

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).  
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE  
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS  
(42 USC 1395g).

FORM APPROVED  
OMB NO. 0938-0050

WORKSHEET S  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-3300	I	FROM 7/ 1/2006	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 6/30/2007	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/28/2007 TIME 13:46

PART I - 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 BY 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: ST. VINCENT PEDIATRIC REHAB CENTER 15-3300 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2006 AND ENDING 6/30/2007 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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ECR ENCRYPTION INFORMATION  
DATE: 11/28/2007 TIME 13:46  
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*Paul Jordan*  
\_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
*SUP-Finance/CFO*  
\_\_\_\_\_  
TITLE  
*11/28/07*  
\_\_\_\_\_  
DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
1 HOSPITAL	1	2	0	3	4	0
	0		0		0	0

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 662 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: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS  
 1 STREET: 1707 WEST 86TH STREET P.O. BOX:  
 1.01 CITY: INDIANAPOLIS STATE: IN ZIP CODE: 46260- COUNTY: MARION

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)		
02.00	HOSPITAL	15-3300	2.01	9/15/1989	V	XVIII	XIX
	ST. VINCENT PEDIATRIC REHAB CENTER				4	5	6
					N	0	0

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2006 TO: 6/30/2007

18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 7  
 20 SUBPROVIDER

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS). N
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N Y
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. Y
- 2 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 3 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 3.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. // //
- 3.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. // //
- 3.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. // //
- 3.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. // //
- 3.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE // //
- 3.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. // //
- 3.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. // //
- 4 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2. // //
- 5 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N
- 5.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N
- 5.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.
- 5.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.
- 5.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
- 5.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) N N
- 5.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS) N N
- 6 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. N N
- 6.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: // // ENDING: // //
- 6.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: // // ENDING: // //
- 7 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. N // //

28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02				
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1	2	3	4
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0	0.0000	0.0000	
	A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)		%	Y/N	
28.03	STAFFING		0.00%		
28.04	RECRUITMENT		0.00%		
28.05	RETENTION		0.00%		
28.06	TRAINING		0.00%		
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	N			
30	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N			
30.01	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)				
30.02	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBLIE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).				
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBLIE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II				
30.04	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
11	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
11.01	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
11.02	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
11.03	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				
11.04	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				
11.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				
	ISCELLANEOUS COST REPORT INFORMATION				
2	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N			
3	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N			
4	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N			
5	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
5.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
5.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
5.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?				
5.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?				
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	V	XVIII	XIX	
6	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	1	2	3	
6.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	Y	N	
7	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N	
7.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N	

TITLE XIX INPATIENT SERVICES

- 38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N  
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N  
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N  
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N  
 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?  
 IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER.  
 IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y  
 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #  
 40.02 STREET: P.O. BOX:  
 40.03 CITY: STATE: ZIP CODE: -  
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? N  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.  
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?  
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?  
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)  
 DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

- |   | PART A | PART B | ASC | RADIOLOGY | DIAGNOSTIC |           |        |       |        |      |
|---|--------|--------|-----|-----------|------------|-----------|--------|-------|--------|------|
|   | 1      | 2      | 3   | 4         | 5          |           |        |       |        |      |
| 7.00 HOSPITAL   | N      | N      | N   | N         | N          |           |        |       |        |      |
| 2 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)  |        |        |     |           |            |           |        |       |        |      |
| 2.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV  |        |        |     |           |            |           |        |       |        |      |
| 3 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.   |        |        |     |           |            |           |        |       |        |      |
| 3.01 MDH PERIOD: BEGINNING: / / ENDING: / /   |        |        |     |           |            |           |        |       |        |      |
| 4 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:<br>PREMIUMS: 0<br>PAID LOSSES: 0<br>AND/OR SELF INSURANCE: 0  |        |        |     |           |            |           |        |       |        |      |
| 4.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.   |        |        |     |           |            |           |        |       |        |      |
| 5 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.  |        |        |     |           |            |           |        |       |        |      |
| 6 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.  |        |        |     |           |            | DATE      | Y OR N | LIMIT | Y OR N | FEES |
|   |        |        |     |           |            | 0         | 1      | 2     | 3      | 4    |
| 6.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.   |        |        |     |           |            | 7/ 1/2006 | N      | 0.00  |        | 0    |
| 5.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.   |        |        |     |           |            |           |        | 0.00  |        | 0    |
| 5.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.  |        |        |     |           |            |           |        | 0.00  |        | 0    |
| 7 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?   |        |        |     |           |            |           |        |       |        |      |
| 3 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.   |        |        |     |           |            |           |        |       |        |      |
| 3.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). |        |        |     |           |            |           |        |       |        | 0    |
| ) ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)   |        |        |     |           |            |           |        |       |        |      |
| ) ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)   |        |        |     |           |            |           |        |       |        |      |
| 1.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). |        |        |     |           |            |           |        |       |        | 0    |

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH N/A	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	1	20	2.01	3	4	4.01	5
2 HMO							1,199
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	20	7,300					
6 INTENSIVE CARE UNIT							1,199
12 TOTAL	20	7,300					
13 RPCH VISITS							1,199
25 TOTAL	20						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED	DISCHARGES / TITLE XVIII NOT ADMITTED	INTERNS & RES. FTES TOTAL	LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			1,963				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			1,963				
6 INTENSIVE CARE UNIT							
12 TOTAL			1,963				
13 RPCH VISITS							
25 TOTAL							
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET	--- FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES / TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO						74	120
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
12 TOTAL		63.00				74	120
13 RPCH VISITS							
25 TOTAL		63.00					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
1	0100 GENERAL SERVICE COST CNTR					
2	0200 OLD CAP REL COSTS-BLDG & FIXT					
3	0300 NEW CAP REL COSTS-BLDG & FIXT					
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				375,346	375,346
5	0500 EMPLOYEE BENEFITS	42,028	1,007,873	1,049,901	114,881	114,881
6	0600 ADMINISTRATIVE & GENERAL	782,158	316,564	1,098,722	-27,863	1,049,901
8	0800 OPERATION OF PLANT	197,803	739,651	937,454	-385,326	1,070,859
9	0900 LAUNDRY & LINEN SERVICE					552,128
10	1000 HOUSEKEEPING					
11	1100 DIETARY					
12	1200 CAFETERIA	68,516	28,410	96,926	-985	95,941
13	1300 MAINTENANCE OF PERSONNEL					
14	1400 NURSING ADMINISTRATION	56,271	16,269	72,540		72,540
15	1500 CENTRAL SERVICES & SUPPLY					
16	1600 PHARMACY	58,164	66,938	125,102	-17,103	107,999
17	1700 MEDICAL RECORDS & LIBRARY	47	2,675	2,722		2,722
18	1800 SOCIAL SERVICE	89,008	66,822	155,830	-87	155,743
25	2500 INPAT ROUTINE SRVC CNTRS					
26	2600 ADULTS & PEDIATRICS	1,015,870	45,243	1,061,113	-32,704	1,028,409
	2600 INTENSIVE CARE UNIT					
	2600 ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM					
41	4100 RADIOLOGY-DIAGNOSTIC					
42	4200 RADIOLOGY-THERAPEUTIC				11,325	11,325
43	4300 RADIOISOTOPE					
44	4400 LABORATORY					
49	4900 RESPIRATORY THERAPY	284,134	21,501	21,501		21,501
50	5000 PHYSICAL THERAPY	616,718	51,918	336,052	-23,047	313,005
51	5100 OCCUPATIONAL THERAPY	313,521	65,033	681,751	-8,576	673,175
52	5200 SPEECH PATHOLOGY	349,864	6,215	319,736		319,736
53	5300 ELECTROCARDIOLOGY		2,250	352,114		352,114
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	5600 DRUGS CHARGED TO PATIENTS					
60	6000 OUTPAT SERVICE COST CNTRS					
61	6100 CLINIC					
62	6200 EMERGENCY					
	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	6200 OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES					
	6500 SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		5,861	5,861	-5,861	
95	9500 SUBTOTALS	3,874,102	2,443,223	6,317,325	-0-	6,317,325
96	9600 NONREIMBURS COST CENTERS					
97	9700 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 RESEARCH					
99	9900 PHYSICIANS' PRIVATE OFFICES					
101.	9900 NONPAID WORKERS					
	TOTAL	3,874,102	2,443,223	6,317,325	-0-	6,317,325



LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
2	OLD CAP REL COSTS-MVBLE EQUIP	0200	
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
13	MAINTENANCE OF PERSONNEL	1300	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
101.	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:  
153300

PERIOD:  
FROM 7/ 1/2006  
TO 6/30/2007

PREPARED 11/28/2007  
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 RENT EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		71,867
2					
3					
4					
5					
6					
7 INSURANCE EXPENSE	B	NEW CAP REL COSTS-MVBLE EQUIP	4		9,991
8 DEPRECIATION	C	NEW CAP REL COSTS-BLDG & FIXT	3		375,346
9		NEW CAP REL COSTS-MVBLE EQUIP	4		27,162
10					
11					
12					
13 RADIOLOGY EXPENSE	D	RADIOLOGY-DIAGNOSTIC	41		11,325
14 INTEREST EXPENSE	E	NEW CAP REL COSTS-MVBLE EQUIP	4		5,861
36 TOTAL RECLASSIFICATIONS					501,552

