22,052	2,431,860	10
11 CAFETERIA	128,126	83,433		35,650		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	629,916					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	409,076	32,904		14,060		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	9,136,388	1,842,753	311,025	787,396	2,431,860	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	10,224					54
60 LABORATORY	367,819					60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66 PHYSICAL THERAPY	66,634					66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS	781,875	14,044		6,001		73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY	210,183	19,014		8,125		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 PARTIAL HOSPILIZATION	2,083,293	171,249		73,174		93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	15,909,849	2,227,785	311,025	946,458	2,431,860	118
NONREIMBURSABLE COST CENTERS						
191 RESEARCH	1,092,780	6,359		2,717		191
192 PHYSICIANS' PRIVATE OFFICES	4,094,437	465,503		198,907		192
194 DUI PROGRAM	35,516					194
194.01 IPFS	407,941					194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	21,540,523	2,699,647	311,025	1,148,082	2,431,860	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA	518,521				11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	17,299	1,981,088			13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	9,902		1,332,177		16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS	283,712	1,578,026	725,890	36,443,711	30
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC			89	31,963	54
60 LABORATORY			53,724	1,200,415	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
66 PHYSICAL THERAPY	1,350		6,246	215,330	66
69 ELECTROCARDIOLOGY					69
73 DRUGS CHARGED TO PATIENTS			82,020	2,539,591	73
74 RENAL DIALYSIS					74
76 ELECTROSHOCK THERAPY	5,912		30,086	718,391	76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
93 PARTIAL HOSPILIZATION	72,467	403,062	434,122	7,648,824	93
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	390,642	1,981,088	1,332,177	48,798,225	118
NONREIMBURSABLE COST CENTERS					
191 RESEARCH	14,951			3,430,813	191
192 PHYSICIANS' PRIVATE OFFICES	92,819			13,521,802	192
194 DUI PROGRAM	1,241			111,963	194
194.01 IPPS	18,868			1,290,640	194.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	518,521	1,981,088	1,332,177	67,153,443	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS DEPARTMENT		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SERVICES-SALARY & FRINGES APPRVD		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	36,443,711	30
ANCILLARY SERVICE COST CENTERS			
54	RADIOLOGY-DIAGNOSTIC	31,963	54
60	LABORATORY	1,200,415	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
66	PHYSICAL THERAPY	215,330	66
69	ELECTROCARDIOLOGY		69
73	DRUGS CHARGED TO PATIENTS	2,539,591	73
74	RENAL DIALYSIS		74
76	ELECTROSHOCK THERAPY	718,391	76
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
93	PARTIAL HOSPILIZATION	7,648,824	93
OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS		94
SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE		113
118	SUBTOTALS (SUM OF LINES 1-117)	48,798,225	118
NONREIMBURSABLE COST CENTERS			
191	RESEARCH	3,430,813	191
192	PHYSICIANS' PRIVATE OFFICES	13,521,802	192
194	DUI PROGRAM	111,963	194
194.01	IPPS	1,290,640	194.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	67,153,443	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVEABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL		337,911	505,888	843,799	843,799	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		5,145	7,702	12,847	33,921	7
