

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

WORKSHEET S
 PARTS I & II

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

PART I - CERTIFICATION

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

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY LORETTO HOSPITAL (14-0083) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2007 AND ENDING 06/30/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII	TITLE XIX	
		PART A	PART B	
	1	2	3	4
1	HOSPITAL			1
2	SUBPROVIDER I	-198195	74595	2
3	SWING BED - SNF			3
4	SWING BED - NF			4
5	SKILLED NURSING FACILITY			5
6	NURSING FACILITY			6
7	HOME HEALTH AGENCY			7
8	OUTPATIENT REHABILITATION PROVIDER			8
9	HEALTH CLINIC			9
100	TOTAL	-198195	74595	100

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 645 SOUTH CENTRAL AVENUE
 1.01 CITY: CHICAGO

STATE: IL

P.O.BOX:

ZIP CODE: 60646

COUNTY: COOK

1
 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)			
				V 4	XVIII 5	XIX 6	
2	HOSPITAL	14-0083	07/01/1966	N	P	O	2
3	SUBPROVIDER I						3
4	SWING BEDS - SNF						4
5	SWING BEDS - NF						5
6	HOSPITAL-BASED SNF						6
7	HOSPITAL-BASED NF						7
8	HOSPITAL-BASED OLTC						8
9	HOSPITAL-BASED HHA						9
11	SEPARATELY CERTIFIED ASC						11
12	HOSPITAL-BASED HOSPICE						12
14	HOSP-BASED RHC						14
15	OUTPATIENT REHABILITATION PROVID						15
16	RENAL DIALYSIS						16
17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2007	TO: 06/30/2008				17
18	TYPE OF CONTROL			1 2			18
19	HOSPITAL		1				19
20	SUBPROVIDER I						20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42.412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.						21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106?		YES				21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.						21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.		1 N		N		21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.		1				21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.		1				21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.		NO				21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?		NO				22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW		NO				23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.						23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.						24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.						24.01
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?		YES				25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?		YES				25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.		YES				25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.		NO				25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2		NO				25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)		NO		NO		25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)		NO		NO		25.06

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES:	BEGINNING:	ENDING:		26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS):	BEGINNING:	ENDING:		26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.			NO	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)					
28.03	STAFFING	0.00		N	28.03
28.04	RECRUITMENT	0.00		N	28.04
28.05	RETENTION OF EMPLOYEES	0.00		N	28.05
28.06	TRAINING	0.00		N	28.06
28.07	OTHER (SPECIFY)				28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?			NO	29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.			NO	30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.				30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?				30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)				30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.				30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).			NO	31
MISCELLANEOUS COST REPORTING INFORMATION					
32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.			NO	32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.			NO	33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?			NO	34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?			NO	35
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL					
		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	YES	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	YES	YES	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	37.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	NO	40
40.01	NAME:	FI/CONTRACTOR'S NAME:	FI/CONTRACTOR'S NUMBER:
40.02	STREET:		P.O.BOX:
40.03	CITY:		STATE: ZIP CODE:
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES	41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO	43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	YES	44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO	45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.		46

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

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC				
	1	2	3	4	5				
47	HOSPITAL	N	N	N	N	47			
48	SUBPROVIDER I	N	N	N	N	48			
49	SKILLED NURSING FACILITY	N	N			49			
50	HOME HEALTH AGENCY	N	N			50			
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?				NO	52			
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.				NO	52.01			
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					53			
53.01	MDH PERIOD:	BEGINNING:		ENDING:		53.01			
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					54			
	PREMIUMS: 695644	PAID LOSSES:	AND/OR SELF INSURANCE:	1500000					
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.				NO	54.01			
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.				NO	55			
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.			DATE / /	Y/N NO	LIMIT 0.00	Y/N NO	FEEES 4	56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?				NO	57			
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.				NO	58			
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)					58.01			
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)				NO	59			

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO				60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)					60.01
MULTICAMPUS						
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.	NO				61
	COUNTY:		STATE:	ZIP CODE	CBSA	FTE/ CAMPUS
	1		2	3	4	5

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

		-----DISCHARGES-----				
COMPONENT	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15		
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		2459	3246	6593	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		2459	3246	6593	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	WORKSHEET S-3 PART II
		1	2	3	4	5	6	
1	SALARIES							
1	TOTAL SALARIES	26941754		26941754	1248919.00	21.57		1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)	31248		31248	2080.00	15.02		6
6.01	CONTRACT SERVICES, I&R	447993		447993	10633.58	42.13		6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES	233864		233864	11820.00	19.79		8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	4889246		4889246			CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	42862		42862			CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)	5727		5727			CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	239922		239922	9890.00	24.26		21
22	ADMINISTRATIVE & GENERAL	3271972		3271972	143453.00	22.81		22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	893215		893215	43194.00	20.68		24
25	LAUNDRY & LINEN SERVICE	30173		30173				25
26	HOUSEKEEPING	610179		610179	69014.00	8.84		26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	812508		812508	67413.00	12.05		27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	1407389		1407389	44792.00	31.42		30
31	CENTRAL SERVICES AND SUPPLY	184641		184641	11916.00	15.50		31
32	PHARMACY	577082		577082	27124.00	21.28		32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	437997		437997	28942.00	15.13		33
34	SOCIAL SERVICE	88112		88112	5731.00	15.37		34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	WORKSHEET S-3 PART III
		1	2	3	4	5	
1	NET SALARIES	26462513		26462513	1236205.42	21.41	1
2	EXCLUDED AREA SALARIES	233864		233864	11820.00	19.79	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	26228649		26228649	1224385.42	21.42	3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS	4889246		4889246		18.64%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	31117895		31117895	1224385.42	25.42	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	8553190		8553190	451469.00	18.95	13

NHCMQ DEMONSTRATION STATISTICAL DATA
 STATISTICAL DATA

WORKSHEET S-7

GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1		SERVICES ON OR AFTER JANUARY 1		TOTAL
		RATE	DAYS	RATE	DAYS	
1	2	3	3.01	4	4.01	5
1	RVC/RUC					1
2	RVB/RUB					2
3	RVA/RUA					3
3.01	RUX					3.01
3.02	RUL					3.02
4	RHD/RVC					4
5	RHC/RVB					5
6	RHB/RVA					6
6.01	RVX					6.01
6.02	RVL					6.02
7	RHA/RHC					7
8	RMC/RHB					8
9	RMB/RHA					9
9.01	RHX					9.01
9.02	RHL					9.02
10	RMA/RMC					10
11	RLB/RMB					11
12	RLA/RMA					12
12.01	RMX					12.01
12.02	RML					12.02
13	SE3/RLB					13
14	SE2/RLA					14
14.01	RLX					14.01
15	SE1/SE3					15
16	SSC/SE2					16
17	SSB/SE1					17
18	SSA/SSC					18
19	CD2/SSB					19
20	CD1/SSA					20
21	CC2					21
22	CC1					22
23	CB2					23
24	CB1					24
25	CA2					25
26	CA1					26
27	IB2					27
28	IB1					28
29	IA2					29
30	IA1					30
31	BB2					31
32	BB1					32
33	BA2					33
34	BA1					34
35	PE2					35
36	PE1					36
37	PD2					37
38	PD1					38
39	PC2					39
40	PC1					40
41	PB2					41
42	PB1					42
43	PA2					43
44	PA1					44
45	DEFAULT RATE					45
46	TOTAL					46

HOSPITAL UNCOMPENSATED CARE DATA

WORKSHEET S-10

UNCOMPENSATED CARE INFORMATION

1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	1
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	2
2.01	IS IT AT THE TIME OF ADMISSION?	2.01
2.02	IS IT AT THE TIME OF FIRST BILLING?	2.02
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	2.03
2.04	OTHER METHODS OF WRITE-OFFS (SPECIFY)	2.04
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	3
4	ARE CHARITY DETERMINATION BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	4
5	ARE CHARITY DETERMINATION BASED UPON INCOME DATA ONLY?	5
6	ARE CHARITY DETERMINATION BASED UPON NET WORTH DATA?	6
7	ARE CHARITY DETERMINATION BASED UPON INCOME AND NET WORTH DATA?	7
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	8
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	8.01
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	9
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	9.01
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	9.02
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	9.03
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	9.04
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE-OFF?	10
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER LINES 11 THRU 11.04	11
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	11.01
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	11.02
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	11.03
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	11.04
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	12
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	13
14	IS YOUR HOSPITAL STATE AND LOCAL GOVERNMENT OWNED? IF YES ANSWER LINE 14.01	14
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THE GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING UNCOMPENSATED CARE?	14.01
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	14.02
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	15
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	16
17	REVENUE RELATED TO UNCOMPENSATED CARE	13399390 17
17.01	GROSS MEDICAID REVENUES	37176013 17.01
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	18
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	19
20	RESTRICTED GRANTS	20
21	NON-RESTRICTED GRANTS	21
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	50575403 22
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	23
24	COST TO CHARGE RATIO	0.509351 24
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST	25
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	26
27	TOTAL SCHIP COST	27
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	37176013 28
29	TOTAL GROSS MEDICAID COST	18935639 29
30	OTHER UNCOMPENSATED CARE CHARGES (FROM YOUR RECORDS)	13399390 30
31	UNCOMPENSATED CARE COST	6824993 31
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL	18935639 32

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
GENERAL SERVICE COST CENTERS									
1	0100								1
2	0200								2
3	0300								3
4	0400		1197154	1197154	-5382	1191772	-24701	1167071	4
5	0500				717338	717338		717338	5
6.01	1160	239922	3077748	3317670	25520	3343190		3343190	6.01
6.04	0640	130655	381517	512172		512172		512172	6.04
6.05	0650	183687	32673	216360		216360		216360	6.05
6.06	0660	305785	76311	382096	34410	416506		416506	6.06
7	0700	2651845	9900217	12552062	-338520	12213542	-4549326	7664216	7
8	0800								8
9	0900	893215	1755892	2649107	191840	2840947	-292787	2548160	9
10	1000	30173	226575	256748		256748		256748	10
11	1100	610179	441252	1051431	104000	1155431		1155431	11
12	1200	812508	343488	1155996		1155996		1155996	12
13	1300		325751	325751		325751	-112866	212885	13
14	1400								14
15	1500	1407389	326636	1734025		1734025		1734025	15
16	1600	184641	294920	479561		479561		479561	16
17	1700	577082	1729513	2306595	-1440500	866095		866095	17
18	1800	437997	493891	931888		931888	-18580	913308	18
20	2000	88112	6650	94762		94762		94762	20
21	2100								21
22	2200	31248		31248		31248		31248	22
23	2300		2099	2099		2099		2099	23
24	2400								24
INPATIENT ROUTINE SERV COST CENTERS									
25	2500	9249621	1319917	10569538	-42710	10526828	-116658	10410170	25
26	2600	1632896	280911	1913807		1913807	-46733	1867074	26
ANCILLARY SERVICE COST CENTERS									
37	3700	604965	496114	1101079		1101079		1101079	37
40	4000		239154	239154		239154	-230000	9154	40
41	4100	998350	738013	1736363		1736363	-24474	1711889	41
44	4400	905120	1155454	2060574		2060574		2060574	44
46.30	4650								46.30
49	4900	775537	364341	1139878		1139878	-24000	1115878	49
50	5000	424391	102263	526654		526654	-5331	521323	50
53	5300	195143	68403	263546		263546		263546	53
54	5400	34408	3742	38150		38150		38150	54
55	5500				217705	217705		217705	55
56	5600				1440500	1440500		1440500	56
57	5700		276780	276780		276780		276780	57
58.01	3951								58.01
59	3550	676649	820189	1496838	-555180	941658	-184991	756667	59
59.10	3950	124158	14071	138229		138229		138229	59.10
OUTPATIENT SERVICE COST CENTERS									
60	6000	501039	84319	585358		585358	-65	585293	60
60.01	6001								60.01
60.02	6002								60.02
60.03	6003								60.03
60.04	6004								60.04
61	6100	2001175	1708683	3709858	-217705	3492153	-1164904	2327249	61
61.01	4950		5877	5877		5877		5877	61.01
62	6200								62
63.50	6310								63.50
63.60	6320								63.60
OTHER REIMBURSABLE COST CENTERS									
69.10	6910								69.10
69.20	6920								69.20
69.30	6930								69.30
69.40	6940								69.40
71	7100								71
SPECIAL PURPOSE COST CENTERS									
85.01	8510								85.01
85.02	8520								85.02
85.03	8530								85.03
88	8800		119116	119116	-119116				88
95		26707890	28409634	55117524	12200	55129724	-6795416	48334308	95
NONREIMBURSABLE COST CENTERS									
96	9600								96
98	9800	6139	28032	34171		34171		34171	98
100	7950		133588	133588		133588		133588	100
100.10	7951	227725	97398	325123	-12200	312923		312923	100.10
101	TOTAL	26941754	28668652	55610406		55610406	-6795416	48814990	101