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate. See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF
			LINE NO	7			
1 RENT EXPENSE	A	ADULTS & PEDIATRICS	25			5,724	14
2		PHARMACY	16			17,103	
3		RESPIRATORY THERAPY	49			23,047	
4		PHYSICAL THERAPY	50			8,576	
5		OPERATION OF PLANT	8			17,039	
6		ADMINISTRATIVE & GENERAL	6			378	
7 INSURANCE EXPENSE	B	ADMINISTRATIVE & GENERAL	6			9,991	12
8 DEPRECIATION	C	ADULTS & PEDIATRICS	25			15,655	9
9		SOCIAL SERVICE	18			87	9
10		DIETARY	11			985	
11		OPERATION OF PLANT	8			368,287	
12		ADMINISTRATIVE & GENERAL	6			17,494	
13 RADIOLOGY EXPENSE	D	ADULTS & PEDIATRICS	25			11,325	
14 INTEREST EXPENSE	E	INTEREST EXPENSE	88			5,861	11
36 TOTAL RECLASSIFICATIONS						501,552	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.  
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.  
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A  
 EXPLANATION : RENT EXPENSE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	71,867	ADULTS & PEDIATRICS	25	5,724	
2.00			0	PHARMACY	16	17,103	
3.00			0	RESPIRATORY THERAPY	49	23,047	
4.00			0	PHYSICAL THERAPY	50	8,576	
5.00			0	OPERATION OF PLANT	8	17,039	
6.00			0	ADMINISTRATIVE & GENERAL	6	378	
TOTAL RECLASSIFICATIONS FOR CODE A			71,867				71,867

RECLASS CODE: B  
 EXPLANATION : INSURANCE EXPENSE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	9,991	ADMINISTRATIVE & GENERAL	6	9,991	
TOTAL RECLASSIFICATIONS FOR CODE B			9,991				9,991

RECLASS CODE: C  
 EXPLANATION : DEPRECIATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	375,346	ADULTS & PEDIATRICS	25	15,655	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	27,162	SOCIAL SERVICE	18	87	
3.00			0	DIETARY	11	985	
4.00			0	OPERATION OF PLANT	8	368,287	
5.00			0	ADMINISTRATIVE & GENERAL	6	17,494	
TOTAL RECLASSIFICATIONS FOR CODE C			402,508				402,508

RECLASS CODE: D  
 EXPLANATION : RADIOLOGY EXPENSE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	RADIOLOGY-DIAGNOSTIC	41	11,325	ADULTS & PEDIATRICS	25	11,325	
TOTAL RECLASSIFICATIONS FOR CODE D			11,325				11,325

RECLASS CODE: E  
 EXPLANATION : INTEREST EXPENSE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	5,861	INTEREST EXPENSE	88	5,861	
TOTAL RECLASSIFICATIONS FOR CODE E			5,861				5,861

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
1	LAND	690,000						690,000	
2	LAND IMPROVEMENTS	29,432						29,432	
3	BUILDINGS & FIXTURE	2,976,034						2,976,034	
4	BUILDING IMPROVEMEN	1,404,155	9,718		9,718			1,413,873	23,778
5	FIXED EQUIPMENT	555,962						1,413,873	
6	MOVABLE EQUIPMENT	721,313	32,819		32,819	71,554	484,408	484,408	
7	SUBTOTAL	6,376,896	42,537		42,537	584,819	169,313	69,960	69,960
8	RECONCILING ITEMS					656,373	5,763,060	93,738	93,738
9	TOTAL	6,376,896	42,537		42,537	656,373	5,763,060	93,738	93,738

ART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS CAPITIALIZED GROSS ASSETS		RATIO 4	ALLOCATION OF OTHER CAPITAL			TOTAL 8
			LEASES 2	FOR RATIO 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
1	OLD CAP REL COSTS-BL								
2	OLD CAP REL COSTS-MV								
3	NEW CAP REL COSTS-BL	5,593,747		5,593,747	.970621				
4	NEW CAP REL COSTS-MV	169,313		169,313	.029379				
5	TOTAL	5,763,060		5,763,060	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	375,346					80,062	455,408
4	NEW CAP REL COSTS-MV	27,162			9,991		71,867	109,020
5	TOTAL	402,508			9,991		151,929	564,428

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV							
5	TOTAL							

1) All lines numbers except line 5 are to be consistent with workshseet A line numbers for capital cost centers.  
 The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4.  
 Columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

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	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.	
1	2	3	4	5	6		
1	3	NEW CAP REL COSTS-BLDG &	ST. VINCENT HEALTH	80,062		80,062	14
2	6	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH	503,875		503,875	
3	5	EMPLOYEE BENEFITS	ST. VINCENT HEALTH	33,843	30,587	3,256	
4	5	EMPLOYEE BENEFITS	ST. VINCENT HEALTH	571,471	233,736	337,735	
5		TOTALS		1,189,251	264,323	924,928	

\* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO 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.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES 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	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	G	0.00	ASCENSION HEALTH	100.00	HOME OFFICE
2	G	0.00	ST. VINCENT HEALTH	100.00	PARENT COMPANY
3		0.00		0.00	
4		0.00		0.00	
5		0.00		0.00	

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
  - B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
  - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
  - D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A 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.

ADJUSTMENTS TO EXPENSES

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO	
1 INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-5,861	NEW CAP REL COSTS-MVBLE E	4	11
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2				
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	924,928			
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-7,029	DIETARY	11	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-140	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES	B	-3,105	ADMINISTRATIVE & GENERAL	6	
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 FAMILY ASSISTANCE	A	-10,436	SOCIAL SERVICE	18	
38					
39					
40					
41					
42 FEE-FOR-SERVICE REVENUE	B	-900	SPEECH PATHOLOGY	52	
43 FEE-FOR-SERVICE REVENUE	B	-900	OCCUPATIONAL THERAPY	51	
44 OTHER REVENUE	B	-3,680	ADMINISTRATIVE & GENERAL	6	
45 LOCKBOX REVENUE	B	-335	ADMINISTRATIVE & GENERAL	6	
46 OTHER ADJUSTMENTS (SPECIFY)					
47 OTHER ADJUSTMENTS (SPECIFY)					
48 OTHER ADJUSTMENTS (SPECIFY)					
49 OTHER ADJUSTMENTS (SPECIFY)					
50 TOTAL (SUM OF LINES 1 THRU 49)		892,542			

- 1) Description - all chapter references in this column pertain to CMS Pub. 15-I.  
 2) Basis for adjustment (see instructions).  
 A. Costs - if cost, including applicable overhead, can be determined.  
 B. Amount Received - if cost cannot be determined.  
 3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.  
 Note: See instructions for column 5 referencing to Worksheet A-7

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	NOT ENTERED
2	OLD CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	NOT ENTERED
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	4	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	7	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	NOT ENTERED
10	HOUSEKEEPING	9	HOURS OF SERVICE	NOT ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	MEALS SERVED	NOT ENTERED
13	MAINTENANCE OF PERSONNEL	12	NUMBER HOUSED	NOT ENTERED
14	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	ENTERED
16	PHARMACY	15	COSTED REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	PATIENT DAYS	ENTERED
18	SOCIAL SERVICE	16	PATIENT DAYS	ENTERED

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	0	1	2	3	4	5	SUBTOTAL
GENERAL SERVICE COST CNTR								5a.00
001 OLD CAP REL COSTS-BLDG &								
002 OLD CAP REL COSTS-MVBLE E								
003 NEW CAP REL COSTS-BLDG &	455,408				455,408			
004 NEW CAP REL COSTS-MVBLE E	109,020					109,020		
005 EMPLOYEE BENEFITS	1,390,892				4,478	1,072	1,396,442	
006 ADMINISTRATIVE & GENERAL	1,567,614				70,673	16,918	285,025	1,940,230
008 OPERATION OF PLANT	552,128				82,326	19,708	72,081	726,243
009 LAUNDRY & LINEN SERVICE								
010 HOUSEKEEPING								
011 DIETARY	88,912				24,860	5,951	24,968	144,691
012 CAFETERIA								
013 MAINTENANCE OF PERSONNEL								
014 NURSING ADMINISTRATION	72,540							
015 CENTRAL SERVICES & SUPPLY							20,506	93,046
016 PHARMACY	107,999							
017 MEDICAL RECORDS & LIBRARY	2,582				6,078	1,455	21,195	136,727
018 SOCIAL SERVICE	145,307				6,306	1,510	17	10,415
INPAT ROUTINE SRVC CNTRS					22,804	5,459	32,435	206,005
025 ADULTS & PEDIATRICS	1,028,409							
026 INTENSIVE CARE UNIT					141,664	33,914	370,192	1,574,179
ANCILLARY SRVC COST CNTRS								
037 OPERATING ROOM								
041 RADIOLOGY-DIAGNOSTIC	11,325							
042 RADIOLOGY-THERAPEUTIC								11,325
043 RADIOISOTOPE								
044 LABORATORY	21,501							
049 RESPIRATORY THERAPY	313,005							21,501
050 PHYSICAL THERAPY	673,175				4,410	1,056	103,541	422,012
051 OCCUPATIONAL THERAPY	318,836				40,078	9,594	224,738	947,585
052 SPEECH PATHOLOGY	351,214				34,594	8,281	114,250	475,961
053 ELECTROCARDIOLOGY					17,137	4,102	127,494	499,947
054 ELECTROENCEPHALOGRAPHY								
055 MEDICAL SUPPLIES CHARGED								
056 DRUGS CHARGED TO PATIENTS								
OUTPAT SERVICE COST CNTRS								
360 CLINIC								
361 EMERGENCY								
362 OBSERVATION BEDS (NON-DIS								
OTHER REIMBURS COST CNTRS								
365 AMBULANCE SERVICES								
SPEC PURPOSE COST CENTERS								
395 SUBTOTALS	7,209,867				455,408	109,020	1,396,442	7,209,867
NONREIMBURS COST CENTERS								
396 GIFT, FLOWER, COFFEE SHOP								
397 RESEARCH								
398 PHYSICIANS' PRIVATE OFFIC								
399 NONPAID WORKERS								
101 CROSS FOOT ADJUSTMENT								
102 NEGATIVE COST CENTER								
103 TOTAL	7,209,867				455,408	109,020	1,396,442	7,209,867