8 LAUNDRY & LINEN SERVICE		2,284	3,419	5,703	3,805	8
9 HOUSEKEEPING		1,284	1,922	3,206	14,368	9
10 DIETARY		14,409	21,571	35,980	29,631	10
11 CAFETERIA		23,293	34,872	58,165	5,019	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					24,675	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		9,186	13,753	22,939	16,024	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS		514,469	770,212	1,284,681	357,901	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC					401	54
60 LABORATORY					14,408	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66 PHYSICAL THERAPY					2,610	66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS		3,921	5,870	9,791	30,628	73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY		5,308	7,947	13,255	8,233	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 PARTIAL HOSPILIZATION		47,810	71,577	119,387	81,608	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		965,020	1,444,733	2,409,753	623,232	118
NONREIMBURSABLE COST CENTERS						
191 RESEARCH		1,775	2,658	4,433	42,807	191
192 PHYSICIANS' PRIVATE OFFICES		129,961	194,566	324,527	160,389	192
194 DUI PROGRAM					1,391	194
194.01 IPPS					15,980	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,096,756	1,641,957	2,738,713	843,799	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7	46,768					7
8	142	9,650				8
9	80		17,654			9
10	894		339	66,844		10
11	1,445		548		65,177	11
12						12
13					2,174	13
14						14
15						15
16	570		216		1,245	16
17						17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	31,924	9,650	12,108	66,844	35,662	30
ADULTS & PEDIATRICS						
ANCILLARY SERVICE COST CENTERS						
54						54
60						60
62.30						62.30
66					170	66
69						69
73	243		92			73
74						74
76	329		125		743	76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
92						92
93	2,967		1,125		9,109	93
PARTIAL HOSPILIZATION						
OTHER REIMBURSABLE COST CENTERS						
94						94
HOME PROGRAM DIALYSIS						
SPECIAL PURPOSE COST CENTERS						
113						113
118	38,594	9,650	14,553	66,844	49,103	118
SUBTOTALS (SUM OF LINES 1-117)						
NONREIMBURSABLE COST CENTERS						
191	110		42		1,879	191
192	8,064		3,059		11,667	192
194					156	194
194.01					2,372	194.01
200						200
201						201
202	46,768	9,650	17,654	66,844	65,177	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	26,849				13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY		40,994			16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS	21,386	22,342	1,842,498		1,842,498
ANCILLARY SERVICE COST CENTERS					30
54 RADIOLOGY-DIAGNOSTIC		3	404	404	54
60 LABORATORY		1,653	16,061	16,061	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
66 PHYSICAL THERAPY		192	2,972	2,972	66
69 ELECTROCARDIOLOGY					69
73 DRUGS CHARGED TO PATIENTS		2,523	43,277	43,277	73
74 RENAL DIALYSIS					74
76 ELECTROSHOCK THERAPY		926	23,611	23,611	76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
93 PARTIAL HOSPILIZATION	5,463	13,355	233,014		233,014
OTHER REIMBURSABLE COST CENTERS					93
94 HOME PROGRAM DIALYSIS					94
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	26,849	40,994	2,161,837		2,161,837
NONREIMBURSABLE COST CENTERS					
191 RESEARCH			49,271	49,271	191
192 PHYSICIANS' PRIVATE OFFICES			507,706	507,706	192
194 DUI PROGRAM			1,547	1,547	194
194.01 IPPS			18,352	18,352	194.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	26,849	40,994	2,738,713		2,738,713