RECLASSIFICATIONS

1	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		1	
			COST CENTER 2	LINE # 3		SALARY 4
1	DRUGS SOLD	A	DRUGS CHARGED TO PATIENTS	56	1440500	1
2		A				2
3						3
4	INTEREST EXPENSE	B	OTHER ADMINISTRATIVE	6.06	119116	4
5						5
6	MHU RECOVERIES	C	EMPLOYEE BENEFITS	5	25520	6
7		C	BUSINESS OFFICE	6.05	34410	7
8		C	OTHER ADMINISTRATIVE	6.06	254320	8
9		C	OPERATION OF PLANT	8	191840	9
10		C	HOUSEKEEPING	10	104000	10
11						11
12	DEPR EXP	D	NEW CAP REL COSTS-MVBLE EQUIP	4	717338	12
13						13
14	SUPPLIES CHARGED	E	MEDICAL SUPPLIES CHARGED TO P	55	217705	14
15						15
16	CAPITAL INSURANCE EXPENSE	F	NEW CAP REL COSTS-BLDG & FIXT	3	711956	16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36	TOTAL RECLASSIFICATIONS				3816705	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 DRUGS SOLD	A	PHARMACY	16		1440500	1
2	A					2
3						3
4 INTEREST EXPENSE	B	INTEREST EXPENSE	88		119116	4
5						5
6 MHU RECOVERIES	C	ADULTS & PEDIATRICS	25		42710	6
7	C	O/P MENTAL HEALTH	59		555180	7
8	C	AUSTIN PRIDE	100.10		12200	8
9	C					9
10	C					10
11						11
12 DEPR EXP	D	NEW CAP REL COSTS-BLDG & FIXT	3		717338	9 12
13						13
14 SUPPLIES CHARGED	E	EMERGENCY	61		217705	14
15						15
16 CAPITAL INSURANCE EXPENSE	F	OTHER ADMINISTRATIVE	6.06		711956	12 16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS					3816705	36

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

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3					
1 LAND	429028					429028		1
2 LAND IMPROVEMENTS	224058					224058		2
3 BUILDINGS AND FIXTURES	20136998	4222283		4222283		24359281		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	3449756					3449756		5
6 MOVABLE EQUIPMENT	11865156	1254467		1254467		13119623		6
7 SUBTOTAL	36104996	5476750		5476750		41581746		7
8 RECONCILING ITEMS								8
9 TOTAL	36104996	5476750		5476750		41581746		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS		
	9	10	11	12	13	14		
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT		455115			711956			1167071 3
4 NEW CAP REL COSTS-MVBLE EQUIP		717338						717338 4
5 TOTAL		1172453			711956			1884409 5

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS		
	9	10	11	12	13	14		
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT		1197154						1197154 3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 TOTAL		1197154						1197154 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER	B	-119116	OTHER ADMINISTRATIVE	6.06	5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES					7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)					9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2287306			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1				14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-112866	CAFETERIA	12	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-18580	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4				35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4				36
37					37
37.02 TELEPHONE CAPITAL	B	-2282	NEW CAP REL COSTS-BLDG & FIXT	3	9 37.02
38 MISCELLANEOUS INCOME	B	-108348	OTHER ADMINISTRATIVE	6.06	38
39					39
40 BAD DEBTS	A	-3823886	OTHER ADMINISTRATIVE	6.06	40
41 LOBBYING EXPENSES	A	-7814	OTHER ADMINISTRATIVE	6.06	41
42 RENTAL INCOME	B	-22419	NEW CAP REL COSTS-BLDG & FIXT	3	9 42
43 MED RECORD RADIOLOGY	B	-12	RADIOLOGY-DIAGNOSTIC	41	43
44 WATER REFUND	B	-30437	OPERATION OF PLANT	8	44
45 FIRE SETTLEMENT	B	-262350	OPERATION OF PLANT	8	45
46					46
47					47
48					48
49					49
50 TOTAL		-6795416			50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ- USTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS					5

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

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

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
- D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
- E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER NO. 14-0083 LORETTO HOSPITAL
 PERIOD FROM 07/01/2007 TO 06/30/2008

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

VERSION: 2008.05
 12/04/2008 09:52

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	1	2		3	4	5	6	7	8	9
1	25	ADULTS & PEDIATRICS	AGGREGATE	116658	116658					
2	26	INTENSIVE CARE UNIT	AGGREGATE	46733	46733					
3	40	ANESTHESIOLOGY	AGGREGATE	230000	230000					
4	41	RADIOLOGY-DIAGNOSTIC	AGGREGATE	24462	24462					
5	50	PHYSICAL THERAPY	AGGREGATE	5331	5331					
6	59	O/P MENTAL HEALTH	AGGREGATE	184991	184991					
7	61	EMERGENCY	AGGREGATE	1164904	1164904					
8	49	RESPIRATORY THERAPY	AGGREGATE	24000	24000					
9	6.06	OTHER ADMINISTRATIVE	AGGREGATE	490162	490162					
10	60	CLINIC	AGGREGATE	65	65					
101		TOTAL		2287306	2287306					