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL
	6	8	9	10	11	12	13
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL	1,940,230						
009 OPERATION OF PLANT	267,395	993,638					
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY	53,274	82,911			280,876		
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	34,259						
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY	50,342	20,271					
018 MEDICAL RECORDS & LIBRARY	3,835	21,033					
025 SOCIAL SERVICE	75,849	76,053					
026 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	579,599	472,470			280,876		
026 INTENSIVE CARE UNIT							
037 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM							
042 RADIOLOGY-DIAGNOSTIC	4,170						
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
049 LABORATORY	7,916						
050 RESPIRATORY THERAPY	155,381	14,708					
051 PHYSICAL THERAPY	348,891	133,664					
052 OCCUPATIONAL THERAPY	175,244	115,374					
053 SPEECH PATHOLOGY	184,075	57,154					
054 ELECTROCARDIOLOGY							
055 ELECTROENCEPHALOGRAPHY							
056 MEDICAL SUPPLIES CHARGED							
060 DRUGS CHARGED TO PATIENTS							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
062 EMERGENCY							
065 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS							
095 AMBULANCE SERVICES							
095 SPEC PURPOSE COST CENTERS							
096 SUBTOTALS	1,940,230	993,638			280,876		
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	1,940,230	993,638			280,876		

COST CENTER DESCRIPTION	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ 26
	14	15	16	17	18	25	
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA							
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	127,305						
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY			207,340				
017 MEDICAL RECORDS & LIBRARY				35,283			
018 SOCIAL SERVICE	5,055				362,962		
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	46,138			35,283	362,962	3,351,507	
026 INTENSIVE CARE UNIT							
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM							
041 RADIOLOGY-DIAGNOSTIC						15,495	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY						29,417	
049 RESPIRATORY THERAPY	13,208					605,309	
050 PHYSICAL THERAPY	30,895					1,461,035	
051 OCCUPATIONAL THERAPY	15,725					782,304	
052 SPEECH PATHOLOGY	16,284					757,460	
053 ELECTROCARDIOLOGY							
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS			207,340			207,340	
060 OUTPAT SERVICE COST CNTRS CLINIC							
061 EMERGENCY							
062 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES							
095 SPEC PURPOSE COST CENTERS							
096 SUBTOTALS	127,305		207,340	35,283	362,962	7,209,867	
097 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP							
099 RESEARCH							
101 PHYSICIANS' PRIVATE OFFIC							
102 NONPAID WORKERS							
103 CROSS FOOT ADJUSTMENT							
104 NEGATIVE COST CENTER							
105 TOTAL	127,305		207,340	35,283	362,962	7,209,867	

COST CENTER DESCRIPTION		TOTAL
	GENERAL SERVICE COST CNTR	27
001	OLD CAP REL COSTS-BLDG &	
002	OLD CAP REL COSTS-MVBLE E	
003	NEW CAP REL COSTS-BLDG &	
004	NEW CAP REL COSTS-MVBLE E	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENERAL	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
013	MAINTENANCE OF PERSONNEL	
014	NURSING ADMINISTRATION	
015	CENTRAL SERVICES & SUPPLY	
016	PHARMACY	
017	MEDICAL RECORDS & LIBRARY	
018	SOCIAL SERVICE	
025	INPAT ROUTINE SRVC CNTRS	
026	ADULTS & PEDIATRICS	3,351,507
026	INTENSIVE CARE UNIT	
026	ANCILLARY SRVC COST CNTRS	
037	OPERATING ROOM	
041	RADIOLOGY-DIAGNOSTIC	15,495
042	RADIOLOGY-THERAPEUTIC	
043	RADIOISOTOPE	
044	LABORATORY	29,417
049	RESPIRATORY THERAPY	605,309
050	PHYSICAL THERAPY	1,461,035
051	OCCUPATIONAL THERAPY	782,304
052	SPEECH PATHOLOGY	757,460
053	ELECTROCARDIOLOGY	
054	ELECTROENCEPHALOGRAPHY	
055	MEDICAL SUPPLIES CHARGED	
056	DRUGS CHARGED TO PATIENTS	207,340
056	OUTPAT SERVICE COST CNTRS	
060	CLINIC	
061	EMERGENCY	
062	OBSERVATION BEDS (NON-DIS	
062	OTHER REIMBURS COST CNTRS	
065	AMBULANCE SERVICES	
065	SPEC PURPOSE COST CENTERS	
095	SUBTOTALS	7,209,867
095	NONREIMBURS COST CENTERS	
096	GIFT, FLOWER, COFFEE SHOP	
097	RESEARCH	
098	PHYSICIANS' PRIVATE OFFIC	
099	NONPAID WORKERS	
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	TOTAL	7,209,867

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS 0	OLD CAP REL COSTS-BLDG & OSTS 1	OLD CAP REL COSTS-MVBLE E 2	NEW CAP REL COSTS-BLDG & OSTS 3	NEW CAP REL COSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENEFITS 5
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS				4,478	1,072	5,550	5,550
008 ADMINISTRATIVE & GENERAL				70,673	16,918	87,591	1,133
009 OPERATION OF PLANT				82,326	19,708	102,034	286
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY				24,860	5,951	30,811	99
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION							81
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY				6,078	1,455	7,533	84
018 MEDICAL RECORDS & LIBRARY				6,306	1,510	7,816	
025 SOCIAL SERVICE				22,804	5,459	28,263	129
026 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS				141,664	33,914	175,578	1,473
037 INTENSIVE CARE UNIT							
041 ANCILLARY SRVC COST CNTRS							
042 OPERATING ROOM							
043 RADIOLOGY-DIAGNOSTIC							
044 RADIOLOGY-THERAPEUTIC							
049 RADIOISOTOPE							
050 LABORATORY							
051 RESPIRATORY THERAPY				4,410	1,056	5,466	411
052 PHYSICAL THERAPY				40,078	9,594	49,672	893
053 OCCUPATIONAL THERAPY				34,594	8,281	42,875	454
054 SPEECH PATHOLOGY				17,137	4,102	21,239	507
055 ELECTROCARDIOLOGY							
056 ELECTROENCEPHALOGRAPHY							
060 MEDICAL SUPPLIES CHARGED							
061 DRUGS CHARGED TO PATIENTS							
062 OUTPAT SERVICE COST CNTRS							
065 CLINIC							
095 EMERGENCY							
096 OBSERVATION BEDS (NON-DIS							
097 OTHER REIMBURS COST CNTRS							
098 AMBULANCE SERVICES							
099 SPEC PURPOSE COST CENTERS							
101 SUBTOTALS				455,408	109,020	564,428	5,550
102 NONREIMBURS COST CENTERS							
103 GIFT, FLOWER, COFFEE SHOP							
RESEARCH							
PHYSICIANS' PRIVATE OFFIC							
NONPAID WORKERS							
CROSS FOOT ADJUSTMENTS							
NEGATIVE COST CENTER							
TOTAL				455,408	109,020	564,428	5,550

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL
	6	8	9	10	11	12	13
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL	88,724						
009 OPERATION OF PLANT	12,228	114,548					
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY	2,436	9,558			42,904		
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	1,567						
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY	2,302	2,337					
018 MEDICAL RECORDS & LIBRARY	175	2,425					
025 SOCIAL SERVICE	3,469	8,767					
026 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	26,503	54,466			42,904		
026 INTENSIVE CARE UNIT							
037 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM							
042 RADIOLOGY-DIAGNOSTIC	191						
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
044 LABORATORY	362						
049 RESPIRATORY THERAPY	7,105	1,696					
050 PHYSICAL THERAPY	15,954	15,409					
051 OCCUPATIONAL THERAPY	8,014	13,301					
052 SPEECH PATHOLOGY	8,418	6,589					
053 ELECTROCARDIOLOGY							
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
062 EMERGENCY							
062 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES							
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	88,724	114,548			42,904		
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	88,724	114,548			42,904		