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVEABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	127,270					1
2 CAP REL COSTS-MVBLE EQUIP		127,270				2
4 EMPLOYEE BENEFITS DEPARTMENT			35,400,061			4
5 ADMINISTRATIVE & GENERAL	39,212	39,212	6,222,057	-21,540,523	45,612,920	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	597	597	199,607		1,833,693	7
8 LAUNDRY & LINEN SERVICE	265	265			205,703	8
9 HOUSEKEEPING	149	149	64,896		776,693	9
10 DIETARY	1,672	1,672	182,149		1,601,770	10
11 CAFETERIA	2,703	2,703	45,861		271,312	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			1,096,834		1,333,873	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,066	1,066	406,304		866,235	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	59,700	59,700	13,718,701		19,346,661	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC					21,650	54
60 LABORATORY					778,872	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66 PHYSICAL THERAPY			115,219		141,100	66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS	455	455			1,655,651	73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY	616	616	317,096		445,071	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
93 PARTIAL HOSPILIZATION	5,548	5,548	3,290,076		4,411,457	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	111,983	111,983	25,658,800	-21,540,523	33,689,741	118
NONREIMBURSABLE COST CENTERS						
191 RESEARCH	206	206	1,466,474		2,314,006	191
192 PHYSICIANS' PRIVATE OFFICES	15,081	15,081	7,525,129		8,670,136	192
194 DUI PROGRAM			61,181		75,206	194
194.01 IPPS			688,477		863,831	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,096,756	1,641,957	4,145,236		21,540,523	202
203 UNIT COST MULT-WS B PT I	8.617553	12.901367	0.117097		0.472246	203
204 COST TO BE ALLOC PER B PT II					843,799	204
205 UNIT COST MULT-WS B PT II					0.018499	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	POUNDS OF	SQUARE	MEALS	FULL TIME	
	FEET	LAUNDRY	FEET	SERVED	EQUIV'S	
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	87,461					7
8 LAUNDRY & LINEN SERVICE	265	100				8
9 HOUSEKEEPING	149		87,047			9
10 DIETARY	1,672		1,672	143,070		10
11 CAFETERIA	2,703		2,703		42,624	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					1,422	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,066		1,066		814	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	59,700	100	59,700	143,070	23,322	30
54 ANCILLARY SERVICE COST CENTERS						
60 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66 PHYSICAL THERAPY					111	66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS	455		455			73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY	616		616		486	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
92 OUTPATIENT SERVICE COST CENTERS						
OBSERVATION BEDS (NON-DISTINCT PART)						92
93 PARTIAL HOSPITALIZATION	5,548		5,548		5,957	93
94 OTHER REIMBURSABLE COST CENTERS						
HOME PROGRAM DIALYSIS						94
118 SPECIAL PURPOSE COST CENTERS						
SUBTOTALS (SUM OF LINES 1-117)	72,174	100	71,760	143,070	32,112	118
NONREIMBURSABLE COST CENTERS						
191 RESEARCH	206		206		1,229	191
192 PHYSICIANS' PRIVATE OFFICES	15,081		15,081		7,630	192
194 DUI PROGRAM					102	194
194.01 IPPS					1,551	194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,699,647	311,025	1,148,082	2,431,860	518,521	202
203 UNIT COST MULT-WS B PT I	30.866866	3,110.250000	13.189220	16.997693	12.165001	203
204 COST TO BE ALLOC PER B PT II	46,768	9,650	17,654	66,844	65,177	204
205 UNIT COST MULT-WS B PT II	0.534730	96.500000	0.202810	0.467212	1.529115	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING 13	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS DEPARTMENT			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION	303,994		13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY		133,931,517	16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SERVICES-SALARY & FRINGES APPRVD			21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	242,145	72,979,710	30
ANCILLARY SERVICE COST CENTERS			
54 RADIOLOGY-DIAGNOSTIC		8,967	54
60 LABORATORY		5,401,056	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
66 PHYSICAL THERAPY		627,925	66
69 ELECTROCARDIOLOGY			69
73 DRUGS CHARGED TO PATIENTS		8,245,671	73
74 RENAL DIALYSIS			74
76 ELECTROSHOCK THERAPY		3,024,649	76
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
93 PARTIAL HOSPILIZATION	61,849	43,643,539	93
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	303,994	133,931,517	118
NONREIMBURSABLE COST CENTERS			
191 RESEARCH			191
192 PHYSICIANS' PRIVATE OFFICES			192
194 DUI PROGRAM			194
194.01 IPSS			194.01
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I	1,981,088	1,332,177	202
203 UNIT COST MULT-WS B PT I	6.516865	0.009947	203
204 COST TO BE ALLOC PER B PT II	26,849	40,994	204
205 UNIT COST MULT-WS B PT II	0.088321	0.000306	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	36,443,711		36,443,711		36,443,711	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	31,963		31,963		31,963	54
60 LABORATORY	1,200,415		1,200,415		1,200,415	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
66 PHYSICAL THERAPY	215,330		215,330		215,330	66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS	2,539,591		2,539,591		2,539,591	73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY	718,391		718,391		718,391	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTI						92
93 PARTIAL HOSPILIZATION	7,648,824		7,648,824		7,648,824	93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	48,798,225		48,798,225		48,798,225	200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	48,798,225		48,798,225		48,798,225	202