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP- REL COSTS BLDG&FIXT 3	NEW CAP- REL COSTS MOV EQUIP 4	EMPLOYEE BENEFITS 5	COMMUNI CATIONS 6.01	ADMITTING 6.04	BUSINESS OFFICE 6.05	SUBTOTAL 5A	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	1167071	1167071							3
4 NEW CAP REL COSTS-MVBLE EQUIP	717338		717338						4
5 EMPLOYEE BENEFITS	3343190	7157	4399	3354746					5
6.01 COMMUNICATIONS	512172	6942	4267	16415	539796				6.01
6.04 ADMITTING	216360	897	551	23078	5166	246052			6.04
6.05 BUSINESS OFFICE	416506	21080	12957	38418	7748		496709		6.05
6.06 OTHER ADMINISTRATIVE	7664216	246470	151496	333170	149798			8545150	6.06
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	2548160	120333	73962	112221	7748			2862424	8
9 LAUNDRY & LINEN SERVICE	256748	14775	9081	3791	2583			286978	9
10 HOUSEKEEPING	1155431	14320	8802	76661	2583			1257797	10
11 DIETARY	1155996	42193	25934	102081	12914			1339118	11
12 CAFETERIA	212885	16400	10080		7748			247113	12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	1734025	7033	4323	176820	25828			1948029	14
15 CENTRAL SERVICES & SUPPLY	479561	69436	42679	23198	7748			622622	15
16 PHARMACY	866095	9718	5973	72503	5166			959455	16
17 MEDICAL RECORDS & LIBRARY	913308	21971	13504	55029	18079			1021891	17
18 SOCIAL SERVICE	94762	2600	1598	11070	18079			128109	18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A	31248	585	360	3926				36119	22
23 I&R SERVICES-OTHER PRGM COSTS A	2099							2099	23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	10410170	176931	108750	1162101	38741	118246	189595	12204534	25
26 INTENSIVE CARE UNIT	1867074	43604	26801	205152	12914	19165	30630	2205340	26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	1101079	58554	35990	76006	49072	4531	10472	1335704	37
40 ANESTHESIOLOGY	9154	2366	1454	2583	836	2121	18514	18514	40
41 RADIOLOGY-DIAGNOSTIC	1711889	56975	35019	125430	20662	8812	24936	1983723	41
44 LABORATORY	2060574	43058	26465	113717	15497	31879	68644	2359834	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	1115878	13404	8238	97436	5166	14464	25460	1280046	49
50 PHYSICAL THERAPY	521323	28725	17656	53319	18079	1262	5772	646136	50
53 ELECTROCARDIOLOGY	263546	3744	2301	24517	7748	6226	12259	320341	53
54 ELECTROENCEPHALOGRAPHY	38150	2542	1562	4323	2583	278	486	49924	54
55 MEDICAL SUPPLIES CHARGED TO PAT	217705					3687	9063	230455	55
56 DRUGS CHARGED TO PATIENTS	1440500					27639	48100	1516239	56
57 RENAL DIALYSIS	276780					653	1069	278502	57
58.01 HYPERBARIC CHAMBER									58.01
59 O/P MENTAL HEALTH	756667	26684	16401	85012	18079	206	8790	911839	59
59.10 PARTIAL HOSPITALIZATION	138229	38956	23944	15599	5166	22	14552	236468	59.10
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC	585293	16420	10092	62949	18079	264	7538	700635	60
60.01 CICERO CLINIC									60.01
60.02 YMCA CLINIC									60.02
60.03 NORTH AVENUE CLINIC									60.03
60.04 CLINIC #4									60.04
61 EMERGENCY	2327249	24974	15350	251422	43907	7882	37177	2707961	61
61.01 GOLDEN LIFE	5877	17440	10720				45	34082	61.01
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	48334308	1156287	710709	3325364	529464	246052	496709	48277181	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		514	316		2583			3413	96
98 PHYSICIANS' PRIVATE OFFICES	34171			771				34942	98
100 PUBLIC RELATIONS	133588	520	320		2583			137011	100
100.10AUSTIN PRIDE	312923	9750	5993	28611	5166			362443	100.10
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	48814990	1167071	717338	3354746	539796	246052	496709	48814990	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OTHER ADMINISTRV & GENERAL 6.06	OPERATION OF PLANT 8	LAUNDRY AND LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINI- STRATION 14	CENTRAL SERVICES & SUPPLY 15	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6.01 COMMUNICATIONS									6.01
6.04 ADMITTING									6.04
6.05 BUSINESS OFFICE									6.05
6.06 OTHER ADMINISTRATIVE	8545150								6.06
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	607398	3469822							8
9 LAUNDRY & LINEN SERVICE	60896	67087	414961						9
10 HOUSEKEEPING	266901	65021		1589719					10
11 DIETARY	284157	191579		14187	1829041				11
12 CAFETERIA	52437	74465		82658		456673			12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	413366	31935				22332	2415662		14
15 CENTRAL SERVICES & SUPPLY	132119	315275		42515		5941		1118472	15
16 PHARMACY	203593	44124		18885		13523			16
17 MEDICAL RECORDS & LIBRARY	216842	99759		14187		14430			17
18 SOCIAL SERVICE	27184	11806		7070		2857			18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A	7664	2656				1424			22
23 I&R SERVICES-OTHER PRGM COSTS A	445								23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	2589776	803357	220750	411015	1729271	200262	1546512		25
26 INTENSIVE CARE UNIT	467967	197984	52747	75588	99770	25812	199330		26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	283432	265867	41721	120476		9494	73320		37
40 ANESTHESIOLOGY	3929	10743							40
41 RADIOLOGY-DIAGNOSTIC	420940	258695	23367	82658		19192			41
44 LABORATORY	500750	195505		82658		25180			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	271622	60859		42515		17322			49
50 PHYSICAL THERAPY	137108	130425	5455	72053		9437			50
53 ELECTROCARDIOLOGY	67975	17000				5361			53
54 ELECTROENCEPHALOGRAPHY	10594	11540				971			54
55 MEDICAL SUPPLIES CHARGED TO PAT	48902							1118472	55
56 DRUGS CHARGED TO PATIENTS	321741								56
57 RENAL DIALYSIS	59097								57
58.01 HYPERBARIC CHAMBER									58.01
59 O/P MENTAL HEALTH	193490	121157		63773		19760	152596		59
59.10 PARTIAL HOSPITALIZATION	50178	176881				3102	23952		59.10
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC	148673	74554		118103		13772	106355		60
60.01 CICERO CLINIC									60.01
60.02 YMCA CLINIC									60.02
60.03 NORTH AVENUE CLINIC									60.03
60.04 CLINIC #4									60.04
61 EMERGENCY	574621	113395	70921	330726		40608	313597		61
61.01 GOLDEN LIFE	7232	79188							61.01
62 OBSERVATION BEDS (NON-DISTINCT)									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	8431029	3420857	414961	1579067	1829041	450780	2415662	1118472	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN	724	2332							96
98 PHYSICIANS' PRIVATE OFFICES	7415					239			98
100 PUBLIC RELATIONS	29073	2361							100
100.10AUSTIN PRIDE	76909	44272		10652		5654			100.10
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	8545150	3469822	414961	1589719	1829041	456673	2415662	1118472	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	I/R-SALARY AND FRINGES 22	I/R-OTHER PROGRAM COSTS 23	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6.01 COMMUNICATIONS									6.01
6.04 ADMITTING									6.04
6.05 BUSINESS OFFICE									6.05
6.06 OTHER ADMINISTRATIVE									6.06
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT									8
9 LAUNDRY & LINEN SERVICE									9
10 HOUSEKEEPING									10
11 DIETARY									11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION									14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY	1239580								16
17 MEDICAL RECORDS & LIBRARY		1367109							17
18 SOCIAL SERVICE			177026						18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A				47863					22
23 I&R SERVICES-OTHER PRGM COSTS A					2544				23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	112171	521823	167606	47863	2544	20557484	-50407	20507077	25
26 INTENSIVE CARE UNIT	45066	84304				3453908		3453908	26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	12915	28822				2171751		2171751	37
40 ANESTHESIOLOGY		5837				39023		39023	40
41 RADIOLOGY-DIAGNOSTIC	1265	68633				2858473		2858473	41
44 LABORATORY	102	188934				3352963		3352963	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	10268	70074				1752706		1752706	49
50 PHYSICAL THERAPY		15886				1016500		1016500	50
53 ELECTROCARDIOLOGY	193	33740				444610		444610	53
54 ELECTROENCEPHALOGRAPHY		1337				74366		74366	54
55 MEDICAL SUPPLIES CHARGED TO PAT		24945				1422774		1422774	55
56 DRUGS CHARGED TO PATIENTS	954902	132388				2925270		2925270	56
57 RENAL DIALYSIS		2943				340542		340542	57
58.01 HYPERBARIC CHAMBER									58.01
59 O/P MENTAL HEALTH		24195				1486810		1486810	59
59.10 PARTIAL HOSPITALIZATION		40051				530632		530632	59.10
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC	7438	20748	4037			1194315		1194315	60
60.01 CICERO CLINIC									60.01
60.02 YMCA CLINIC									60.02
60.03 NORTH AVENUE CLINIC									60.03
60.04 CLINIC #4									60.04
61 EMERGENCY	90610	102325	5383			4350147		4350147	61
61.01 GOLDEN LIFE		124				120626		120626	61.01
62 OBSERVATION BEDS (NON-DISTINCT)									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	1234930	1367109	177026	47863	2544	48092900	-50407	48042493	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN						6469		6469	96
98 PHYSICIANS' PRIVATE OFFICES	4650					47246		47246	98
100 PUBLIC RELATIONS						168445		168445	100
100.10AUSTIN PRIDE						499930		499930	100.10
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	1239580	1367109	177026	47863	2544	48814990	-50407	48764583	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP- REL COSTS BLDG&FIXT 3	NEW CAP- REL COSTS MOV EQUIP 4	CAP REL COST TO BE ALLOC 4A	EMPLOYEE BENEFITS 5	COMMUNI CATIONS 6.01	ADMITTING 6.04	BUSINESS OFFICE 6.05	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS		7157	4399	11556	11556				5
6.01 COMMUNICATIONS		6942	4267	11209	57	11266			6.01
6.04 ADMITTING		897	551	1448	80	108	1636		6.04
6.05 BUSINESS OFFICE		21080	12957	34037	132	162		34331	6.05
6.06 OTHER ADMINISTRATIVE		246470	151496	397966	1148	3125			6.06
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT		120333	73962	194295	387	162			8
9 LAUNDRY & LINEN SERVICE		14775	9081	23856	13	54			9
10 HOUSEKEEPING		14320	8802	23122	264	54			10
11 DIETARY		42193	25934	68127	352	270			11
12 CAFETERIA		16400	10080	26480		162			12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION		7033	4323	11356	609	539			14
15 CENTRAL SERVICES & SUPPLY		69436	42679	112115	80	162			15
16 PHARMACY		9718	5973	15691	250	108			16
17 MEDICAL RECORDS & LIBRARY		21971	13504	35475	190	377			17
18 SOCIAL SERVICE		2600	1598	4198	38	377			18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A		585	360	945	14				22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS		176931	108750	285681	3997	809	781	13101	25
26 INTENSIVE CARE UNIT		43604	26801	70405	707	270	128	2117	26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		58554	35990	94544	262	1024	30	724	37
40 ANESTHESIOLOGY		2366	1454	3820		54	6	147	40
41 RADIOLOGY-DIAGNOSTIC		56975	35019	91994	432	431	59	1724	41
44 LABORATORY		43058	26465	69523	392	323	213	4745	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY		13404	8238	21642	336	108	97	1760	49
50 PHYSICAL THERAPY		28725	17656	46381	184	377	8	399	50
53 ELECTROCARDIOLOGY		3744	2301	6045	84	162	42	847	53
54 ELECTROENCEPHALOGRAPHY		2542	1562	4104	15	54	2	34	54
55 MEDICAL SUPPLIES CHARGED TO PAT							25	626	55
56 DRUGS CHARGED TO PATIENTS							185	3325	56
57 RENAL DIALYSIS							4	74	57
58.01 HYPERBARIC CHAMBER									58.01
59 O/P MENTAL HEALTH		26684	16401	43085	293	377	1	608	59
59.10 PARTIAL HOSPITALIZATION		38956	23944	62900	54	108		1006	59.10
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC		16420	10092	26512	217	377	2	521	60
60.01 CICERO CLINIC	12800			12800					60.01
60.02 YMCA CLINIC	10663			10663					60.02
60.03 NORTH AVENUE CLINIC	9625			9625					60.03
60.04 CLINIC #4	2425			2425					60.04
61 EMERGENCY		24974	15350	40324	867	916	53	2570	61
61.01 GOLDEN LIFE		17440	10720	28160				3	61.01
62 OBSERVATION BEDS (NON-DISTINCT)									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	35513	1156287	710709	1902509	11454	11050	1636	34331	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		514	316	830		54			96
98 PHYSICIANS' PRIVATE OFFICES					3				98
100 PUBLIC RELATIONS		520	320	840		54			100
100.10AUSTIN PRIDE	31110	9750	5993	46853	99	108			100.10
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	66623	1167071	717338	1951032	11556	11266	1636	34331	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	OTHER ADMINISTRV & GENERAL 6.06	OPERATION OF PLANT 8	LAUNDRY AND LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINI- STRATION 14	CENTRAL SERVICES & SUPPLY 15	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6.01 COMMUNICATIONS									6.01
6.04 ADMITTING									6.04
6.05 BUSINESS OFFICE									6.05
6.06 OTHER ADMINISTRATIVE	402239								6.06
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	28593	223437							8
9 LAUNDRY & LINEN SERVICE	2867	4320	31110						9
10 HOUSEKEEPING	12564	4187		40191					10
11 DIETARY	13376	12337		359	94821				11
12 CAFETERIA	2468	4795		2090		35995			12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	19459	2056				1760	35779		14
15 CENTRAL SERVICES & SUPPLY	6219	20302		1075		468		140421	15
16 PHARMACY	9584	2841		477		1066			16
17 MEDICAL RECORDS & LIBRARY	10208	6424		359		1137			17
18 SOCIAL SERVICE	1280	760		179		225			18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A	361	171				112			22
23 I&R SERVICES-OTHER PRGM COSTS A	21								23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	121896	51732	16549	10390	89649	15785	22906		25
26 INTENSIVE CARE UNIT	22029	12749	3955	1911	5172	2034	2952		26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	13342	17120	3128	3046		748	1086		37
40 ANESTHESIOLOGY	185	692							40
41 RADIOLOGY-DIAGNOSTIC	19815	16659	1752	2090		1513			41
44 LABORATORY	23572	12589		2090		1985			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	12786	3919		1075		1365			49
50 PHYSICAL THERAPY	6454	8399	409	1822		744			50
53 ELECTROCARDIOLOGY	3200	1095				423			53
54 ELECTROENCEPHALOGRAPHY	499	743				77			54
55 MEDICAL SUPPLIES CHARGED TO PAT	2302							140421	55
56 DRUGS CHARGED TO PATIENTS	15146								56
57 RENAL DIALYSIS	2782								57
58.01 HYPERBARIC CHAMBER									58.01
59 O/P MENTAL HEALTH	9108	7802		1612		1557	2260		59
59.10 PARTIAL HOSPITALIZATION	2362	11390				244	355		59.10
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC	6999	4801		2986		1086	1575		60
60.01 CICERO CLINIC									60.01
60.02 YMCA CLINIC									60.02
60.03 NORTH AVENUE CLINIC									60.03
60.04 CLINIC #4									60.04
61 EMERGENCY	27050	7302	5317	8361		3201	4645		61
61.01 GOLDEN LIFE	340	5099							61.01
62 OBSERVATION BEDS (NON-DISTINCT)									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	396867	220284	31110	39922	94821	35530	35779	140421	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN	34	150							96
98 PHYSICIANS' PRIVATE OFFICES	349					19			98
100 PUBLIC RELATIONS	1369	152							100
100.10AUSTIN PRIDE	3620	2851		269		446			100.10
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	402239	223437	31110	40191	94821	35995	35779	140421	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	I/R-SALARY AND FRINGES 22	I/R-OTHER PROGRAM COSTS 23	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6.01 COMMUNICATIONS								6.01
6.04 ADMITTING								6.04
6.05 BUSINESS OFFICE								6.05
6.06 OTHER ADMINISTRATIVE								6.06
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING								10
11 DIETARY								11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION								14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY	30017							16
17 MEDICAL RECORDS & LIBRARY		54170						17
18 SOCIAL SERVICE			7057					18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A				1603				22
23 I&R SERVICES-OTHER PRGM COSTS A					21			23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	2716	20695	6681			663368	663368	25
26 INTENSIVE CARE UNIT	1091	3339				128859	128859	26
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	313	1141				136508	136508	37
40 ANESTHESIOLOGY		231				5135	5135	40
41 RADIOLOGY-DIAGNOSTIC	31	2718				139218	139218	41
44 LABORATORY	2	7482				122916	122916	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY	249	2775				46112	46112	49
50 PHYSICAL THERAPY		629				65806	65806	50
53 ELECTROCARDIOLOGY	5	1336				13239	13239	53
54 ELECTROENCEPHALOGRAPHY		53				5581	5581	54
55 MEDICAL SUPPLIES CHARGED TO PAT		988				144362	144362	55
56 DRUGS CHARGED TO PATIENTS	23123	5243				47022	47022	56
57 RENAL DIALYSIS		117				2977	2977	57
58.01 HYPERBARIC CHAMBER								58.01
59 O/P MENTAL HEALTH		958				67661	67661	59
59.10 PARTIAL HOSPITALIZATION		1586				80005	80005	59.10
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC	180	822	161			46239	46239	60
60.01 CICERO CLINIC						12800	12800	60.01
60.02 YMCA CLINIC						10663	10663	60.02
60.03 NORTH AVENUE CLINIC						9625	9625	60.03
60.04 CLINIC #4						2425	2425	60.04
61 EMERGENCY	2194	4052	215			107067	107067	61
61.01 GOLDEN LIFE		5				33607	33607	61.01
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	29904	54170	7057			1891195	1891195	95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN						1068	1068	96
98 PHYSICIANS' PRIVATE OFFICES	113					484	484	98
100 PUBLIC RELATIONS						2415	2415	100
100.10AUSTIN PRIDE						54246	54246	100.10
101 CROSS FOOT ADJUSTMENTS				1603	21	1624	1624	101
102 NEGATIVE COST CENTER								102
103 TOTAL	30017	54170	7057	1603	21	1951032	1951032	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP- REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP- REL COSTS MOV EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS GROSS SALARIES	COMMUNI- CATIONS (PHONES	ADMITTING INPATIENT REVENUE	BUSINESS OFFICE GROSS REVENUE	RECON- CILIATION
	3	4	5	6.01	6.04	6.05	6A.06
GENERAL SERVICE COST CENTERS							
1							1
2							2
3	179542						3
4		179542					4
5			26701832				5
6.01			130655	209			6.01
6.04			183687	2	74674422		6.04
6.05			305785	3		94321038	6.05
6.06	37917	37917	2651845	58			-8545150 6.06
7							7
8	18512	18512	893215	3			8
9	2273	2273	30173	1			9
10	2203	2203	610179	1			10
11	6491	6491	812508	5			11
12	2523	2523		3			12
13							13
14	1082	1082	1407389	10			14
15	10682	10682	184641	3			15
16	1495	1495	577082	2			16
17	3380	3380	437997	7			17
18	400	400	88112	7			18
20							20
21							21
22	90	90	31248				22
23							23
24							24
INPATIENT ROUTINE SERV COST CENTERS							
25	27219	27219	9249621	15	35886130	36001236	25
26	6708	6708	1632896	5	5816473	5816473	26
ANCILLARY SERVICE COST CENTERS							
37	9008	9008	604965	19	1375190	1988542	37
40	364	364		1	253867	402704	40
41	8765	8765	998350	8	2674232	4735278	41
44	6624	6624	905120	6	9675066	13035346	44
46.30							46.30
49	2062	2062	775537	2	4389750	4834707	49
50	4419	4419	424391	7	383070	1096016	50
53	576	576	195143	3	1889485	2327891	53
54	391	391	34408	1	84474	92254	54
55					1119073	1721074	55
56					8388075	9133990	56
57					198055	203060	57
58.01							58.01
59	4105	4105	676649	7	62666	1669286	59
59.10	5993	5993	124158	2	6714	2763314	59.10
OUTPATIENT SERVICE COST CENTERS							
60	2526	2526	501039	7	80020	1431478	60
60.01							60.01
60.02							60.02
60.03							60.03
60.04							60.04
61	3842	3842	2001175	17	2392058	7059841	61
61.01	2683	2683			24	8548	61.01
62							62
63.50							63.50
63.60							63.60
OTHER REIMBURSABLE COST CENTERS							
69.10							69.10
69.20							69.20
69.30							69.30
69.40							69.40
71							71
SPECIAL PURPOSE COST CENTERS							
85.01							85.01
85.02							85.02
85.03							85.03
95	177883	177883	26467968	205	74674422	94321038	-8545150 95
NONREIMBURSABLE COST CENTERS							
96	79	79		1			96
98			6139				98
100	80	80		1			100
100.10	1500	1500	227725	2			100.10