	COST CENTER DESCRIPTION	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT
		14	15	16	17	18	25	26
001	GENERAL SERVICE COST CNTR							
002	OLD CAP REL COSTS-BLDG &							
003	OLD CAP REL COSTS-MVBLE E							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING							
011	DIETARY							
012	CAFETERIA							
013	MAINTENANCE OF PERSONNEL							
014	NURSING ADMINISTRATION	1,648						
015	CENTRAL SERVICES & SUPPLY							
016	PHARMACY			12,256				
017	MEDICAL RECORDS & LIBRARY				10,416			
018	SOCIAL SERVICE	65				40,693		
025	INPAT ROUTINE SRVC CNTRS							
026	ADULTS & PEDIATRICS	597			10,416	40,693	352,630	
026	INTENSIVE CARE UNIT							
026	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM							
041	RADIOLOGY-DIAGNOSTIC						191	
042	RADIOLOGY-THERAPEUTIC							
043	RADIOISOTOPE							
044	LABORATORY						362	
049	RESPIRATORY THERAPY	171					14,849	
050	PHYSICAL THERAPY	400					82,328	
051	OCCUPATIONAL THERAPY	204					64,848	
052	SPEECH PATHOLOGY	211					36,964	
053	ELECTROCARDIOLOGY							
054	ELECTROENCEPHALOGRAPHY							
055	MEDICAL SUPPLIES CHARGED							
056	DRUGS CHARGED TO PATIENTS			12,256			12,256	
056	OUTPUT SERVICE COST CNTRS							
060	CLINIC							
061	EMERGENCY							
062	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES							
065	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	1,648		12,256	10,416	40,693	564,428	
096	NONREIMBURS COST CENTERS							
097	GIFT, FLOWER, COFFEE SHOP							
097	RESEARCH							
098	PHYSICIANS' PRIVATE OFFIC							
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	1,648		12,256	10,416	40,693	564,428	

COST CENTER DESCRIPTION	TOTAL
	27
001 GENERAL SERVICE COST CNTR	
002 OLD CAP REL COSTS-BLDG &	
003 OLD CAP REL COSTS-MVBLE E	
004 NEW CAP REL COSTS-BLDG &	
005 NEW CAP REL COSTS-MVBLE E	
006 EMPLOYEE BENEFITS	
008 ADMINISTRATIVE & GENERAL	
009 OPERATION OF PLANT	
010 LAUNDRY & LINEN SERVICE	
011 HOUSEKEEPING	
012 DIETARY	
013 CAFETERIA	
014 MAINTENANCE OF PERSONNEL	
015 NURSING ADMINISTRATION	
016 CENTRAL SERVICES & SUPPLY	
017 PHARMACY	
018 MEDICAL RECORDS & LIBRARY	
025 SOCIAL SERVICE	
026 INPAT ROUTINE SRVC CNTRS	352,630
ADULTS & PEDIATRICS	
037 INTENSIVE CARE UNIT	
041 ANCILLARY SRVC COST CNTRS	
042 OPERATING ROOM	
043 RADIOLOGY-DIAGNOSTIC	191
044 RADIOLOGY-THERAPEUTIC	
049 RADIOISOTOPE	
050 LABORATORY	362
051 RESPIRATORY THERAPY	14,849
052 PHYSICAL THERAPY	82,328
053 OCCUPATIONAL THERAPY	64,848
054 SPEECH PATHOLOGY	36,964
055 ELECTROCARDIOLOGY	
056 ELECTROENCEPHALOGRAPHY	
060 MEDICAL SUPPLIES CHARGED	
061 DRUGS CHARGED TO PATIENTS	12,256
062 OUTPAT SERVICE COST CNTRS	
CLINIC	
065 EMERGENCY	
095 OBSERVATION BEDS (NON-DIS	
OTHER REIMBURS COST CNTRS	
096 AMBULANCE SERVICES	
097 SPEC PURPOSE COST CENTERS	
098 SUBTOTALS	564,428
099 NONREIMBURS COST CENTERS	
101 GIFT, FLOWER, COFFEE SHOP	
102 RESEARCH	
103 PHYSICIANS' PRIVATE OFFIC	
NONPAID WORKERS	
CROSS FOOT ADJUSTMENTS	
NEGATIVE COST CENTER	
TOTAL	564,428

	COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION
		OSTS-BLDG & (SQUARE FEET	OSTS-MVBLE E (DOLLAR VALUE	OSTS-BLDG & (SQUARE FEET	OSTS-MVBLE E (SQUARE FEET	FITS (GROSS SALARIES	
		1	2	3	4	5	6a.00
001	GENERAL SERVICE COST CNTR						
002	OLD CAP REL COSTS-BLDG &						
003	OLD CAP REL COSTS-MVBLE E						
004	NEW CAP REL COSTS-BLDG &			19,931			
005	NEW CAP REL COSTS-MVBLE E					19,931	
006	EMPLOYEE BENEFITS			196		196	3,832,074
008	ADMINISTRATIVE & GENERAL			3,093		3,093	782,158
009	OPERATION OF PLANT			3,603		3,603	197,803
010	LAUNDRY & LINEN SERVICE						
011	HOUSEKEEPING						
012	DIETARY			1,088		1,088	68,516
013	CAFETERIA						
014	MAINTENANCE OF PERSONNEL						
015	NURSING ADMINISTRATION						56,271
016	CENTRAL SERVICES & SUPPLY						
017	PHARMACY			266		266	58,164
018	MEDICAL RECORDS & LIBRARY			276		276	47
025	SOCIAL SERVICE			998		998	89,008
026	INPAT ROUTINE SRVC CNTRS						
037	ADULTS & PEDIATRICS			6,200		6,200	1,015,870
041	INTENSIVE CARE UNIT						
042	ANCILLARY SRVC COST CNTRS						
043	OPERATING ROOM						
044	RADIOLOGY-DIAGNOSTIC						
049	RADIOLOGY-THERAPEUTIC			193		193	284,134
050	RADIOISOTOPE			1,754		1,754	616,718
051	LABORATORY			1,514		1,514	313,521
052	RESPIRATORY THERAPY			750		750	349,864
053	PHYSICAL THERAPY						
054	OCCUPATIONAL THERAPY						
055	SPEECH PATHOLOGY						
056	ELECTROCARDIOLOGY						
060	ELECTROENCEPHALOGRAPHY						
061	MEDICAL SUPPLIES CHARGED						
062	DRUGS CHARGED TO PATIENTS						
065	OUTPAT SERVICE COST CNTRS						
095	CLINIC						
096	EMERGENCY						
097	OBSERVATION BEDS (NON-DIS						
098	OTHER REIMBURS COST CNTRS						
099	AMBULANCE SERVICES						
101	SPEC PURPOSE COST CENTERS						
102	SUBTOTALS			19,931		19,931	3,832,074
103	NONREIMBURS COST CENTERS						-1,940,230
104	GIFT, FLOWER, COFFEE SHOP						
105	RESEARCH						
106	PHYSICIANS' PRIVATE OFFIC						
107	NONPAID WORKERS						
108	CROSS FOOT ADJUSTMENT						
109	NEGATIVE COST CENTER						
110	COST TO BE ALLOCATED						
111	(WRKSHT B, PART I)			455,408		109,020	1,396,442
112	UNIT COST MULTIPLIER			22.849230		5.469871	.364409
113	(WRKSHT B, PT I)						
114	COST TO BE ALLOCATED						
115	(WRKSHT B, PART II)						
116	UNIT COST MULTIPLIER						
117	(WRKSHT B, PT II)						
118	COST TO BE ALLOCATED						5,550
119	(WRKSHT B, PART III)						
120	UNIT COST MULTIPLIER						.001448
121	(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	ADMINISTRATIVE OPERATION OF E & GENERAL PLANT		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL
	( ACCUM. COST	(SQUARE FEET	(POUNDS OF LAUNDRY	(HOURS OF SERVICE	(MEALS SERVED	(MEALS SERVED	(NUMBER HOUSED
	6	8	9	10	11	12	13
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL	5,269,637						
009 OPERATION OF PLANT	726,243	13,039					
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY	144,691	1,088				5,889	
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	93,046						
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY	136,727		266				
018 MEDICAL RECORDS & LIBRARY	10,415		276				
025 SOCIAL SERVICE	206,005		998				
026 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS	1,574,179	6,200				5,889	
041 INTENSIVE CARE UNIT							
042 ANCILLARY SRVC COST CNTRS							
043 OPERATING ROOM							
044 RADIOLOGY-DIAGNOSTIC	11,325						
049 RADIOLOGY-THERAPEUTIC							
050 RADIOISOTOPE							
051 LABORATORY	21,501						
052 RESPIRATORY THERAPY	422,012		193				
053 PHYSICAL THERAPY	947,585		1,754				
054 OCCUPATIONAL THERAPY	475,961		1,514				
055 SPEECH PATHOLOGY	499,947		750				
056 ELECTROCARDIOLOGY							
060 ELECTROENCEPHALOGRAPHY							
061 MEDICAL SUPPLIES CHARGED							
062 DRUGS CHARGED TO PATIENTS							
065 OUTPAT SERVICE COST CNTRS							
095 CLINIC							
096 EMERGENCY							
097 OBSERVATION BEDS (NON-DIS							
098 OTHER REIMBURS COST CNTRS							
099 AMBULANCE SERVICES							
101 SPEC PURPOSE COST CENTERS							
102 SUBTOTALS	5,269,637	13,039				5,889	
103 NONREIMBURS COST CENTERS							
104 GIFT, FLOWER, COFFEE SHOP							
105 RESEARCH							
106 PHYSICIANS' PRIVATE OFFIC							
107 NONPAID WORKERS							
108 CROSS FOOT ADJUSTMENT							
109 NEGATIVE COST CENTER							
110 COST TO BE ALLOCATED	1,940,230	993,638				280,876	
111 (WRKSHT B, PART I)							
112 UNIT COST MULTIPLIER	.368190	76.205077				47.695025	
113 (WRKSHT B, PT I)							
114 COST TO BE ALLOCATED							
115 (WRKSHT B, PART II)							
116 UNIT COST MULTIPLIER							
117 (WRKSHT B, PT II)							
118 COST TO BE ALLOCATED	88,724	114,548				42,904	
119 (WRKSHT B, PART III)							
120 UNIT COST MULTIPLIER	.016837	8.785030				7.285447	
121 (WRKSHT B, PT III)							