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 (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	72,979,710		72,979,710			30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	8,967		8,967	3.564514	3.564514	3.564514 54
60 LABORATORY	5,400,216	840	5,401,056	0.222256	0.222256	0.222256 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
66 PHYSICAL THERAPY	627,925		627,925	0.342923	0.342923	0.342923 66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS	7,113,966	1,131,705	8,245,671	0.307991	0.307991	0.307991 73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY	1,688,669	1,335,980	3,024,649	0.237512	0.237512	0.237512 76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTI						92
93 PARTIAL HOSPILIZATION		43,643,539	43,643,539	0.175257	0.175257	0.175257 93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	87,819,453	46,112,064	133,931,517			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	87,819,453	46,112,064	133,931,517			202

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK
 APPLICABLE
 BOXES

[] TITLE V
 [XX] TITLE XVIII-PT A
 [] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,842,498		1,842,498	47,690	38.63	17,770	686,455	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	1,842,498		1,842,498	47,690		17,770	686,455	200

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[XX] HOSPITAL (14-4031) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA				
		CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	404	8,967	0.045054	4,069	183	54	
60	LABORATORY	16,061	5,401,056	0.002974	2,167,431	6,446	60	
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30	
66	PHYSICAL THERAPY	2,972	627,925	0.004733	541,493	2,563	66	
69	ELECTROCARDIOLOGY						69	
73	DRUGS CHARGED TO PATIENTS	43,277	8,245,671	0.005248	3,715,280	19,498	73	
74	RENAL DIALYSIS						74	
76	ELECTROSHOCK THERAPY	23,611	3,024,649	0.007806	956,597	7,467	76	
76.97	CARDIAC REHABILITATION						76.97	
76.98	HYPERBARIC OXYGEN THERAPY						76.98	
76.99	LITHOTRIPSY						76.99	
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINC						92	
93	PARTIAL HOSPILIZATION	233,014	43,643,539	0.005339			93	
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94	
200	TOTAL (SUM OF LINES 50-199)	319,339	60,951,807		7,384,870	36,157	200	

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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	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

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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	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	47,690		17,770		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	47,690		17,770		200

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

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 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINC						92
93 PARTIAL HOSPILIZATION						93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

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 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (14-4031)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	8,967		4,069			54
60	LABORATORY	5,401,056		2,167,431			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
66	PHYSICAL THERAPY	627,925		541,493			66
69	ELECTROCARDIOLOGY						69
73	DRUGS CHARGED TO PATIENTS	8,245,671		3,715,280		414,732	73
74	RENAL DIALYSIS						74
76	ELECTROSHOCK THERAPY	3,024,649		956,597		681,830	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTIN						92
93	PARTIAL HOSPILIZATION	43,643,539				1,518,692	93
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	60,951,807		7,384,870		2,615,254	200

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK TITLE V - O/P HOSPITAL (14-4031) SUB (OTHER) S/B-SNF
 APPLICABLE TITLE XVIII-PT B IPF SNF S/B-NF
 BOXES TITLE XIX - O/P IRF NF ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
54 ANCILLARY SERVICE COST CENTERS								54
60 RADIOLOGY-DIAGNOSTIC LABORATORY	3.564514							60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS	0.222256							62.30
66 PHYSICAL THERAPY	0.342923							66
69 ELECTROCARDIOLOGY			4,208					69
73 DRUGS CHARGED TO PATIENTS	0.307991		414,732		127,734			73
74 RENAL DIALYSIS								74
76 ELECTROSHOCK THERAPY	0.237512		681,830		161,943			76
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
92 OUTPATIENT SERVICE COST CENTERS								92
93 OBSERVATION BEDS (NON-DISTINCT PARTIAL HOSPILIZATION)	0.175257		1,518,692		266,161			93
94 OTHER REIMBURSABLE COST CENTERS								94
200 HOME PROGRAM DIALYSIS								200
201 SUBTOTAL (SEE INSTRUCTIONS)			2,619,462		555,838			201
202 LESS PBP CLINIC LAB SERVICES								202
NET CHARGES (LINE 200 - LINE 201)			2,619,462		555,838			

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
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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	CAP-REL	SWING-BED	REDUCED	TOTAL	PER	INPAT	INPAT PGM
	(FROM WKST		COST		(COL.1 MINUS		DIEM
	B, PT. II,	ADJUSTMENT	COL.2)	PATIENT	(COL.3 ÷	DAYS	COL.6)
	COL. 26)			DAYS	COL.4)		
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,842,498		1,842,498	47,690	38.63	3,250	125,548 30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY							43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	1,842,498		1,842,498	47,690		3,250	125,548 200

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

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 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-4031) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC	404	8,967	0.045054		54
60 LABORATORY	16,061	5,401,056	0.002974		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
66 PHYSICAL THERAPY	2,972	627,925	0.004733		66
69 ELECTROCARDIOLOGY					69
73 DRUGS CHARGED TO PATIENTS	43,277	8,245,671	0.005248		73
74 RENAL DIALYSIS					74
76 ELECTROSHOCK THERAPY	23,611	3,024,649	0.007806		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS (NON-DISTINC					92
93 PARTIAL HOSPILIZATION	233,014	43,643,539	0.005339		93
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-199)	319,339	60,951,807			200

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
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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	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 11/17/2013 10:31