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP- REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP- REL COSTS MOV EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS GROSS SALARIES	COMMUNI CATIONS (PHONES	ADMITTING INPATIENT REVENUE	BUSINESS OFFICE GROSS REVENUE	RECON- CILIATION 6A.06
	3	4	5	6.01	6.04	6.05	
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 COST TO BE ALLOC PER B PT I	1167071	717338	3354746	539796	246052	496709	103
104 UNIT COST MULT-WS B PT I		3.995377		2582.755981		.005266	104
104 UNIT COST MULT-WS B PT I	6.500267		.125637		.003295		104
105 COST TO BE ALLOC PER B PT II							105
106 UNIT COST MULT-WS B PT II							106
106 UNIT COST MULT-WS B PT II							106
107 COST TO BE ALLOC PER B PT III			11556	11266	1636	34331	107
108 UNIT COST MULT-WS B PT III				53.904306		.000364	108
108 UNIT COST MULT-WS B PT III			.000433		.000022		108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OTHER ADMINISTRV & GENERAL ACCUM COST	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINI-STRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	
	6.06	8	9	10	11	12	14	15	
GENERAL SERVICE COST CENTERS									
1									1
2									2
3									3
4									4
5									5
6.01									6.01
6.04									6.04
6.05									6.05
6.06	40269840								6.06
7									7
8	2862424	117563							8
9	286978	2273	25253						9
10	1257797	2203		34176					10
11	1339118	6491			305	106164			11
12	247113	2523		1777			915956		12
13									13
14	1948029	1082				44792	627407		14
15	622622	10682		914		11916		100	15
16	959455	1495		406		27124			16
17	1021891	3380		305		28942			17
18	128109	400		152		5731			18
20									20
21									21
22	36119	90				2857			22
23	2099								23
24									24
INPATIENT ROUTINE SERV COST CENTERS									
25	12204534	27219	13434	8836	100373	401667	401667		25
26	2205340	6708	3210	1625	5791	51771	51771		26
ANCILLARY SERVICE COST CENTERS									
37	1335704	9008	2539	2590		19043	19043		37
40	18514	364							40
41	1983723	8765	1422	1777		38494			41
44	2359834	6624		1777		50504			44
46.30									46.30
49	1280046	2062		914		34743			49
50	646136	4419	332	1549		18927			50
53	320341	576				10752			53
54	49924	391				1947			54
55	230455							100	55
56	1516239								56
57	278502								57
58.01									58.01
59	911839	4105		1371		39633	39633		59
59.10	236468	5993				6221	6221		59.10
OUTPATIENT SERVICE COST CENTERS									
60	700635	2526		2539		27623	27623		60
60.01									60.01
60.02									60.02
60.03									60.03
60.04									60.04
61	2707961	3842	4316	7110		81449	81449		61
61.01	34082	2683							61.01
62									62
63.50									63.50
63.60									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10									69.10
69.20									69.20
69.30									69.30
69.40									69.40
71									71
SPECIAL PURPOSE COST CENTERS									
85.01									85.01
85.02									85.02
85.03									85.03
95	39732031	115904	25253	33947	106164	904136	627407	100	95
NONREIMBURSABLE COST CENTERS									
96	3413	79							96
98	34942					479			98
100	137011	80							100
100.10	362443	1500		229		11341			100.10

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OTHER ADMINISTRV & GENERAL ACCUM COST	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINI-STRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	
	6.06	8	9	10	11	12	14	15	
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 COST TO BE ALLOC PER B PT I	8545150	3469822	414961	1589719	1829041	456673	2415662	1118472	103
104 UNIT COST MULT-WS B PT I	.212197		16.432147		17.228448		3.850231		104
104 UNIT COST MULT-WS B PT I		29.514575		46.515654		.498575		11184.720000	104
105 COST TO BE ALLOC PER B PT II									105
106 UNIT COST MULT-WS B PT II									106
106 UNIT COST MULT-WS B PT II									106
107 COST TO BE ALLOC PER B PT III	402239	223437	31110	40191	94821	35995	35779	140421	107
108 UNIT COST MULT-WS B PT III	.009989		1.231933		.893156		.057027		108
108 UNIT COST MULT-WS B PT III		1.900572		1.176001		.039298		1404.210000	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	
	(COSTED REQUIS) 16	GROSS REVENUE 17	(TIME SPENT) 18	(ASSIGNED TIME) 22	(ASSIGNED TIME) 23	
GENERAL SERVICE COST CENTERS						
1 OLD CAP REL COSTS-BLDG & FIXT						1
2 OLD CAP REL COSTS-MVBLE EQUIP						2
3 NEW CAP REL COSTS-BLDG & FIXT						3
4 NEW CAP REL COSTS-MVBLE EQUIP						4
5 EMPLOYEE BENEFITS						5
6.01 COMMUNICATIONS						6.01
6.04 ADMITTING						6.04
6.05 BUSINESS OFFICE						6.05
6.06 OTHER ADMINISTRATIVE						6.06
7 MAINTENANCE & REPAIRS						7
8 OPERATION OF PLANT						8
9 LAUNDRY & LINEN SERVICE						9
10 HOUSEKEEPING						10
11 DIETARY						11
12 CAFETERIA						12
13 MAINTENANCE OF PERSONNEL						13
14 NURSING ADMINISTRATION						14
15 CENTRAL SERVICES & SUPPLY						15
16 PHARMACY	1741635					16
17 MEDICAL RECORDS & LIBRARY		94321038				17
18 SOCIAL SERVICE			13680			18
20 NONPHYSICIAN ANESTHETISTS						20
21 NURSING SCHOOL						21
22 I&R SERVICES-SALARY & FRINGES				10000		22
23 I&R SERVICES-OTHER PRGM COSTS					10000	23
24 PARAMED ED PRGM-(SPECIFY)						24
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	157603	36001236	12952	10000	10000	25
26 INTENSIVE CARE UNIT	63318	5816473				26
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	18146	1988542				37
40 ANESTHESIOLOGY		402704				40
41 RADIOLOGY-DIAGNOSTIC	1778	4735278				41
44 LABORATORY	143	13035346				44
46.30 BLOOD CLOTTING FACTORS ADMIN						46.30
49 RESPIRATORY THERAPY	14427	4834707				49
50 PHYSICAL THERAPY		1096016				50
53 ELECTROCARDIOLOGY	271	2327891				53
54 ELECTROENCEPHALOGRAPHY		92254				54
55 MEDICAL SUPPLIES CHARGED TO P		1721074				55
56 DRUGS CHARGED TO PATIENTS	1341655	9133990				56
57 RENAL DIALYSIS		203060				57
58.01 HYPERBARIC CHAMBER						58.01
59 O/P MENTAL HEALTH		1669286				59
59.10 PARTIAL HOSPITALIZATION		2763314				59.10
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	10451	1431478	312			60
60.01 CICERO CLINIC						60.01
60.02 YMCA CLINIC						60.02
60.03 NORTH AVENUE CLINIC						60.03
60.04 CLINIC #4						60.04
61 EMERGENCY	127309	7059841	416			61
61.01 GOLDEN LIFE		8548				61.01
62 OBSERVATION BEDS (NON-DISTINC						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
69.10 CMHC						69.10
69.20 OUTPATIENT PHYSICAL THERAPY						69.20
69.30 OUTPATIENT OCCUPATIONAL THERA						69.30
69.40 OUTPATIENT SPEECH PATHOLOGY						69.40
71 HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS						
85.01 PANCREAS ACQUISITION						85.01
85.02 INTESTINAL ACQUISITION						85.02
85.03 ISLET CELL ACQUISITION						85.03
95 SUBTOTALS	1735101	94321038	13680	10000	10000	95
NONREIMBURSABLE COST CENTERS						
96 GIFT, FLOWER, COFFEE SHOP & C						96
98 PHYSICIANS' PRIVATE OFFICES	6534					98
100 PUBLIC RELATIONS						100
100.10 AUSTIN PRIDE						100.10

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL	SOCIAL	I/R-SALARY	I/R-OTHER	
	(COSTED REQUIS) 16	RECORDS & LIBRARY GROSS REVENUE 17	SERVICE (TIME SPENT) 18	AND FRINGES (ASSIGNED TIME) 22	PROGRAM COSTS (ASSIGNED TIME) 23	
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 COST TO BE ALLOC PER B PT I	1239580	1367109	177026	47863	2544	103
104 UNIT COST MULT-WS B PT I	.711734		12.940497		.254400	104
104 UNIT COST MULT-WS B PT I		.014494		4.786300		104
105 COST TO BE ALLOC PER B PT II						105
106 UNIT COST MULT-WS B PT II						106
106 UNIT COST MULT-WS B PT II						106
107 COST TO BE ALLOC PER B PT III	30017	54170	7057	1603	21	107
108 UNIT COST MULT-WS B PT III	.017235		.515863		.002100	108
108 UNIT COST MULT-WS B PT III		.000574		.160300		108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 27)	LIMIT ADJUSTMENT		DISALLOWANCE		
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	20507077		20507077		20507077	25
26 INTENSIVE CARE UNIT	3453908		3453908		3453908	26
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	2171751		2171751		2171751	37
40 ANESTHESIOLOGY	39023		39023		39023	40
41 RADIOLOGY-DIAGNOSTIC	2858473		2858473		2858473	41
44 LABORATORY	3352963		3352963		3352963	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	1752706		1752706		1752706	49
50 PHYSICAL THERAPY	1016500		1016500		1016500	50
53 ELECTROCARDIOLOGY	444610		444610		444610	53
54 ELECTROENCEPHALOGRAPHY	74366		74366		74366	54
55 MEDICAL SUPPLIES CHARGED TO	1422774		1422774		1422774	55
56 DRUGS CHARGED TO PATIENTS	2925270		2925270		2925270	56
57 RENAL DIALYSIS	340542		340542		340542	57
58.01 HYPERBARIC CHAMBER						58.01
59 O/P MENTAL HEALTH	1486810		1486810		1486810	59
59.10 PARTIAL HOSPITALIZATION	530632		530632		530632	59.10
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	1194315		1194315		1194315	60
60.01 CICERO CLINIC						60.01
60.02 YMCA CLINIC						60.02
60.03 NORTH AVENUE CLINIC						60.03
60.04 CLINIC #4						60.04
61 EMERGENCY	4350147		4350147		4350147	61
61.01 GOLDEN LIFE	120626		120626		120626	61.01
62 OBSERVATION BEDS (NON-DISTI						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	48042493		48042493		48042493	101
102 LESS OBSERVATION BEDS						102
103 TOTAL	48042493		48042493		48042493	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	35886130		35886130			25
26 INTENSIVE CARE UNIT	5816473		5816473			26
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	1375190	613352	1988542	1.092132	1.092132	1.092132 37
40 ANESTHESIOLOGY	253867	148837	402704	.096902	.096902	.096902 40
41 RADIOLOGY-DIAGNOSTIC	2674232	2061046	4735278	.603655	.603655	.603655 41
44 LABORATORY	9675066	3360280	13035346	.257221	.257221	.257221 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	4389750	444957	4834707	.362526	.362526	.362526 49
50 PHYSICAL THERAPY	383070	712946	1096016	.927450	.927450	.927450 50
53 ELECTROCARDIOLOGY	1889485	438406	2327891	.190993	.190993	.190993 53
54 ELECTROENCEPHALOGRAPHY	84474	7780	92254	.806101	.806101	.806101 54
55 MEDICAL SUPPLIES CHARGED TO	1119073	602001	1721074	.826678	.826678	.826678 55
56 DRUGS CHARGED TO PATIENTS	8388075	745915	9133990	.320262	.320262	.320262 56
57 RENAL DIALYSIS	198055	5005	203060	1.677051	1.677051	1.677051 57
58.01 HYPERBARIC CHAMBER						58.01
59 O/P MENTAL HEALTH	62666	1606620	1669286	.890686	.890686	.890686 59
59.10 PARTIAL HOSPITALIZATION	6714	2756600	2763314	.192027	.192027	.192027 59.10
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	80020	1351458	1431478	.834323	.834323	.834323 60
60.01 CICERO CLINIC						60.01
60.02 YMCA CLINIC						60.02
60.03 NORTH AVENUE CLINIC						60.03
60.04 CLINIC #4						60.04
61 EMERGENCY	2392058	4667783	7059841	.616182	.616182	.616182 61
61.01 GOLDEN LIFE	24	8524	8548	14.111605	14.111605	14.111605 61.01
62 OBSERVATION BEDS (NON-DISTI		115106	115106			62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	74674422	19646616	94321038			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	74674422	19646616	94321038			103