	COST CENTER DESCRIPTION	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR	SOCIAL SERVIC
		ISTRATION	CES & SUPPLY		DS & LIBRARY	E
		(DIRECT NRSING HRS	(COSTED )REQUIS.	(COSTED )REQUIS.	(PATIENT )DAYS	(PATIENT )DAYS
	GENERAL SERVICE COST CNTR	14	15	16	17	18
001	OLD CAP REL COSTS-BLDG &					
002	OLD CAP REL COSTS-MVBLE E					
003	NEW CAP REL COSTS-BLDG &					
004	NEW CAP REL COSTS-MVBLE E					
005	EMPLOYEE BENEFITS					
006	ADMINISTRATIVE & GENERAL					
008	OPERATION OF PLANT					
009	LAUNDRY & LINEN SERVICE					
010	HOUSEKEEPING					
011	DIETARY					
012	CAFETERIA					
013	MAINTENANCE OF PERSONNEL					
014	NURSING ADMINISTRATION	94,129				
015	CENTRAL SERVICES & SUPPLY		100			
016	PHARMACY			100		
017	MEDICAL RECORDS & LIBRARY				1,963	
018	SOCIAL SERVICE	3,738				1,963
025	INPAT ROUTINE SRVC CNTRS					1,963
026	ADULTS & PEDIATRICS	34,114			1,963	1,963
	INTENSIVE CARE UNIT					
	ANCILLARY SRVC COST CNTRS					
037	OPERATING ROOM					
041	RADIOLOGY-DIAGNOSTIC					
042	RADIOLOGY-THERAPEUTIC					
043	RADIOISOTOPE					
044	LABORATORY					
049	RESPIRATORY THERAPY	9,766				
050	PHYSICAL THERAPY	22,844				
051	OCCUPATIONAL THERAPY	11,627				
052	SPEECH PATHOLOGY	12,040				
053	ELECTROCARDIOLOGY					
054	ELECTROENCEPHALOGRAPHY					
055	MEDICAL SUPPLIES CHARGED		100			
056	DRUGS CHARGED TO PATIENTS			100		
	OUTPAT SERVICE COST CNTRS					
060	CLINIC					
061	EMERGENCY					
062	OBSERVATION BEDS (NON-DIS					
	OTHER REIMBURS COST CNTRS					
065	AMBULANCE SERVICES					
	SPEC PURPOSE COST CENTERS					
095	SUBTOTALS	94,129	100	100	1,963	1,963
096	NONREIMBURS COST CENTERS					
097	GIFT, FLOWER, COFFEE SHOP					
098	RESEARCH					
099	PHYSICIANS' PRIVATE OFFIC					
	NONPAID WORKERS					
001	CROSS FOOT ADJUSTMENT					
002	NEGATIVE COST CENTER					
003	COST TO BE ALLOCATED	127,305		207,340	35,283	362,962
	(PER WRKSHT B, PART I)					
004	UNIT COST MULTIPLIER				17.974019	
	(WRKSHT B, PT I)					
005	COST TO BE ALLOCATED	1.352452		2,073.400000		184.901681
	(PER WRKSHT B, PART II)					
006	UNIT COST MULTIPLIER					
	(WRKSHT B, PT II)					
007	COST TO BE ALLOCATED	1,648		12,256	10,416	40,693
	(PER WRKSHT B, PART III)					
008	UNIT COST MULTIPLIER	.017508		122.560000	5.306164	20.730005
	(WRKSHT B, PT III)					

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	3,351,507				
37	OPERATING ROOM					
41	RADIOLOGY-DIAGNOSTIC					
42	RADIOLOGY-THERAPEUTIC	15,495				
43	RADIOISOTOPE					
44	LABORATORY			29,417		
49	RESPIRATORY THERAPY			605,309		
50	PHYSICAL THERAPY			1,461,035		
51	OCCUPATIONAL THERAPY			782,304		
52	SPEECH PATHOLOGY			757,460		
53	ELECTROCARDIOLOGY					
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED					
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	207,340				
60	CLINIC					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL			7,209,867		
102	LESS OBSERVATION BEDS					
103	TOTAL			7,209,867		

VKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	3,439,567		3,439,567			
	INTENSIVE CARE UNIT						
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
41	RADIOLOGY-DIAGNOSTIC	52,688		52,688	.294090		
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	117,523	1,435	118,958	.247289		
49	RESPIRATORY THERAPY	1,473,308	1,005	1,474,313	.410570		
50	PHYSICAL THERAPY	363,165	1,132,140	1,495,305	.977082		
51	OCCUPATIONAL THERAPY	422,850	1,001,146	1,423,996	.549372		
52	SPEECH PATHOLOGY	313,479	828,093	1,141,572	.663524		
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS	409,036	1,037	410,073	.505617		
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	SUBTOTAL	6,591,616	2,964,856	9,556,472			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,591,616	2,964,856	9,556,472			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,351,507				
26	INTENSIVE CARE UNIT					
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
41	RADIOLOGY-DIAGNOSTIC	15,495				
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	29,417				
49	RESPIRATORY THERAPY	605,309				
50	PHYSICAL THERAPY	1,461,035				
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY	782,304				
53	ELECTROCARDIOLOGY	757,460				
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED					
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	207,340				
60	CLINIC					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL	7,209,867				
102	LESS OBSERVATION BEDS					
103	TOTAL	7,209,867				



WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
41	OPERATING ROOM						
42	RADIOLOGY-DIAGNOSTIC	15,495	191	15,304			15,495
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
44	LABORATORY	29,417	362	29,055			29,417
49	RESPIRATORY THERAPY	605,309	14,849	590,460			605,309
50	PHYSICAL THERAPY	1,461,035	82,328	1,378,707			1,461,035
51	OCCUPATIONAL THERAPY	782,304	64,848	717,456			782,304
52	SPEECH PATHOLOGY	757,460	36,964	720,496			757,460
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS	207,340	12,256	195,084			207,340
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
62	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	SUBTOTAL	3,858,360	211,798	3,646,562			3,858,360
102	LESS OBSERVATION BEDS						
103	TOTAL	3,858,360	211,798	3,646,562			3,858,360

AKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM			
41	RADIOLOGY-DIAGNOSTIC	52,688	.294090	.294090
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	118,958	.247289	.247289
49	RESPIRATORY THERAPY	1,474,313	.410570	.410570
50	PHYSICAL THERAPY	1,495,305	.977082	.977082
51	OCCUPATIONAL THERAPY	1,423,996	.549372	.549372
52	SPEECH PATHOLOGY	1,141,572	.663524	.663524
53	ELECTROCARDIOLOGY			
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED			
56	DRUGS CHARGED TO PATIENTS	410,073	.505617	.505617
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	6,116,905		
102	LESS OBSERVATION BEDS			
103	TOTAL	6,116,905		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST		OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		WKST B, PT I COL. 27 1	WKST B PT II & III, COL. 27 2				
37	ANCILLARY SRVC COST CNTRS						
41	OPERATING ROOM						
42	RADIOLOGY-DIAGNOSTIC	15,495	191	15,304	19	888	14,588
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
44	LABORATORY	29,417	362	29,055	36	1,685	27,696
49	RESPIRATORY THERAPY	605,309	14,849	590,460	1,485	34,247	569,577
50	PHYSICAL THERAPY	1,461,035	82,328	1,378,707	8,233	79,965	1,372,837
51	OCCUPATIONAL THERAPY	782,304	64,848	717,456	6,485	41,612	734,207
52	SPEECH PATHOLOGY	757,460	36,964	720,496	3,696	41,789	711,975
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS	207,340	12,256	195,084	1,226	11,315	194,799
56	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
62	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	SUBTOTAL	3,858,360	211,798	3,646,562	21,180	211,501	3,625,679
102	LESS OBSERVATION BEDS						
103	TOTAL	3,858,360	211,798	3,646,562	21,180	211,501	3,625,679