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	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS	47,690		3,250		31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
40 OTHER SPECIAL CARE (SPECIFY)					40
41 SUBPROVIDER - IPF					41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY					45
200 NURSING FACILITY					200
TOTAL (SUM OF LINES 30-199)	47,690		3,250		

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 11/17/2013 10:31

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINC						92
93 PARTIAL HOSPILIZATION						93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 11/17/2013 10:31

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (14-4031)	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[XX] TITLE XIX	[] IRF	[] NF		[XX] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	8,967					54
60	LABORATORY	5,401,056					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
66	PHYSICAL THERAPY	627,925					66
69	ELECTROCARDIOLOGY						69
73	DRUGS CHARGED TO PATIENTS	8,245,671					73
74	RENAL DIALYSIS						74
76	ELECTROSHOCK THERAPY	3,024,649					76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTIN						92
93	PARTIAL HOSPILIZATION	43,643,539					93
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	60,951,807					200

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[XX]	HOSPITAL (14-4031)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[]	SNF	[]		[]	TEFRA
BOXES	[]	TITLE XIX-INPT	[]	IRF	[]	NF	[]		[]	OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS										
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	47,690	1							
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	47,690	2							
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3							
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	47,690	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8							
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	17,770	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 (SEE INSTRUCTIONS)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13							
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14							
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15							
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16							
SWING-BED ADJUSTMENT										
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 (SEE INSTRUCTIONS)	36,443,711	21							
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22							
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23							
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24							
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25							
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26							
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	36,443,711	27							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT										
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28							
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29							
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30							
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31							
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32							
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33							
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34							
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35							
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36							
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	36,443,711	37							

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-4031) SUB (OTHER) PPS
 APPLICABLE TITLE XVIII-PT A IPF TEFRA
 BOXES TITLE XIX-INPT IRF OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 764.18 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 13,579,479 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 13,579,479 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					2,053,395 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					15,632,874 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 686,455 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 36,157 51
 52 TOTAL PROGRAM EXCLUDABLE COST 722,612 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 14,910,262 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 764.18 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST					90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-4031) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	47,690	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	47,690	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	47,690	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,250	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 (SEE INSTRUCTIONS)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
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 (SEE INSTRUCTIONS)	36,443,711	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	36,443,711	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	36,443,711	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-4031) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS 764.18 38
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,483,585 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 2,483,585 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
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42	NURSERY (TITLES V AND XIX ONLY)				42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				43
44	CORONARY CARE UNIT				44
45	BURN INTENSIVE CARE UNIT				45
46	SURGICAL INTENSIVE CARE UNIT				46
47	OTHER SPECIAL CARE (SPECIFY)				47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)				48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)				2,483,585 49

50	PASS-THROUGH COST ADJUSTMENTS				
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)				125,548 50
52	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)				51
53	TOTAL PROGRAM EXCLUDABLE COST				125,548 52
54	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)				53

54	TARGET AMOUNT AND LIMIT COMPUTATION				
55	PROGRAM DISCHARGES				54
56	TARGET AMOUNT PER DISCHARGE				55
57	TARGET AMOUNT (LINE 54 x LINE 55)				56
58	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT				57
59	BONUS PAYMENT (SEE INSTRUCTIONS)				58
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET				59
61	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET				60
62	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)				61
63	RELIEF PAYMENT (SEE INSTRUCTIONS)				62
64	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)				63

64	PROGRAM INPATIENT ROUTINE SWING BED COST				
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)				64
66	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)				65
67	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)				66
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)				67
69	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)				68
70	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)				69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)				87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)				88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)				89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
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90	CAPITAL-RELATED COST				90
91	NURSING SCHOOL COST				91
92	ALLIED HEALTH COST				92
93	ALL OTHER MEDICAL EDUCATION				93

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 11/17/2013 10:31

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-4031)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	S/B SNF	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input checked="" type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>	S/B NF	<input type="checkbox"/>	TEFRA
BOXES	<input type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		27,519,394		30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	3.564514	4,069	14,504	54
60 LABORATORY	0.222256	2,167,431	481,725	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66 PHYSICAL THERAPY	0.342923	541,493	185,690	66
69 ELECTROCARDIOLOGY				69
73 DRUGS CHARGED TO PATIENTS	0.307991	3,715,280	1,144,273	73
74 RENAL DIALYSIS				74
76 ELECTROSHOCK THERAPY	0.237512	956,597	227,203	76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS (NON-DISTINCT				92
93 PARTIAL HOSPILIZATION	0.175257			93
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		7,384,870	2,053,395	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		7,384,870		202