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST
	1	2	3	4	5	6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				663368		663368
26 INTENSIVE CARE UNIT				128859		128859
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL				792227		792227

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST
	7	8	9	10	11	12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	37175	14199			17.84	253310
26 INTENSIVE CARE UNIT	3217	1620			40.06	64897
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL	40392	15819				318207

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0083) [] SUB III [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [] TITLE XIX [] SUB II

COST CENTER DESCRIPTION	OLD CAPITAL	NEW CAPITAL	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	----- OLD CAPITAL -----		----- NEW CAPITAL -----	
	RELATED COST	RELATED COST			RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		136508	1988542	758129			.068647	52043 37
40 ANESTHESIOLOGY		5135	402704	140334			.012751	1789 40
41 RADIOLOGY-DIAGNOSTIC		139218	4735278	1132948			.029400	33309 41
44 LABORATORY		122916	13035346	3905334			.009429	36823 44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY		46112	4834707	2202668			.009538	21009 49
50 PHYSICAL THERAPY		65806	1096016	199690			.060041	11990 50
53 ELECTROCARDIOLOGY		13239	2327891	858160			.005687	4880 53
54 ELECTROENCEPHALOGRAPHY		5581	92254	42148			.060496	2550 54
55 MEDICAL SUPPLIES CHARGED TO P		144362	1721074	543950			.083879	45626 55
56 DRUGS CHARGED TO PATIENTS		47022	9133990	3516826			.005148	18105 56
57 RENAL DIALYSIS		2977	203060				.014661	57
58.01 HYPERBARIC CHAMBER								58.01
59 O/P MENTAL HEALTH		67661	1669286				.040533	59
59.10 PARTIAL HOSPITALIZATION		80005	2763314	5929			.028953	172 59.10
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		46239	1431478	17793			.032302	575 60
60.01 CICERO CLINIC		12800						60.01
60.02 YMCA CLINIC		10663						60.02
60.03 NORTH AVENUE CLINIC		9625						60.03
60.04 CLINIC #4		2425						60.04
61 EMERGENCY		107067	7059841	856623			.015166	12992 61
61.01 GOLDEN LIFE		33607	8548	21			3.931563	83 61.01
62 OBSERVATION BEDS (NON-DISTINC			115106					62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
101 TOTAL		1098968	52618435	14180553				241946 101

PROVIDER NO. 14-0083 LORETTO HOSPITAL
 PERIOD FROM 07/01/2007 TO 06/30/2008

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

VERSION: 2008.05
 12/04/2008 09:52

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					37175		14199	25
26 INTENSIVE CARE UNIT					3217		1620	26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					40392		15819	101

PROVIDER NO. 14-0083 LORETTO HOSPITAL
 PERIOD FROM 07/01/2007 TO 06/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05
 12/04/2008 09:52

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0083) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST	NONPHYSICIAN ANESTHETIST	MEDICAL EDUCATION				
	COST	COST	COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
54 ELECTROENCEPHALOGRAPHY							54
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
57 RENAL DIALYSIS							57
58.01 HYPERBARIC CHAMBER							58.01
59 O/P MENTAL HEALTH							59
59.10 PARTIAL HOSPITALIZATION							59.10
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
60.01 CICERO CLINIC							60.01
60.02 YMCA CLINIC							60.02
60.03 NORTH AVENUE CLINIC							60.03
60.04 CLINIC #4							60.04
61 EMERGENCY							61
61.01 GOLDEN LIFE							61.01
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0083) [] SUB IV [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [] TITLE XIX [] SUB II [] NF
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		1988542			758129		225044 37
40 ANESTHESIOLOGY		402704			140334		54338 40
41 RADIOLOGY-DIAGNOSTIC		4735278			1132948		371705 41
44 LABORATORY		13035346			3905334		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		4834707			2202668		104929 49
50 PHYSICAL THERAPY		1096016			199690		50
53 ELECTROCARDIOLOGY		2327891			858160		130512 53
54 ELECTROENCEPHALOGRAPHY		92254			42148		2287 54
55 MEDICAL SUPPLIES CHARGED TO P		1721074			543950		157612 55
56 DRUGS CHARGED TO PATIENTS		9133990			3516826		214840 56
57 RENAL DIALYSIS		203060					57
58.01 HYPERBARIC CHAMBER							58.01
59 O/P MENTAL HEALTH		1669286					100276 59
59.10 PARTIAL HOSPITALIZATION		2763314			5929		59.10
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		1431478			17793		544737 60
60.01 CICERO CLINIC							60.01
60.02 YMCA CLINIC							60.02
60.03 NORTH AVENUE CLINIC							60.03
60.04 CLINIC #4							60.04
61 EMERGENCY		7059841			856623		473814 61
61.01 GOLDEN LIFE		8548			21		61.01
62 OBSERVATION BEDS (NON-DISTINC		115106					62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		52618435			14180553		2380094 101

PROVIDER NO. 14-0083 LORETTO HOSPITAL
 PERIOD FROM 07/01/2007 TO 06/30/2008

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-0083)	<input type="checkbox"/>	SUB IV	<input type="checkbox"/>	PPS
APPLICABLE	<input checked="" type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	SUB I	<input type="checkbox"/>	SNF	<input type="checkbox"/>	TEFRA
BOXES	<input type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	SUB II	<input type="checkbox"/>	NF		
			<input type="checkbox"/>	SUB III	<input type="checkbox"/>	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTting FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
57 RENAL DIALYSIS					57
58.01 HYPERBARIC CHAMBER					58.01
59 O/P MENTAL HEALTH					59
59.10 PARTIAL HOSPITALIZATION					59.10
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
60.01 CICERO CLINIC					60.01
60.02 YMCA CLINIC					60.02
60.03 NORTH AVENUE CLINIC					60.03
60.04 CLINIC #4					60.04
61 EMERGENCY					61
61.01 GOLDEN LIFE					61.01
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL					101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0083) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	1.092132	1.092132	1.092132			37
40 ANESTHESIOLOGY	.096902	.096902	.096902			40
41 RADIOLOGY-DIAGNOSTIC	.603655	.603655	.603655			41
44 LABORATORY	.257221	.257221	.257221			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	.362526	.362526	.362526			49
50 PHYSICAL THERAPY	.927450	.927450	.927450			50
53 ELECTROCARDIOLOGY	.190993	.190993	.190993			53
54 ELECTROENCEPHALOGRAPHY	.806101	.806101	.806101			54
55 MEDICAL SUPPLIES CHARGED TO PAT	.826678	.826678	.826678			55
56 DRUGS CHARGED TO PATIENTS	.320262	.320262	.320262			56
57 RENAL DIALYSIS	1.677051	1.677051	1.677051			57
58.01 HYPERBARIC CHAMBER						58.01
59 O/P MENTAL HEALTH	.890686	.890686	.890686			59
59.10 PARTIAL HOSPITALIZATION	.192027	.192027	.192027			59.10
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	.834323	.834323	.834323			60
60.01 CICERO CLINIC						60.01
60.02 YMCA CLINIC						60.02
60.03 NORTH AVENUE CLINIC						60.03
60.04 CLINIC #4						60.04
61 EMERGENCY	.616182	.616182	.616182			61
61.01 GOLDEN LIFE	14.111605	14.111605	14.111605			61.01
62 OBSERVATION BEDS (NON-DISTINCT						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65.01 AMBULANCE SERVICES (2ND PERIOD)						65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)						65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)						65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	1	.320262	1
2 PROGRAM VACCINE CHARGES	2	540	2
2.01 PROGRAM VACCINE CHARGES	2.01		2.01
3 PROGRAM COSTS	3	173	3
3.01 PROGRAM COSTS	3.01		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0083) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
	ALL OTHER (1) (SEE INSTRU.)	PPS SER-VICES (SEE INSTRU.)	ALL OTHER (SEE INSTRU.)	PPS SER-VICES (SEE INSTRU.)	PPS SER-VICES (SEE INSTRU.)	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	5	5.01	5.02	5.03	5.04	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		225044						37
40 ANESTHESIOLOGY		54338						40
41 RADIOLOGY-DIAGNOSTIC		371705						41
44 LABORATORY								44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY		104929						49
50 PHYSICAL THERAPY								50
53 ELECTROCARDIOLOGY		130512						53
54 ELECTROENCEPHALOGRAPHY		2287						54
55 MEDICAL SUPPLIES CHARGED TO PA		157612						55
56 DRUGS CHARGED TO PATIENTS		214840						56
57 RENAL DIALYSIS								57
58.01 HYPERBARIC CHAMBER								58.01
59 O/P MENTAL HEALTH		100276						59
59.10 PARTIAL HOSPITALIZATION								59.10
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		544737						60
60.01 CICERO CLINIC								60.01
60.02 YMCA CLINIC								60.02
60.03 NORTH AVENUE CLINIC								60.03
60.04 CLINIC #4								60.04
61 EMERGENCY		473814						61
61.01 GOLDEN LIFE								61.01
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE SERVICES (2ND PERIOD)								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)								65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)								65.03
101 SUBTOTAL		2380094						101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES		2380094						104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0083) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5) 9	PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS 1.01x5.03) 9.03	PPS SERVICES (COLUMNS 1.01x5.04) 9.04	I/P PART B CHARGES (SEE INSTRU.) 10	I/P PART B COST (COLUMNS 1.02x10) 11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		245778					37
40 ANESTHESIOLOGY		5265					40
41 RADIOLOGY-DIAGNOSTIC		224382					41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY		38039					49
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY		24927					53
54 ELECTROENCEPHALOGRAPHY		1844					54
55 MEDICAL SUPPLIES CHARGED TO PAT		130294					55
56 DRUGS CHARGED TO PATIENTS		68805					56
57 RENAL DIALYSIS							57
58.01 HYPERBARIC CHAMBER							58.01
59 O/P MENTAL HEALTH		89314					59
59.10 PARTIAL HOSPITALIZATION							59.10
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		454487					60
60.01 CICERO CLINIC							60.01
60.02 YMCA CLINIC							60.02
60.03 NORTH AVENUE CLINIC							60.03
60.04 CLINIC #4							60.04
61 EMERGENCY		291956					61
61.01 GOLDEN LIFE							61.01
62 OBSERVATION BEDS (NON-DISTINCT)							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL		1575091					101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES		1575091					104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	----- OLD CAPITAL -----			----- NEW CAPITAL -----			
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	
	1	2	3	4	5	6	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS				663368		663368	25
26 INTENSIVE CARE UNIT				128859		128859	26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL				792227		792227	101