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGR RATIO	I/P PT B COST TO CHRGR RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM			
41	RADIOLOGY-DIAGNOSTIC	52,688	.276875	.293729
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	118,958	.232822	.246986
49	RESPIRATORY THERAPY	1,474,313	.386334	.409563
50	PHYSICAL THERAPY	1,495,305	.918098	.971576
51	OCCUPATIONAL THERAPY	1,423,996	.515596	.544818
52	SPEECH PATHOLOGY	1,141,572	.623679	.660286
53	ELECTROCARDIOLOGY			
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED			
56	DRUGS CHARGED TO PATIENTS	410,073	.475035	.502628
	OUTPUT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	6,116,905		
102	LESS OBSERVATION BEDS			
103	TOTAL	6,116,905		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	1,963
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,963
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,963
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
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)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,351,507
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,351,507

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,439,567
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	3,439,567
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	.974398
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	1,752.20
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,351,507

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

						1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,707.34
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					
		TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST
		1	2	3	4	5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49	TOTAL PROGRAM INPATIENT COSTS					

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,707.34
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

- 1 INPATIENT SERVICES
- 1.01 NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT
- 2 ORGAN ACQUISITION
- 3 COST OF TEACHING PHYSICIANS
- 4 SUBTOTAL
- 5 PRIMARY PAYER PAYMENTS
- 6 TOTAL COST. FOR CAH (SEE INSTRUCTIONS)
  
- COMPUTATION OF LESSER OF COST OR CHARGES
  
- REASONABLE CHARGES
- 7 ROUTINE SERVICE CHARGES
- 8 ANCILLARY SERVICE CHARGES
- 9 ORGAN ACQUISITION CHARGES, NET OF REVENUE
- 10 TEACHING PHYSICIANS
- 11 TOTAL REASONABLE CHARGES
  
- CUSTOMARY CHARGES
- 12 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
- 13 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)
- 14 RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)
- 15 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
- 16 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST
- 17 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
  
- COMPUTATION OF REIMBURSEMENT SETTLEMENT
- 18 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
- 19 COST OF COVERED SERVICES
- 20 DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)
- 21 EXCESS REASONABLE COST
- 22 SUBTOTAL
- 23 COINSURANCE
- 24 SUBTOTAL
- 25 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS))
- 25.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)
- 25.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
- 26 SUBTOTAL
- 27 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION
- 28 OTHER ADJUSTMENTS (SPECIFY)
- 29 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS
- 30 SUBTOTAL
- 31 SEQUESTRATION ADJUSTMENT
- 32 INTERIM PAYMENTS
- 32.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
- 33 BALANCE DUE PROVIDER/PROGRAM
- 34 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS				
2	TEMPORARY INVESTMENTS	2,016,275			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE				
5	OTHER RECEIVABLES	896,877			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	2,198,461			
7	INVENTORY				
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	5,111,613			
FIXED ASSETS					
12	LAND	630,000			
12.01	LAND IMPROVEMENTS				
13	LESS ACCUMULATED DEPRECIATION	719,432			
14	BUILDINGS				
14.01	LESS ACCUMULATED DEPRECIATION	5,043,627			
15	LEASEHOLD IMPROVEMENTS	-2,900,683			
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	3,492,376			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS				
27	TOTAL ASSETS	8,603,989			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE				
29 SALARIES, WAGES & FEES PAYABLE				
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	2,336			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	4,765,386			
35 OTHER CURRENT LIABILITIES	307,275			
36 TOTAL CURRENT LIABILITIES	5,074,997			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	131,692			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02     ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	-37,038			
42 TOTAL LONG-TERM LIABILITIES	94,654			
43 TOTAL LIABILITIES	5,169,651			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	3,434,338			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	3,434,338			
52 TOTAL LIABILITIES AND FUND BALANCES	8,603,989			

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		2,759,206		
2 NET INCOME (LOSS)		576,362		
3 TOTAL		3,335,568		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADJUST BGN FUND BALANCE	98,770			
6				
7				
8				
9				
10 TOTAL ADDITIONS		98,770		
11 SUBTOTAL		3,434,338		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		3,434,338		

	ENDOWMENT FUND		PLANT FUND	
	5	6	7	8
1 FUND BALANCE AT BEGINNING OF PERIOD				
2 NET INCOME (LOSS)				
3 TOTAL				
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADJUST BGN FUND BALANCE				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
4 00 HOSPITAL	3,439,567		3,439,567
5 00 SWING BED - SNF			
9 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,439,567		3,439,567
10 00 INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS	3,439,567		3,439,567
17 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,152,049		6,116,905
18 00 ANCILLARY SERVICES		2,964,856	6,116,905
20 00 OUTPATIENT SERVICES		107,678	107,678
24 00 AMBULANCE SERVICES			
25 00 TOTAL PATIENT REVENUES	6,591,616	3,072,534	9,664,150

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		6,317,325	
ADD (SPECIFY)			
27 00 BAD DEBT	85,894		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		85,894	
DEDUCT (SPECIFY)			
34 00			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		6,403,219	

DESCRIPTION

1	TOTAL PATIENT REVENUES	9,664,150
2	LESS: ALLOWANCES AND DISCOUNTS ON	2,748,068
3	NET PATIENT REVENUES	6,916,082
4	LESS: TOTAL OPERATING EXPENSES	6,403,219
5	NET INCOME FROM SERVICE TO PATIENT	512,863
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OPERATING REVENUE	16,089
24.01	NONOPERATING GAIN	47,410
24.02	ROUNDING	
25	TOTAL OTHER INCOME	63,499
26	TOTAL	576,362
	OTHER EXPENSES	
27		
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	576,362

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM					
41 RADIOLOGY-DIAGNOSTIC	.276875				
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY	.232822				
49 RESPIRATORY THERAPY	.386334				
50 PHYSICAL THERAPY	.918098				
51 OCCUPATIONAL THERAPY	.515596				
52 SPEECH PATHOLOGY	.623679				
53 ELECTROCARDIOLOGY					
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS	.475035				
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
65 OTHER REIMBURS COST CNTRS					
101 AMBULANCE SERVICES					
102 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
104 PROGRAM ONLY CHARGES					
NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XIX - O/P

HOSPITAL

PPS Services  
FYB to 12/31

Non-PPS  
Services

PPS Services  
1/1 to FYE

Outpatient  
Ambulatory  
Surgical Ctr

Outpatient  
Radiology

Cost Center Description	5.01	5.02	5.03	6	7
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM					
41 RADIOLOGY-DIAGNOSTIC					
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY					
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
62 EMERGENCY					
65 OBSERVATION BEDS (NON-DISTINCT PART)					
101 OTHER REIMBURS COST CNTRS					
102 AMBULANCE SERVICES					
103 SUBTOTAL					
104 CRNA CHARGES					
LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
(A) ANCILLARY SRVC COST CNTRS	8	9	9.01	9.02	9.03
37 OPERATING ROOM					
41 RADIOLOGY-DIAGNOSTIC					
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY					
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)



TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,707.34  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 2,047,101  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 2,047,101

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					998,263
					3,045,364

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES  
 52 TOTAL PROGRAM EXCLUDABLE COST  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES  
 55 TARGET AMOUNT PER DISCHARGE  
 56 TARGET AMOUNT  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT  
 58 BONUS PAYMENT  
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET  
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET  
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.  
 58.04 RELIEF PAYMENT  
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT  
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)  
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1  
 59.03 PROGRAM DISCHARGES AFTER JULY 1  
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)  
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)  
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)  
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS  
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD  
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD  
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XIX - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,707.34
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

WKST A LINE NO.	TITLE XIX COST CENTER DESCRIPTION	HOSPITAL	OTHER		
			RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			2,195,769	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM				
41	RADIOLOGY-DIAGNOSTIC		.294090	35,636	10,480
42	RADIOLOGY-THERAPEUTIC				
43	RADIOISOTOPE				
44	LABORATORY		.247289	72,225	17,860
49	RESPIRATORY THERAPY		.410570	1,048,862	430,631
50	PHYSICAL THERAPY		.977082	176,239	172,200
51	OCCUPATIONAL THERAPY		.549372	214,047	117,591
52	SPEECH PATHOLOGY		.663524	172,380	114,378
53	ELECTROCARDIOLOGY				
54	ELECTROENCEPHALOGRAPHY				
55	MEDICAL SUPPLIES CHARGED TO PATIENTS				
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS		.505617	267,244	135,123
60	CLINIC				
61	EMERGENCY				
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS				
65	AMBULANCE SERVICES				
101	TOTAL			1,986,633	998,263
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			1,986,633	

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX	TITLE XVIII SNF PPS
			1	2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES			
2	MEDICAL AND OTHER SERVICES			
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
6	SUBTOTAL			
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL			
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES			
11	ANCILLARY SERVICE CHARGES			
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
16	TOTAL REASONABLE CHARGES			
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
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)			
19	RATIO OF LINE 17 TO LINE 18			
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES			
	PROSPECTIVE PAYMENT AMOUNT			
24	OTHER THAN OUTLIER PAYMENTS			
25	OUTLIER PAYMENTS			
26	PROGRAM CAPITAL PAYMENTS			
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
30	SUBTOTAL			
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30			
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL			
36	COINSURANCE			
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)			
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
39	UTILIZATION REVIEW			
40	SUBTOTAL (SEE INSTRUCTIONS)			
41	INPATIENT ROUTINE SERVICE COST			
42	MEDICARE INPATIENT ROUTINE CHARGES			
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES			
45	RATIO OF LINE 43 TO 44			
46	TOTAL CUSTOMARY CHARGES			
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
50	OTHER ADJUSTMENTS (SPECIFY)			
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
52	SUBTOTAL			
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER			
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS			
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
58	BALANCE DUE PROVIDER/PROGRAM			
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.			