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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-4031)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	S/B SNF	<input type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>	S/B NF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>	ICF/MR	<input checked="" type="checkbox"/>	OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)	
			3	
INPATIENT ROUTINE SERVICE COST CENTERS				30
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	3.564514			54
60 LABORATORY	0.222256			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66 PHYSICAL THERAPY	0.342923			66
69 ELECTROCARDIOLOGY				69
73 DRUGS CHARGED TO PATIENTS	0.307991			73
74 RENAL DIALYSIS				74
76 ELECTROSHOCK THERAPY	0.237512			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS (NON-DISTINCT				92
93 PARTIAL HOSPITALIZATION	0.175257			93
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS BPP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

PROVIDER CCN: 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK HOSPITAL (14-4031) SUB (OTHER)
 APPLICABLE IPF SNF
 BOX: IRF SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		14,244,886		558,497
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
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		3.01
	.02			3.02
PROGRAM	.03			3.03
TO	.04			3.04
PROVIDER	.05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50	NONE		3.50
	.51			3.51
PROVIDER	.52			3.52
TO	.53			3.53
PROGRAM	.54			3.54
	.55			3.55
	.56			3.56
	.57			3.57
	.58			3.58
	.59			3.59
	.99			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		14,244,886		558,497
TO BE COMPLETED BY CONTRACTOR				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE
	TO .02			5.02
	PROVIDER .03			5.03
	.04			5.04
	.05			5.05
	.06			5.06
	.07			5.07
	.08			5.08
	.09			5.09
	PROVIDER .50	NONE		NONE
	TO .51			5.51
	PROGRAM .52			5.52
	.53			5.53
	.54			5.54
	.55			5.55
	.56			5.56
	.57			5.57
	.58			5.58
	.59			5.59
	.99			5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	59,551		6,566
	TO PROVIDER			6.01
	PROVIDER			
	TO			6.02
	PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		14,304,437		565,063
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

CHECK [XX] HOSPITAL (14-4031)
APPLICABLE BOX: [] IPF

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS)	15,016,931	1
2	NET IPF PPS OUTLIER PAYMENT	21,883	2
3	NET IPF PPS ECT PAYMENT	246,153	3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTES IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	130.657534	9
10	TEACHING ADJUSTMENT FACTOR $\{(1 + (\text{LINE 8/LINE 9})) \text{ RAISED TO THE POWER OF } .5150 - 1\}$		10
11	TEACHING ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	15,284,967	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	15,284,967	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	15,284,967	18
19	DEDUCTIBLES	884,920	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	14,400,047	20
21	COINSURANCE	242,012	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	14,158,035	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	209,146	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	146,402	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	182,110	25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	14,304,437	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IPF ONLY)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	14,304,437	31
31.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	71,522	31.01
32	INTERIM PAYMENTS	14,244,886	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)	-11,971	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35
TO BE COMPLETED BY CONTRACTOR			
50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-4031)	[]	SNF	[]	PPS
APPLICABLE	[XX]	TITLE XIX	[]	IPF	[]	NF	[]	TEFRA
BOXES:			[]	IRF	[]	ICF/MR	[XX]	OTHER
			[]	SUB (OTHER)				