COST CENTER DESCRIPTION	---- OLD CAPITAL ----			---- NEW CAPITAL ----			
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST	
	7	8	9	10	11	12	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS	37175	19505			17.84	347969	25
26 INTENSIVE CARE UNIT	3217	630			40.06	25238	26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL	40392	20135				373207	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0083) [] SUB III [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [XX] OTHER

COST CENTER DESCRIPTION	OLD	NEW	TOTAL	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----	
	CAPITAL RELATED COST	CAPITAL RELATED COST			RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		136508	1988542				.068647	37
40 ANESTHESIOLOGY		5135	402704				.012751	40
41 RADIOLOGY-DIAGNOSTIC		139218	4735278				.029400	41
44 LABORATORY		122916	13035346				.009429	44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY		46112	4834707				.009538	49
50 PHYSICAL THERAPY		65806	1096016				.060041	50
53 ELECTROCARDIOLOGY		13239	2327891				.005687	53
54 ELECTROENCEPHALOGRAPHY		5581	92254				.060496	54
55 MEDICAL SUPPLIES CHARGED TO P		144362	1721074				.083879	55
56 DRUGS CHARGED TO PATIENTS		47022	9133990				.005148	56
57 RENAL DIALYSIS		2977	203060				.014661	57
58.01 HYPERBARIC CHAMBER								58.01
59 O/P MENTAL HEALTH		67661	1669286				.040533	59
59.10 PARTIAL HOSPITALIZATION		80005	2763314				.028953	59.10
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		46239	1431478				.032302	60
60.01 CICERO CLINIC		12800						60.01
60.02 YMCA CLINIC		10663						60.02
60.03 NORTH AVENUE CLINIC		9625						60.03
60.04 CLINIC #4		2425						60.04
61 EMERGENCY		107067	7059841				.015166	61
61.01 GOLDEN LIFE		33607	8548				3.931563	61.01
62 OBSERVATION BEDS (NON-DISTINC			115106					62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
101 TOTAL		1098968	52618435					101

PROVIDER NO. 14-0083 LORETTO HOSPITAL
 PERIOD FROM 07/01/2007 TO 06/30/2008

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

VERSION: 2008.05
 12/04/2008 09:52

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL COSTS	TOTAL	PER DIEM	INPATIENT	INPATIENT
	ANESTHETIST COST	EDUCATION COST	ADJUSTMENT AMOUNT		PATIENT DAYS		PROGRAM DAYS	PASS THRU COSTS
	1	2	3	4	5	6	7	8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					37175		19505	25
26 INTENSIVE CARE UNIT					3217		630	26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					40392		20135	101

PROVIDER NO. 14-0083 LORETTO HOSPITAL
 PERIOD FROM 07/01/2007 TO 06/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05
 12/04/2008 09:52

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0083) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
54 ELECTROENCEPHALOGRAPHY							54
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
57 RENAL DIALYSIS							57
58.01 HYPERBARIC CHAMBER							58.01
59 O/P MENTAL HEALTH							59
59.10 PARTIAL HOSPITALIZATION							59.10
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
60.01 CICERO CLINIC							60.01
60.02 YMCA CLINIC							60.02
60.03 NORTH AVENUE CLINIC							60.03
60.04 CLINIC #4							60.04
61 EMERGENCY							61
61.01 GOLDEN LIFE							61.01
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

PROVIDER NO. 14-0083 LORETTO HOSPITAL
 PERIOD FROM 07/01/2007 TO 06/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05
 12/04/2008 09:52

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0083) [] SUB IV [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] NF [] OTHER
 [] SUB III [] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		1988542					37
40 ANESTHESIOLOGY		402704					40
41 RADIOLOGY-DIAGNOSTIC		4735278					41
44 LABORATORY		13035346					44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		4834707					49
50 PHYSICAL THERAPY		1096016					50
53 ELECTROCARDIOLOGY		2327891					53
54 ELECTROENCEPHALOGRAPHY		92254					54
55 MEDICAL SUPPLIES CHARGED TO P		1721074					55
56 DRUGS CHARGED TO PATIENTS		9133990					56
57 RENAL DIALYSIS		203060					57
58.01 HYPERBARIC CHAMBER							58.01
59 O/P MENTAL HEALTH		1669286					59
59.10 PARTIAL HOSPITALIZATION		2763314					59.10
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		1431478					60
60.01 CICERO CLINIC							60.01
60.02 YMCA CLINIC							60.02
60.03 NORTH AVENUE CLINIC							60.03
60.04 CLINIC #4							60.04
61 EMERGENCY		7059841					61
61.01 GOLDEN LIFE		8548					61.01
62 OBSERVATION BEDS (NON-DISTINC		115106					62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		52618435					101

PROVIDER NO. 14-0083 LORETTO HOSPITAL
 PERIOD FROM 07/01/2007 TO 06/30/2008

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05
 12/04/2008 09:52

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-0083)	<input type="checkbox"/>	SUB IV	<input type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	SUB I	<input type="checkbox"/>	SNF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	SUB II	<input type="checkbox"/>	NF	<input type="checkbox"/>	OTHER
			<input type="checkbox"/>	SUB III	<input type="checkbox"/>	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
	8.01	8.02	9	9.01	9.02
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
57 RENAL DIALYSIS					57
58.01 HYPERBARIC CHAMBER					58.01
59 O/P MENTAL HEALTH					59
59.10 PARTIAL HOSPITALIZATION					59.10
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
60.01 CICERO CLINIC					60.01
60.02 YMCA CLINIC					60.02
60.03 NORTH AVENUE CLINIC					60.03
60.04 CLINIC #4					60.04
61 EMERGENCY					61
61.01 GOLDEN LIFE					61.01
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL					101

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-0083)	SUB I	SUB II	SUB III	SUB IV	SNF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	37175						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	37175						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	37175						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	14199						9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-0083)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT							
	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	20507077						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	20507077						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	30271282						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	30271282						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.677443						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	814.29						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	20507077						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-0083)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	551.64					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	7832736					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	7832736					41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
44 INTENSIVE CARE UNIT	3453908	3217	1073.64	1620	1739297	43
45 CORONARY CARE UNIT						44
46 BURN INTENSIVE CARE UNIT						45
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (14-0083)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	5831718					48
49 TOTAL PROGRAM INPATIENT COSTS	15403751					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	318207					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	241946					51
52 TOTAL PROGRAM EXCLUDABLE COST	560153					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	14843598					53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-0083)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

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

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

SNF

1

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

PROVIDER NO. 14-0083 LORETTO HOSPITAL
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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

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

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV
	(PPS)				
	(14-0083)				
	1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS		83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	551.64	84
85 OBSERVATION BED COST		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL					
	ROUTINE	COLUMN 1	TOTAL	OBSERVATION	OBSERVATION BED
	COST	DIVIDED BY	OBSERVATION	BED COST	PASS-THROUGH COST
	(FROM LINE 27)	COLUMN 2	(FROM LINE 85)	COL 3	TIMES COL 4
	1	2	3	4	5

86 OLD CAPITAL-RELATED COST		20507077			86
87 NEW CAPITAL-RELATED COST	663368	20507077	.032348		87
88 NON PHYSICIAN ANESTHETIST		20507077			88
89 MEDICAL EDUCATION		20507077			89

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-0083)	SUB I	SUB II	SUB III	SUB IV	NF
INPATIENT DAYS	1	1	1	1	1	1
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	37175					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	37175					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	37175					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	19505					9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)						14
15 TOTAL NURSERY DAYS						15
16 TITLE V OR XIX NURSERY DAYS						16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-0083)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT							
17		1	1	1	1	1	17
MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							
18							18
MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							
19							19
MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							
20							20
MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							
21	20507077						21
TOTAL GENERAL INPATIENT ROUTINE SERVICE COST							
22							22
SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							
23							23
SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							
24							24
SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							
25							25
SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							
26							26
TOTAL SWING-BED COST							
27	20507077						27
GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	30271282						28
GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)							
29							29
PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							
30	30271282						30
SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							
31	.677443						31
GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO							
32							32
AVERAGE PRIVATE ROOM PER DIEM CHARGE							
33	814.29						33
AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE							
34							34
AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							
35							35
AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							
36							36
PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							
37	20507077						37
GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL							

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-0083)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	551.64					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	10759738					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	10759738					41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
44 INTENSIVE CARE UNIT	3453908	3217	1073.64	630	676393	43
45 CORONARY CARE UNIT						44
46 BURN INTENSIVE CARE UNIT						45
47 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-0083)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49 TOTAL PROGRAM INPATIENT COSTS	11436131					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	373207					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST	373207					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-0083)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
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 LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (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 INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60						MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61						MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
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

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

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

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

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

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-0083)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS		83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	551.64	84
85 OBSERVATION BED COST		85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-0083)	<input type="checkbox"/> SNF	<input checked="" type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		13128758		25
26 INTENSIVE CARE UNIT		2961971		26
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	1.092132	758129	827977	37
40 ANESTHESIOLOGY	.096902	140334	13599	40
41 RADIOLOGY-DIAGNOSTIC	.603655	1132948	683910	41
44 LABORATORY	.257221	3905334	1004534	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.362526	2202668	798524	49
50 PHYSICAL THERAPY	.927450	199690	185202	50
53 ELECTROCARDIOLOGY	.190993	858160	163903	53
54 ELECTROENCEPHALOGRAPHY	.806101	42148	33976	54
55 MEDICAL SUPPLIES CHARGED TO PAT	.826678	543950	449671	55
56 DRUGS CHARGED TO PATIENTS	.320262	3516826	1126306	56
57 RENAL DIALYSIS	1.677051			57
58.01 HYPERBARIC CHAMBER				58.01
59 O/P MENTAL HEALTH	.890686			59
59.10 PARTIAL HOSPITALIZATION	.192027	5929	1139	59.10
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	.834323	17793	14845	60
60.01 CICERO CLINIC				60.01
60.02 YMCA CLINIC				60.02
60.03 NORTH AVENUE CLINIC				60.03
60.04 CLINIC #4				60.04
61 EMERGENCY	.616182	856623	527836	61
61.01 GOLDEN LIFE	14.111605	21	296	61.01
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS				62
63.50 RHC				63.50
63.60 FQHC				63.60
101 TOTAL		14180553	5831718	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		14180553		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-0083)	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input checked="" type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	3
INPATIENT ROUTINE SERVICE COST CENTERS			
25 ADULTS & PEDIATRICS			25
26 INTENSIVE CARE UNIT			26
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	1.092132		37
40 ANESTHESIOLOGY	.096902		40
41 RADIOLOGY-DIAGNOSTIC	.603655		41
44 LABORATORY	.257221		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
49 RESPIRATORY THERAPY	.362526		49
50 PHYSICAL THERAPY	.927450		50
53 ELECTROCARDIOLOGY	.190993		53
54 ELECTROENCEPHALOGRAPHY	.806101		54
55 MEDICAL SUPPLIES CHARGED TO PAT	.826678		55
56 DRUGS CHARGED TO PATIENTS	.320262		56
57 RENAL DIALYSIS	1.677051		57
58.01 HYPERBARIC CHAMBER			58.01
59 O/P MENTAL HEALTH	.890686		59
59.10 PARTIAL HOSPITALIZATION	.192027		59.10
OUTPATIENT SERVICE COST CENTERS			
60 CLINIC	.834323		60
60.01 CICERO CLINIC			60.01
60.02 YMCA CLINIC			60.02
60.03 NORTH AVENUE CLINIC			60.03
60.04 CLINIC #4			60.04
61 EMERGENCY	.616182		61
61.01 GOLDEN LIFE	14.111605		61.01
62 OBSERVATION BEDS (NON-DISTINCT			62
OTHER REIMBURSABLE COST CENTERS			
63.50 RHC			63.50
63.60 FQHC			63.60
101 TOTAL			101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			102
103 NET CHARGES			103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