(You MUST USE Instructions For Completing This Form Located In PRM-II, §§1100ff.)

This questionnaire is required under the authority of sections 1815(a) and 1833(e) of the Social Security Act. Failure to submit this questionnaire will result in suspension of Medicare payments.

To the degree that the information in CMS-339: 1) constitutes commercial or financial information which is confidential, and/or 2) is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act.

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 0938-0301. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED TO AVERAGE 17 HOURS AND 20 MINUTES PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING DATA RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

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 information prepared by ST. VINCENT PEDIATRIC REHAB CENTER 153300

(Provider name(s) and number(s)) for the cost report period beginning 07/01/2006 and ending 06/30/2007, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

(Signed) *John W. Jordan*  
Officer or Administrator of Provider(s)

11/30/07 Date SUP-Executive/CFO Title

Name and Telephone Number of Person to Contact for More Information

GARY MARKER  
(317)583-3232 EXT.

NOTE: 42 CFR 413.20 and instructions contained in the PRM-1 require that the provider maintain adequate financial and statistical data necessary for the intermediary to use for a proper determination of costs payable under the program. Providers are, therefore, required to maintain and have available for audit all records necessary to verify the amounts and allowability of costs and equity capital included in the filed cost report. Failure to have such records available for review by fiscal intermediaries acting under the authority of the Secretary of the Department of Health and Human Services will render the amount claimed in the cost report unallowable.

YES NO N/A  
 --- --- ---

A. Provider Organization and Operation

NOTE: SECTION A TO BE COMPLETED BY ALL PROVIDERS.

1. The provider has:

- a. Changed ownership.  
 If "yes", submit name and address of new owner, date of change, copy of sales agreement, or any similar agreement affecting change of ownership. [ ] [X] [ ]
- b. Terminated participation.  
 If "yes", list date of termination, and reason (Voluntary/Involuntary) [ ] [X] [ ]

2. The provider, members of the board of directors, officers, medical staff or management personnel are associated with or involved in business transactions with the following:

- a. Related organizations, management contracts and services under arrangements as owners (stockholders), management, by family relationship, or any other similar type relationship. [ ] [X] [ ]
- b. Management personnel of major suppliers of the provider (drug, medical supply companies, etc.).  
 If "yes" to question 2a and/or 2b, attach a list of the individuals, the organizations involved, and description of the transactions. [ ] [X] [ ]

B. Financial Data and Reports

NOTE: SECTION B TO BE COMPLETED BY ALL PROVIDERS.

1. During this cost reporting period, the financial statements are prepared by Certified Public Accountants or Public Accountants (submit complete copy or indicate available date) and are:

- a. Audited [X] [ ] [ ]
- b. Compiled; and [ ] [X] [ ]
- c. Reviewed [ ] [X] [ ]

NOTE: Where there is no affirmative response to the above described financial statements, attach a copy of the financial statements prepared and a description of the changes in accounting policies and practices if not mentioned in those statements.

- 2. Cost report total expenses and total revenues differ from those on the filed financial statement.  
 If "yes", submit reconciliation. [ ] [X] [ ]

C. Capital Related Cost

NOTE: SECTION C TO BE COMPLETED ONLY BY HOSPITALS EXCLUDED FROM PPS (EXCEPT CHILDREN'S) AND PPS HOSPITALS THAT HAVE A UNIT EXCLUDED FROM PPS.

- 1. Assets have been relifed for Medicare purposes.  
 If "yes", attach detailed listing of these specific assets, by classes, as shown in the Fixed Asset Register. [ ] [ ] [X]

NOTE: For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, under the capital - PPS consistency rule (42 CRF 412.302 (d)), PPS hospitals are precluded from relifing old capital.

- 2. Due to appraisals made during this cost reporting period, changes have occurred to Medicare depreciation expense.  
 If "yes", attach copy of Appraisal Report and Appraisal Summary by class of asset. [ ] [ ] [X]

- 3. New leases and/or amendments to existing leases for land, equipment, or facilities with annual rental payment in excess of the amounts listed in the instructions, have been entered into during this cost reporting period.  
 If "yes", submit a listing of these new leases and/or amendments to existing leases that have the following information: [ ] [ ] [X]

- o A new lease or lease renewal;
- o Parties to the lease;
- o Period covered by the lease;
- o Description of the asset being leased; and
- o Annual charge by the lessor.

NOTE: Providers are required to submit copies of the lease, or significant extracts, upon request from the intermediary.

- 4. There have been new capitalized leases entered into during the current cost reporting period.  
 If "yes", attach a list of individual assets by class, the department assigned to, and respective dollar amounts for all capitalized leases in accordance with the thresholds discussed in the instructions. [ ] [X] [ ]

- |  | YES                      | NO                                  | N/A                      |
|--|--------------------------|-------------------------------------|--------------------------|
|  | ---                      | ---                                 | ---                      |
| 5. Assets which were subject to §2314 of DEFRA were acquired during the period.<br>If "yes", supply a computation of the basis.  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Provider's capitalization policy changed during cost reporting period.<br>If "yes", submit copy.  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Obligated capital has been placed into use during cost reporting period.<br>If "yes", attach schedule listing each project, the cost of these projects and the date placed into service for patient care. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

D. Interest Expense

NOTE: SECTION D TO BE COMPLETED ONLY BY HOSPITALS EXCLUDED FROM PPS (EXCEPT CHILDREN'S) AND PPS HOSPITALS THAT HAVE A UNIT EXCLUDED FROM PPS.

- |  |                          |                          |                                     |
|--|--------------------------|--------------------------|-------------------------------------|
| 1. New loan, mortgage agreements or letters of credit were entered into during the cost reporting period.<br>If "yes", state the purpose and submit copies of debt documents and amortization schedules.   | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. The provider has a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account.<br>If "yes", submit a detailed analysis of the funded depreciation account for the cost reporting period. (See CMS PRM-1, §226.4.) | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Provider replaced existing debt prior to its scheduled maturity with new debt.<br>If "yes", submit support for new debt and calculation of allowable cost. (See §233.3 for description of allowable cost.)  | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Provider recalled debt before scheduled maturity without issuance of new debt.<br>If "yes", submit detail of debt cancellation costs. (See §215 for description and treatment of debt cancellation costs.)  | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

E. Approved Educational Activities

NOTE: SECTION E TO BE COMPLETED BY ALL PROVIDERS.

- |   |                          |                                     |                                     |
|---|--------------------------|-------------------------------------|-------------------------------------|
| 1. Costs were claimed for Nursing School and Allied Health Programs.<br>If "yes", attach list of the programs and annotate for each whether the provider is the legal operator of the program.  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 2. Approvals and/or renewals were obtained during this cost reporting period for Nursing School and/or Allied Health Programs.<br>If "yes", submit copies.  | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 3. Provider has claimed Intern-Resident costs on the current cost report.<br>If "yes", submit the current year Intern-Resident Information System (IRIS) on diskette.   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 4. Provider has initiated an Intern-Resident program in the current year or obtained a renewal of an existing program.<br>If "yes", Submit certification/program approval.  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 5. Graduate Medical Education costs have been directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program, on worksheet A, Form CMS-2552.<br>If "yes", submit appropriate workpapers indicating to which cost centers assigned and the amounts. | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

F. Purchased Services

NOTE: QUESTIONS 1 AND 2 TO BE COMPLETED ONLY BY HOSPITALS EXCLUDED FROM PPS (EXCEPT CHILDREN'S) AND PPS HOSPITALS THAT HAVE A UNIT EXCLUDED FROM PPS. QUESTION 3 TO BE COMPLETED ONLY BY INPATIENT PPS (IPPS) HOSPITALS, HOSPITALS WITH AN IPPS SUBPROVIDER, HOSPITALS THAT WOULD BE SUBJECT TO IPPS IF NOT GRANTED A WAIVER, AND SNFS.