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
1	COMPUTATION OF NET COST OF COVERED SERVICES			
2	INPATIENT HOSPITAL SNF/NF SERVICES	2,483,585		1
3	MEDICAL AND OTHER SERVICES			2
4	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
5	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	2,483,585		4
6	INPATIENT PRIMARY PAYER PAYMENTS			5
7	OUTPATIENT PRIMARY PAYER PAYMENTS			6
8	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	2,483,585		7
9	COMPUTATION OF LESSER OF COST OR CHARGES			
10	REASONABLE CHARGES			8
11	ROUTINE SERVICE CHARGES			9
12	ANCILLARY SERVICE CHARGES			10
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			11
14	INCENTIVE FROM TARGET AMOUNT COMPUTATION			12
15	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)			13
16	CUSTOMARY CHARGES			14
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			15
18	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)			16
19	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000	17
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			18
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))			19
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	2,483,585		20
23	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			21
24	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			22
25	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)			23
26	PROSPECTIVE PAYMENT AMOUNT			24
27	OTHER THAN OUTLIER PAYMENTS			25
28	OUTLIER PAYMENTS			26
29	PROGRAM CAPITAL PAYMENTS			27
30	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			28
31	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			29
32	SUBTOTAL (SUM OF LINES 22 THROUGH 26)			30
33	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)			31
34	SUM OF LINES 27 AND 21			32
35	COMPUTATION OF REIMBURSEMENT SETTLEMENT			33
36	EXCESS OF REASONABLE COST (FROM LINE 18)			34
37	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)			35
38	DEDUCTIBLES			36
39	COINSURANCE			37
40	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			38
41	UTILIZATION REVIEW			39
42	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)			40
43	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			41
44	SUBTOTAL (LINE 36 ± LINE 37)			42
45	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)			43
46	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)			
47	INTERIM PAYMENTS			
48	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)			
49	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,285,000			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	7,573,000			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	93,000			7
8	PREPAID EXPENSES				8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS	205,000			10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	10,156,000			11
FIXED ASSETS					
12	LAND	1,540,000			12
13	LAND IMPROVEMENTS	33,000			13
14	ACCUMULATED DEPRECIATION	-2,000			14
15	BUILDINGS	21,305,000			15
16	ACCUMULATED DEPRECIATION	-889,000			16
17	LEASEHOLD IMPROVEMENTS	616,000			17
18	ACCUMULATED AMORTIZATION	-55,000			18
19	FIXED EQUIPMENT	207,000			19
20	ACCUMULATED DEPRECIATION	-19,000			20
21	AUTOMOBILES AND TRUCKS	13,000			21
22	ACCUMULATED DEPRECIATION	-10,000			22
23	MAJOR MOVABLE EQUIPMENT	1,561,000			23
24	ACCUMULATED DEPRECIATION	-406,000			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE	3,000			29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	23,897,000			30
OTHER ASSETS					
31	INVESTMENTS	94,000			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	21,000			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	115,000			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	34,168,000			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	3,850,000			37
38	SALARIES, WAGES & FEES PAYABLE				38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	7,321,000			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	11,171,000			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	1,783,000			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	1,783,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	12,954,000			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	21,214,000			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	21,214,000			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	34,168,000			60

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	72,979,000		72,979,000	2
3 SUBPROVIDER IPF				3
4 SUBPROVIDER IRF				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 (SUM OF LINES 1-9)	72,979,000		72,979,000	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
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	72,979,000		72,979,000	17
18 ANCILLARY SERVICES	14,840,000	2,469,000	17,309,000	18
19 OUTPATIENT SERVICES		43,643,000	43,643,000	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 RESEARCH	1,065,000		1,065,000	27
27.01 PHYSICIAN PRIVATE OFFICE		13,796,000	13,796,000	27.01
27.02 OTHER NRCC		61,000	61,000	27.02
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	88,884,000	59,969,000	148,853,000	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		71,711,793	29
30 ROUNDING	207		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		207	36
37 DEDUCT (SPECIFY)			37
38 BAD DEBTS	-2,061,000		38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-2,061,000	42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		69,651,000	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	148,853,000	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	82,774,000	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	66,079,000	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	69,651,000	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-3,572,000	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	2,000	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		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	180,000	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE 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		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (CAPITATION REVENUE)	603,000	24
24.01	OTHER (SCHOOL EDUCATION REIMBURSEMENT)	1,254,000	24.01
24.02	OTHER (BUSINESS DEVELOPMENT)	69,000	24.02
24.03	OTHER (RESTRICTED FUNDS)	244,000	24.03
24.04	OTHER (CLINICAL RESEARCH)	2,150,000	24.04
24.05	OTHER (MISC REVENUE)	225,000	24.05
24.06	OTHER (IPPS REVENUE)	379,000	24.06
24.07	OTHER (ABMP PROFESSIONAL FEES)	15,000	24.07
24.08	OTHER (INTERNS AND RESIDENTS)	361,000	24.08
24.09	OTHER (INTAKE)	356,000	24.09
24.10	OTHER (ECT PUBLIC AID)	36,000	24.10
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	5,874,000	25
26	TOTAL (LINE 5 PLUS LINE 25)	2,302,000	26
27	OTHER EXPENSES (RECONCILING AMOUNT)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	2,302,000	29