DRG AMOUNT	HOSPITAL (14-0083)	SUB I	SUB II	SUB III	SUB IV	
1 OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1	2811691					1
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1	2811691					1.01
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS	5623382					1.02
1.03 PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1	1					1.03
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1						1.04
1.05 PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08 SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2 OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01 OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT	169249					2.01
3 BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD	183.00					3
3.01 NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI,LN.15][PLUS LN.3.06]						3.06
3.07 SUM OF LINES 3.04-3.06	0.00		0.00			3.07
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS						3.08
3.09 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13 FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS	3.00					3.13
3.14 CURRENT YEAR ALLOWABLE FTE	3.00					3.14
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..	2.00					3.15
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..	3.00					3.16
RES. IN INIT YRS						
3.17 SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO	0.00	2.67				3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL (14-0083)	SUB I	SUB II	SUB III	SUB IV	
3.18	CURRENT YEAR RESIDENT TO BED RATIO	0.014590				3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO	0.014592				3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19	0.014590				3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1	21836				3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1	22330				3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES][PLUS E-3,PT.VI] [3.21-3.23][LINE 23]	44661				3.23
3.24	SUM OF LINES 3.21-3.23 DISPROPORTIONATE SHARE ADJUSTMENT	88827	0	88827		3.24
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS	0.2007				4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS	0.5137				4.01
4.02	SUM OF 4 AND 4.01	0.7144				4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE	0.4815				4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES	5415317				4.04
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317					5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317					5.01
5.02	DIVIDE LINE 5.01 BY LINE 5					5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317					5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK					5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS					5.05
5.06	TOTAL ADDITIONAL PAYMENT					5.06
6	SUBTOTAL	16920157				6
7	HOSPITAL SPECIFIC PAYMENTS					7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)					7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS	16920157				8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL	1129976				9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL					10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT	87393				11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE					11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES					11.02
12	NET ORGAN ACQUISITION COST					12
13	COST OF TEACHING PHYSICIANS					13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS					14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS					15
16	TOTAL	18137526				16
17	PRIMARY PAYER PAYMENTS					17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES	18137526				18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	1072800				19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	373240				20
21	REIMBURSABLE BAD DEBTS	750278				21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS	525195				21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	750278				21.02
22	SUBTOTAL	17216681				22

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WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL (14-0083)	SUB I	SUB II	SUB III	SUB IV	
23	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					23
24	OTHER ADJUSTMENTS					24
25	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					25
26	AMOUNT DUE PROVIDER	17216681				26
27	SEQUESTRATION ADJUSTMENT					27
28	INTERIM PAYMENTS	17414876				28
28.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					28.01
29	BALANCE DUE PROVIDER (PROGRAM)	-198195				29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					30
	TO BE COMPLETED BY INTERMEDIARY					
50	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01					50
51	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01					51
52	OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTR.)					52
53	CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)					53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY					54
55	TIME VALUE OF MONEY (SEE INSTRUCTIONS)					55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)					56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-0083) 1	HOSPITAL (14-0083) 1.01	HOSPITAL (14-0083) 1.02	
1 MEDICAL AND OTHER SERVICES	173			1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000	1575091			1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS	1002526			1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO	0.872			1.03
1.04 LINE 1.01 TIMES LINE 1.03	1373479			1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04	72.99			1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST	173			5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES	540			6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES	540			10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES	540			14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST	367			15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES	173			17
17.01 TOTAL PPS PAYMENTS	1002526			17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-0083) 1	HOSPITAL (14-0083) 1.01	HOSPITAL (14-0083) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES AND COINSURANCE			18
18.01 DEDUCTIBLES AND COINSURANCE RELATING TO	285868		18.01
LINE 17.01			
19 SUBTOTAL	716831		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	8937		21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	725768		23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL	725768		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	94322		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	66025		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	94322		27.02
28 SUBTOTAL	791793		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	791793		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	717198		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	74595		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36

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WORKSHEET E
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(14-0083)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

1	STANDARD OVERHEAD AMOUNTS (ASC FEES)	1
2	DEDUCTIBLES	2
3	SUBTOTAL	3
4	80 PERCENT OF LINE 3	4
5	ASC PORTION OF BLEND	5
6	OUTPATIENT ASC COST	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	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)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	HOSPITAL SPECIFIC PORTION OF BLEND	17
18	ASC BLENDED AMOUNT	18
19	LESSER OF LINES 16 OR 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	ASC PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(14-0083)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

1	PREVAILING CHARGES	1
2	62 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OUTPATIENT RADIOLOGY	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	RADIOLOGY PAYMENT AMOUNT	21

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(14-0083)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

1	PREVAILING CHARGES	1
2	42 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	DIAGNOSTIC PAYMENT AMOUNT	21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (14-0083)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B		
	PART A				
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		17414876		717198	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM					
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .01				3.01
REVISION OF THE INTERIM RATE FOR THE COST	TO .02				3.02
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .03	NONE		NONE	3.03
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .04				3.04
	.05				3.05
	.50				3.50
	PROVIDER .51				3.51
	TO .52	NONE		NONE	3.52
	PROGRAM .53				3.53
	.54				3.54
SUBTOTAL	.99				3.99
4 TOTAL INTERIM PAYMENTS		17414876		717198	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02	NONE		NONE	5.02
	PROVIDER .03				5.03
	PROVIDER .50				5.50
	TO .51	NONE		NONE	5.51
	PROGRAM .52				5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01			74595	6.01
	PROVIDER TO .02	-198195			6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		17216681		791793	7
NAME OF INTERMEDIARY: _____			INTERMEDIARY NUMBER: _____		
SIGNATURE OF AUTHORIZED PERSON: _____			DATE (MO/DAY/YR): _____		

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

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX		
	HOSPITAL (14-0083) (OTHER)	SUB I	SUB II	SUB III	
		SUB IV	NF I		
1	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1
2	INPATIENT HOSPITAL/SNF/NF SERVICES	11436131			1
3	MEDICAL AND OTHER SERVICES				2
4	INTERNS AND RESIDENTS				3
5	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O				4
6	COST OF TEACHING PHYSICIANS				5
7	SUBTOTAL	11436131			6
8	INPATIENT PRIMARY PAYER PAYMENTS				7
9	OUTPATIENT PRIMARY PAYER PAYMENTS				8
10	SUBTOTAL	11436131			9
11	COMPUTATION OF LESSER OF COST OR CHARGES				
12	ROUTINE SERVICE CHARGES				10
13	ANCILLARY SERVICE CHARGES				11
14	INTERNS AND RESIDENTS SERVICE CHARGES				12
15	ORGAN ACQUISITION CHARGES, NET OF REVENUE				13
16	TEACHING PHYSICIANS				14
17	INCENTIVE FROM TARGET AMOUNT COMPUTATION				15
18	TOTAL REASONABLE CHARGES				16
19	CUSTOMARY CHARGES				
20	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE				17
21	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM				18
22	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN				
23	ACCORDANCE WITH 42 CFR 413.13(E)				
24	RATIO OF LINE 17 TO LINE 18				19
25	TOTAL CUSTOMARY CHARGES				20
26	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST				21
27	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	11436131			22
28	COST OF COVERED SERVICES	11436131			23
29	PROSPECTIVE PAYMENT AMOUNT				
30	OTHER THAN OUTLIER PAYMENTS				24
31	OUTLIER PAYMENTS				25
32	PROGRAM CAPITAL PAYMENTS				26
33	CAPITAL EXCEPTION PAYMENTS				27
34	ROUTINE SERVICE OTHER PASS THROUGH COSTS				28
35	ANCILLARY SERVICE OTHER PASS THROUGH COSTS				29
36	SUBTOTAL	11436131			30
37	CUSTOMARY CHARGES (TITLE XIX PPS COVERED				31
38	LESSER OF LINES 30 OR 31	11436131			32
39	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)				33

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

WORKSHEET E-3
 PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX			
	HOSPITAL (14-0083) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
	1	1	1	1	1	1
34	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
35	EXCESS OF REASONABLE COST	11436131				34
36	SUBTOTAL					35
37	COINSURANCE					36
38	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,					37
38	REIMBURSABLE BAD DEBTS					38
38.01	REDUCED REIMBURSABLE BAD DEBTS					38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)					38.02
39	UTILIZATION REVIEW					39
40	SUBTOTAL					40
41	INPATIENT ROUTINE SERVICE COST					41
42	MEDICARE INPATIENT ROUTINE CHARGES					42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE					43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)					44
45	RATIO OF LINE 43 TO LINE 44					45
46	TOTAL CUSTOMARY CHARGES					46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST					47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES					48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION					49
50	OTHER ADJUSTMENTS					50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS					51
52	SUBTOTAL					52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT					53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS					54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER					55
56	SEQUESTRATION ADJUSTMENT					56
57	INTERIM PAYMENTS					57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					57.01
58	BALANCE DUE PROVIDER/PROGRAM					58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2					59

DIRECT GRADUATE MEDICAL EDUCATION (GME)
 & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
 PART IV

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	NUMBER OF FTE RESIDENTS FOR OB/GYN & PRIMARY CARE		1
1.01	NUMBER OF FTE RESIDENTS FOR ALL OTHERS		1.01
2	UPDATED PER RESIDENT AMOUNT FOR OB/GYN & PRIMARY CARE		2
2.01	UPDATED PER RESIDENT AMOUNT FOR ALL OTHERS		2.01
3	AGGREGATE APPROVED AMOUNT		3
3.01	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR CR PERIODS ENDING ON OR BEFORE DEC 31, 1996		3.01
3.02	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(6)		3.02
3.03	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(4) [E-3,PT.VI,LN.4] [PLUS LINE 3.03]		3.03
3.04	FTE ADJUSTMENT CAP		3.04
3.05	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR		3.05
3.06	LESSER OF LINE 3.04 OR LINE 3.05		3.06
3.07	WEIGHTED FTE COUNT FOR PRIMARY CARE PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO		3.07
3.08	WEIGHTED FTE COUNT FOR ALL OTHER PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO		3.08
3.09	SUM OF LINES 3.07 AND LINE 3.08		3.09
3.10	SEE INSTRUCTIONS		3.10
3.11	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO	3.00	3.11
3.12	SEE INSTRUCTIONS	3.00	3.12
3.13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR CR YEAR. (SEE INSTRUCTIONS)	3.00	3.13
3.14	TOTAL WEIGHTED RESIDENT FTE COUNT FOR PENULTIMATE CR YEAR. (SEE INSTRUCTIONS)	3.00	3.14
3.15	ROLLING AVERAGE FTE COUNT (SEE INSTRUCTIONS)	3.00	3.15
3.16	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]	3.00	3.16
3.17	SEE INSTRUCTIONS	81989.37	3.17
3.18	SEE INSTRUCTIONS	245968	3.18

DIRECT GRADUATE MEDICAL EDUCATION (GME)
 & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
 PART IV
 (CONT)

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

3.19	SEE INSTRUCTIONS			3.19
3.20	SEE INSTRUCTIONS			3.20
3.21	SEE INSTRUCTIONS			3.21
3.22	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]		0.00	3.22
3.23	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		81989.37	3.23
3.24	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001			3.24
3.25	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		245968	3.25
COMPUTATION OF PROGRAM PATIENT LOAD				
4	PROGRAM PART A INPATIENT DAYS		15819	4
5	TOTAL INPATIENT DAYS		40392	5
6	RATIO OF PROGRAM INPATIENT DAYS TO TOTAL INPATIENT DAYS		.391637	6
		[LINE 6 x] [E-3,PART 6]		
		[LINE 3.25] [LINE 11]		
6.01	TOTAL GME PAYMENT FOR NON-MANAGED CARE DAYS 96330		96330	6.01
6.02	PROGRAM MANAGED CARE DAYS OCCURRING ON OR AFTER JAN 1 OF THIS COST REPORTING PERIOD			6.02
6.03	TOTAL INPATIENT DAYS FROM LINE 5 ABOVE		40392	6.03
6.04	APPROPRIATE PERCENTAGE FOR INCLUSION OF MANAGED CARE DAYS		100.00	6.04
6.05	GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE DAYS ON OR AFTER JAN 1 THROUGH THE END OF THE COST REPORTING PERIOD			6.05
6.06	PROGRAM MANAGED CARE DAYS OCCURRING BEFORE JAN 1 OF THIS COST REPORTING YEAR			6.06
6.07	APPROPRIATE PERCENTAGE USING THE CRITERIA IDENTIFIED ON LINE 6.04 ABOVE		100.00	6.07
		[PRIOR TO] [E-3,PART 6]		
		[422] [LINE 12]		
6.08	GRAD.MED.ED.PAYMENT FOR MANAGED CARE DAYS 0		0	6.08
	PRIOR TO JAN 1 OF THIS COST REPORTING PERIOD			
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
7	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS			7
8	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES		203060	8
9	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES			9
10	MEDICARE O/P ESRD CHARGES			10
11	MEDICARE O/P ESRD DIRECT MEDICAL EDUCATION COSTS			11