- |  |                          |                          |                                     |
|--|--------------------------|--------------------------|-------------------------------------|
| 1. Changes or new agreements have occurred in patient care services furnished through contractual arrangements with suppliers of services.<br>If "yes", submit copies of changes or contracts, or where there are no written agreements, attach description. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|--|--------------------------|--------------------------|-------------------------------------|

NOTE: Hospitals are only required to submit such information where the cost of the individual's services exceed \$25,000 per year.

- |   |                          |                          |                                     |
|---|--------------------------|--------------------------|-------------------------------------|
| 2. The requirements of §2135.2 were applied pertaining to competitive bidding.<br>If "no", attach explanation.  | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Contract services are reported on worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNFs).<br>If "yes", submit a schedule showing the total direct patient care related contract labor, hours and calculated rate for each invoice paid during the year for the direct patient care related contract labor reported on worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNFs).<br>Contracted labor will include any wage related costs. The contracted amounts for the top four management personnel (CEO, CFO, COO and Nursing Administrator) are not required to be reported by individuals. The total aggregate wage and hours will be reported for these management contracts. Other contracts or contracts for other management personnel should NOT be reported as they are not allowed in the computation of the wage index. | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

YES NO N/A  
 --- --- ---

G. Provider-Based Physicians

NOTE: SECTION G TO BE COMPLETED ONLY BY HOSPITALS EXCLUDED FROM PPS (EXCEPT CHILDREN'S) AND PPS HOSPITALS THAT HAVE A UNIT EXCLUDED FROM PPS.

- 1. Services are furnished at the provider facility under an arrangement with provider-based physicians.  
 If "yes", submit completed provider-based physician questionnaire (Exhibits 2 through 4A). [ ] [ ] [X]
- 2. The provider has entered into new agreements or amended existing agreements with provider-based physicians during this cost reporting period.  
 If "yes", submit copies of new agreements or amendments to existing agreements and assignment authorizations. [ ] [ ] [X]

H. Home Office Costs

NOTE: QUESTIONS 1 THROUGH 6 TO BE COMPLETED ONLY BY HOSPITALS EXCLUDED FROM PPS (EXCEPT CHILDREN'S) AND PPS HOSPITALS THAT HAVE A UNIT EXCLUDED FROM PPS. QUESTION 7 TO BE COMPLETED ONLY BY IPSS HOSPITALS, HOSPITALS WITH AN IPSS SUBPROVIDER, HOSPITALS THAT WOULD BE SUBJECT TO IPSS IF NOT GRANTED A WAIVER, AND SNFS.

- 1. The provider is part of a chain organization.  
 If "yes", give full name and address of the home office: [X] [ ] [ ]

Name: ST. VINCENT HEALTH, INC.  
 Address: 8425 HARCOURT RD  
 City: INDIANAPOLIS State: IN  
 Zip: 46260-

Designated Intermediary: ASF

- 2. A home office cost statement has been prepared by the home office.  
 If "yes", submit a schedule displaying the entire chain's direct, functional and pooled cost as provided to the designated home office intermediary as part of the home office cost statement. [X] [ ] [ ]
- 3. The fiscal year end of the home office is different from that of the provider.  
 If "yes", indicate the fiscal year end of the home office.  
 Home Office FYE: \_\_\_\_\_ [ ] [X] [ ]

NOTE: Where the year ends of the provider and home office are not the same (nonconcurrent year ends), the summary listing, as described in number 2 above, will be necessary to support the provider's cost report.

- 4. Describe the operation of the intercompany accounts. Include in this description the types of costs included from these intercompany accounts and their location on the cost report.  
 (Provide informative attachments not shown on worksheet A-8-1.) [ ] [ ] [X]
- 5. Actual expense amounts are transferred by the home office to the provider components on an interim basis.  
 (Provide informative attachments if not shown on worksheet A-8-1.) [ ] [X] [ ]
- 6. The provider renders services to:
  - a. Other chain components. [ ] [X] [ ]
  - b. The home office. [ ] [X] [ ]
 If "yes", to either of the above, provide informative attachments.
- 7. Home Office or Related Organization personnel cost are reported on worksheet S-3, Part II, line 11 (hospitals) or line 18 (SNFs).  
 If "yes", submit a schedule displaying the wages, wage-related costs, and hours allocated to the individual chain components as provided to the designated home office intermediary to support the amount reported on worksheet S-3, Part II, line 11 (hospitals) or line 18 (SNFs). [ ] [ ] [X]

I. Bad Debts

NOTE: SECTION I TO BE COMPLETED BY ALL PROVIDERS.

- 1. The provider seeks Medicare reimbursement for bad debts.  
 If "yes", complete Exhibit 5 or submit internal schedules duplicating documentation required on Exhibit 5 to support bad debts claimed. (see instructions) [ ] [X] [ ]
- 2. The provider's bad debt collection policy changed during the cost reporting period.  
 If "yes", submit copy. [ ] [ ] [X]
- 3. The provider waives patient deductibles and/or copayments.  
 If yes, insure that they are not included on Exhibit 5. [ ] [X] [ ]

J. Bed Complement

NOTE: SECTION J TO BE COMPLETED BY ALL PROVIDERS.

- The provider's total available beds have changed from prior cost reporting period.  
 If "yes", provide an analysis of available beds and explain any changes during the cost reporting period. [ ] [X] [ ]

YES NO N/A  
 --- --- ---

K. PS&R Data

NOTE 1: SECTION K TO BE COMPLETED BY ALL PROVIDERS.

NOTE 2: Refer to the instruction regarding required documentation and attachments.

1. The cost report was prepared using the PS&R only.

a) Part A (including subproviders, SNF, etc.)?

b) Part B (inpatient and outpatient)?

If yes, attach a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

2. The cost report was prepared using the PS&R for totals and the provider records for allocation.

a) Part A (including subproviders, SNF, etc.)?

b) Part B (inpatient and outpatient)?

If yes, include a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.

If the PS&R is used for the allocation of ASC, Radiology, Other Diagnostic, and All Other Part B, explain how the total charges are detailed to the various PS&R Medicare outpatient types. Include workpapers supporting the allocation of charges into the various cost centers. If internal records are used for either the type of service breakdown or the charge allocation, the source of this information must be included in the documentation.

3. Provider records only were used to complete the cost report.

a) Part A (including subproviders, SNF, etc.)?

b) Part B (inpatient and outpatient)?

If yes, attach detailed documentation of the system used to support the data reported on the cost report. If the detail documentation was previously supplied, submit only necessary updated documentation. The minimum requirements are:

o Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components, capital PPS rate components, ASC payment group rates, Radiology and Other Diagnostic prevailing rates and other claims PRICING information.

o Log summaries and log detail supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.

o Reconciliation of remittance totals to the provider consolidated log totals.

Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material.

Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

4. If yes to questions 1 or 2 above, were any of the following adjustments made to the Part A PS&R data?

Part A:

a) Addition of claims billed but not on PS&R?

Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log.

b) Correction of other PS&R information?

c) Late charges?

d) Other (describe)?

Part B (inpatient and outpatient)

a) Addition of claims billed but not on PS&R?

Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log.

b) Correction of other PS&R information?

c) Late charges?

d) Other (describe)?

Attach documentation which provides an audit trail from the PS&R to the cost report. The documentation should include the details of the PS&R, reclassifications, adjustments, and groupings necessary to trace to the cost center totals and in addition, for outpatient services, there should be an audit trail from the PS&R to the amounts shown on the cost report for outpatient charges by ASC, radiology, other diagnostic and all other service categories including standard overhead amounts and prevailing charges.

YES NO N/A  
 --- --- ---

L. Wage Related Costs

NOTE: SECTION L TO BE COMPLETED ONLY BY IPPS HOSPITALS, HOSPITALS WITH AN IPPS SUBPROVIDER, HOSPITALS THAT WOULD BE SUBJECT TO IPPS IF NOT GRANTED A WAIVER, AND SNFS.

1. Complete EXHIBIT 6, Part I. (Per instructions) Part III must be completed to reconcile any differences between any fringe benefit cost reported on worksheet A, Column 2, using Medicare principles and the corresponding wage-related costs reported under GAAP for purposes of the wage index computation. [ ] [ ] [X]
2. The individual wage-related cost exceeds one percent of total adjusted salaries after removing excluded salaries. (Salaries reported on worksheet S-3, PART III, COLUMN 3, LINE 3 (CMS-2552-96), OR WORKSHEET S-3, PART II, COLUMN 3, LINE 16 (CMS-2540-96).) [ ] [ ] [X]
3. Additional wage-related costs were provided that meet ALL of the following tests:
  - a. The cost is not listed on Part I of EXHIBIT 6. [ ] [ ] [X]
  - b. If any of the additional wage-related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test in question 2 above. [ ] [ ] [X]
  - c. The wage-related cost has been reported to the IRS as a fringe benefit if so required by the IRS. [ ] [ ] [X]
  - d. The individual wage-related cost is not included in salaries reported on the WORKSHEET S-3, PART III, COLUMN 3, LINE 3, (CMS-2552-96) OR WORKSHEET S-3, PART II, COLUMN 3, LINE 16 (CMS-2540-96). [ ] [ ] [X]
  - e. The wage-related cost is not being furnished for the convenience of the employer. [ ] [ ] [X]