COST CENTER		---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	1,096,756	1.63	-1,096,756	-3.29			1
2	CAP REL COSTS-MVBLE EQUIP	1,641,957	2.45	-1,641,957	-4.92			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	4,145,236	6.17	-4,145,236	-12.42			4
5	ADMINISTRATIVE & GENERAL	19,968,140	29.74	-19,968,140	-59.84			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,797,473	2.68	-1,797,473	-5.39			7
8	LAUNDRY & LINEN SERVICE	200,000	0.30	-200,000	-0.60			8
9	HOUSEKEEPING	765,888	1.14	-765,888	-2.30			9
10	DIETARY	1,544,461	2.30	-1,544,461	-4.63			10
11	CAFETERIA	207,777	0.31	-207,777	-0.62			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,205,437	1.80	-1,205,437	-3.61			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	795,719	1.18	-795,719	-2.38			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES A							21
22	I&R SERVICES-OTHER PRGM COSTS A							22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	16,455,566	24.50	19,988,145	59.90	36,443,711	54.27	30
ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	21,650	0.03	10,313	0.03	31,963	0.05	54
60	LABORATORY	778,872	1.16	421,543	1.26	1,200,415	1.79	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY	127,608	0.19	87,722	0.26	215,330	0.32	66
69	ELECTROCARDIOLOGY							69
73	DRUGS CHARGED TO PATIENTS	1,645,860	2.45	893,731	2.68	2,539,591	3.78	73
74	RENAL DIALYSIS							74
76	ELECTROSHOCK THERAPY	394,685	0.59	323,706	0.97	718,391	1.07	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
92	OBSERVATION BEDS (NON-DISTINCT							92
93	PARTIAL HOSPILIZATION	3,906,812	5.82	3,742,012	11.21	7,648,824	11.39	93
OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS							94
OUTPATIENT SERVICE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
191	RESEARCH	2,137,853	3.18	1,292,960	3.87	3,430,813	5.11	191
192	PHYSICIANS' PRIVATE OFFICES	7,464,439	11.12	6,057,363	18.15	13,521,802	20.14	192
194	DUI PROGRAM	68,042	0.10	43,921	0.13	111,963	0.17	194
194.01	IPPS	783,212	1.17	507,428	1.52	1,290,640	1.92	194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	67,153,443	100.00			67,153,443	100.00	202

PROVIDER NO. 14-4031 ALEXIAN BROTHERS BEHAVIORAL HE
 PERIOD FROM 07/01/2012 TO 06/30/2013

KPMG LLP COMPU-MAX MICRO SYSTEM

VERSION: 2013.11
 11/17/2013

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	404	8,967	0.045054	4,069	183	54
60 LABORATORY	16,061	5,401,056	0.002974	2,167,431	6,446	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66 PHYSICAL THERAPY	2,972	627,925	0.004733	541,493	2,563	66
69 ELECTROCARDIOLOGY						69
73 DRUGS CHARGED TO PATIENTS	43,277	8,245,671	0.005248	3,715,280	19,498	73
74 RENAL DIALYSIS						74
76 ELECTROSHOCK THERAPY	23,611	3,024,649	0.007806	956,597	7,467	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT						92
93 PARTIAL HOSPITALIZATION	233,014	43,643,539	0.005339			93
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL	319,339	60,951,807		7,384,870	36,157	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	REDUCED CAPITAL RELATED COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	1,842,498		1,842,498	47,690	38.63	17,770	686,455 30
200	TOTAL	1,842,498		1,842,498	47,690		17,770	686,455 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								686,455
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								36,157
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								722,612
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								1,391
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								17,770
PER DISCHARGE CAPITAL COSTS								519.49
PER DIEM CAPITAL COSTS								40.66

I. COST TO CHARGE RATIO FOR FREESTANDING IPF

1.	TOTAL MEDICARE COSTS	15,632,874
	(WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 9 LINES 30-35 + WKST D PART IV COL 11 LINE 200))	
2.	TOTAL MEDICARE CHARGES	34,904,264
	(WKST D-3 COLUMN 2 LINES 30-35 + LINE 202)	
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.448

II. COST TO CHARGE RATIO FOR CAPITAL

1.	TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS	722,612
	(WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	
2.	RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.021

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, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	555,838
2.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	2,619,462
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.212