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DIRECT GRADUATE MEDICAL EDUCATION (GME)
& ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
PART IV
(CONT)

[] TITLE V

[XX] TITLE XVIII

[] TITLE XIX

APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY
PART A REASONABLE COST

12	REASONABLE COST	15403751	12
13	ORGAN ACQUISITION COSTS		13
14	COST OF TEACHING PHYSICIANS		14
15	PRIMARY PAYER PAYMENTS		15
16	TOTAL PART A REASONABLE COST	15403751	16
PART B REASONABLE COST			
17	REASONABLE COST	1575264	17
18	PRIMARY PAYER PAYMENTS		18
19	TOTAL PART B REASONABLE COST	1575264	19
20	TOTAL REASONABLE COST	16979015	20
21	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST	.907223	21
22	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST	.092777	22
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
23	TOTAL PROGRAM GME PAYMENT		23
23.01	FOR COST REPORTING PERIODS ENDING ON OR AFTER JAN 1, 1998	96330	23.01
24	PART A MEDICARE GME PAYMENT - TITLE XVIII ONLY	87393	24
25	PART B MEDICARE GME PAYMENT - TITLE XVIII ONLY	8937	25

DIRECT GRADUATE MEDICAL EDUCATION (GME)
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WORKSHEET E-3
PART IV

[] TITLE V

[] TITLE XVIII

[XX] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1	NUMBER OF FTE RESIDENTS FOR OB/GYN & PRIMARY CARE	1
1.01	NUMBER OF FTE RESIDENTS FOR ALL OTHERS	1.01
2	UPDATED PER RESIDENT AMOUNT FOR OB/GYN & PRIMARY CARE	2
2.01	UPDATED PER RESIDENT AMOUNT FOR ALL OTHERS	2.01
3	AGGREGATE APPROVED AMOUNT	3
3.01	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR CR PERIODS ENDING ON OR BEFORE DEC 31, 1996	3.01
3.02	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(6)	3.02
3.03	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR 413.86(g)(4) [E-3,PT.VI,LN.4] [PLUS LINE 3.03]	3.03
3.04	FTE ADJUSTMENT CAP	3.04
3.05	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC & OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR	3.05
3.06	LESSER OF LINE 3.04 OR LINE 3.05	3.06
3.07	WEIGHTED FTE COUNT FOR PRIMARY CARE PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO	3.07
3.08	WEIGHTED FTE COUNT FOR ALL OTHER PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO	3.08
3.09	SUM OF LINES 3.07 AND LINE 3.08	3.09
3.10	SEE INSTRUCTIONS	3.10
3.11	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR. IF CURRENT YEAR IS ZERO AND TEACHING PROGRAM WAS IN EXISTENCE IN PRIOR YEAR ENTER COUNT IN COLUMN ZERO	3.11
3.12	SEE INSTRUCTIONS	3.12
3.13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR CR YEAR. (SEE INSTRUCTIONS)	3.13
3.14	TOTAL WEIGHTED RESIDENT FTE COUNT FOR PENULTIMATE CR YEAR. (SEE INSTRUCTIONS)	3.14
3.15	ROLLING AVERAGE FTE COUNT (SEE INSTRUCTIONS)	3.15
3.16	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]	3.16
3.17	SEE INSTRUCTIONS	3.17
3.18	SEE INSTRUCTIONS	3.18

DIRECT GRADUATE MEDICAL EDUCATION (GME)
 & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-3
 PART IV
 (CONT)

[] TITLE V [] TITLE XVIII [XX] TITLE XIX

3.19	SEE INSTRUCTIONS		3.19
3.20	SEE INSTRUCTIONS		3.20
3.21	SEE INSTRUCTIONS		3.21
3.22	SEE INSTRUCTIONS [RESIDENTS IN INITIAL YEARS 0.00]	0.00	3.22
3.23	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001	0.00	3.23
3.24	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		3.24
3.25	SEE INSTRUCTIONS DEPENDING ON THE COST REPORTING PERIODS BEGINNING PRIOR TO 10/01/2001 OR ON OR AFTER 10/01/2001		3.25
COMPUTATION OF PROGRAM PATIENT LOAD			
4	PROGRAM PART A INPATIENT DAYS	20135	4
5	TOTAL INPATIENT DAYS	40392	5
6	RATIO OF PROGRAM INPATIENT DAYS TO TOTAL INPATIENT DAYS [LINE 6 x] [E-3,PART 6] [LINE 3.25] [LINE 11]	.498490	6
6.01	TOTAL GME PAYMENT FOR NON-MANAGED CARE DAYS	0	6.01
6.02	PROGRAM MANAGED CARE DAYS OCCURRING ON OR AFTER JAN 1 OF THIS COST REPORTING PERIOD		6.02
6.03	TOTAL INPATIENT DAYS FROM LINE 5 ABOVE	40392	6.03
6.04	APPROPRIATE PERCENTAGE FOR INCLUSION OF MANAGED CARE DAYS	100.00	6.04
6.05	GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE DAYS ON OR AFTER JAN 1 THROUGH THE END OF THE COST REPORTING PERIOD		6.05
6.06	PROGRAM MANAGED CARE DAYS OCCURRING BEFORE JAN 1 OF THIS COST REPORTING YEAR		6.06
6.07	APPROPRIATE PERCENTAGE USING THE CRITERIA IDENTIFIED ON LINE 6.04 ABOVE	100.00	6.07
6.08	GRAD.MED.ED.PAYMENT FOR MANAGED CARE DAYS PRIOR TO JAN 1 OF THIS COST REPORTING PERIOD [PRIOR TO] [E-3,PART 6] [422] [LINE 12]	0 0	6.08
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
7	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS		7
8	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES		8
9	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES		9
10	MEDICARE O/P ESRD CHARGES		10
11	MEDICARE O/P ESRD DIRECT MEDICAL EDUCATION COSTS		11

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DIRECT GRADUATE MEDICAL EDUCATION (GME)
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WORKSHEET E-3
PART IV
(CONT)

[] TITLE V

[] TITLE XVIII

[XX] TITLE XIX

APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY
PART A REASONABLE COST

12	REASONABLE COST	12
13	ORGAN ACQUISITION COSTS	13
14	COST OF TEACHING PHYSICIANS	14
15	PRIMARY PAYER PAYMENTS	15
16	TOTAL PART A REASONABLE COST	16

PART B REASONABLE COST

17	REASONABLE COST	17
18	PRIMARY PAYER PAYMENTS	18
19	TOTAL PART B REASONABLE COST	19
20	TOTAL REASONABLE COST	20
21	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST	21
22	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST	22

ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B

23	TOTAL PROGRAM GME PAYMENT	23
23.01	FOR COST REPORTING PERIODS ENDING ON OR AFTER JAN 1, 1998	23.01
24	PART A MEDICARE GME PAYMENT - TITLE XVIII ONLY	24
25	PART B MEDICARE GME PAYMENT - TITLE XVIII ONLY	25

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	77709			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	5222350			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY				7
8	PREPAID EXPENSES	232596			8
9	OTHER CURRENT ASSETS	396372			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	5929027			11
FIXED ASSETS					
12	LAND	429028			12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	3552123			13
13.01	ACCUMULATED DEPRECIATION	-27713123			13.01
14	BUILDINGS	20378127			14
14.01	ACCUMULATED DEPRECIATION				14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT	16569382			16
16.01	ACCUMULATED DEPRECIATION				16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT				18
18.01	ACCUMULATED DEPRECIATION				18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	13215537			21
OTHER ASSETS					
22	INVESTMENTS	157083			22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	18025271			25
26	TOTAL OTHER ASSETS	18182354			26
27	TOTAL ASSETS	37326918			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	3260511			28
29	SALARIES, WAGES & FEES PAYABLE	4128095			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)	1190168			31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES	1454501			35
36	TOTAL CURRENT LIABILITIES	10033275			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE				37
38	NOTES PAYABLE	1649715			38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES	6673606			41
42	TOTAL LONG TERM LIABILITIES	8323321			42
43	TOTAL LIABILITIES	18356596			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	18970322			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	18970322			51
52	TOTAL LIABILITIES AND FUND BALANCES	37326918			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	16483935			1
2 NET INCOME (LOSS)	1264930			2
3 TOTAL	17748865			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5 CHNG IN NET UNR GAINS AND INV DIFF				5
6 CUMULATIVE CHANGE IN ACCTG				6
7 NET CHANGE IN TEMP RESTR ASSETS				7
8	1221457			8
9				9
10 TOTAL ADDITIONS	1221457			10
11 SUBTOTAL	18970322			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13 NET ASSETS				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	18970322			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	36083108		36083108	2
4 SUBPROVIDER I				4
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES	36083108		36083108	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	5816473		5816473	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	5816473		5816473	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	41899581		41899581	18
18.50 ANCILLARY SERVICES	32774841	19646616	52421457	18.50
18.60 OUTPATIENT SERVICES				18.60
19 RHC				19
20 FQHC				20
21 HOME HEALTH AGENCY				21
22 AMBULANCE				22
23 CORF				23
24 ASC				24
25 HOSPICE				25
25 TOTAL PATIENT REVENUES	74674422	19646616	94321038	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		55610406	26
27 ADD (SPECIFY)			27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS			33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		55610406	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	94321038	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	40469378	2
3	NET PATIENT REVENUES	53851660	3
4	LESS - TOTAL OPERATING EXPENSES	55610406	4
5	NET INCOME FROM SERVICE TO PATIENTS	-1758746	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	3031	6
7	INCOME FROM INVESTMENTS	90869	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	112866	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	18592	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	22419	22
23	GOVERNMENTAL APPROPRIATIONS	2775899	23
24	OTHER INCOME		24
24.01	OTHER MISC		24.01
25	TOTAL OTHER INCOME	3023676	25
26	TOTAL	1264930	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	1264930	31

CALCULATION OF CAPITAL PAYMENT - TITLE XVIII - FULLY PROSPECTIVE METHOD

WORKSHEET L

	HOSPITAL (14-0083)	SUB I	SUB II	SUB III	SUB IV
PART I - FULLY PROSPECTIVE METHOD					
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS				1
	CAPITAL FEDERAL AMOUNT				
2	CAPITAL DRG OTHER THAN OUTLIER	971824			2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997				3
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997	133			3.01
4	INDIRECT MEDICAL EDUCATION ADJUSTMENT TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD [E-3,PT VI,LN.18] [E,PT A,LN.3.17][x E-3,PT VI,LN.1]	110.36			4
4.01	NO. OF INTERNS & RESIDENTS	2.67	0.00		4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE	0.69			4.02
4.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT DISPROPORTIONATE SHARE ADJUSTMENT	6706			4.03
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS	0.2007			5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I	0.5137			5.01
5.02	SUM OF LINES 5 AND 5.01	0.7144			5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE	0.1557			5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT	151313			5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS	1129976			6
PART II - HOLD HARMLESS METHOD					
1	NEW CAPITAL				1
2	OLD CAPITAL				2
3	TOTAL CAPITAL				3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL				4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE				5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT				6
7	REDUCED OLD CAPITAL AMOUNT				7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL				8
9	SUBTOTAL				9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)				10
PART III - PAYMENT UNDER REASONABLE COST					
1	PROGRAM INPATIENT ROUTINE CAPITAL COST				1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST				2
3	TOTAL INPATIENT PROGRAM CAPITAL				3
4	CAPITAL COST PAYMENT FACTOR				4
5	TOTAL INPATIENT PROGRAM CAPITAL COST				5
PART IV - COMPUTATION OF EXCEPTION PAYMENTS					
1	PROGRAM INPATIENT CAPITAL COSTS				1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES				2
3	NET PROGRAM INPATIENT CAPITAL COSTS				3
4	APPLICABLE EXCEPTION PERCENTAGE				4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS				5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES				6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES				7
8	CAPITAL MINIMUM PAYMENT LEVEL				8
9	CURRENT YEAR CAPITAL PAYMENTS				9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS				10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT				11
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS				12
13	CURRENT YEAR EXCEPTION PAYMENT				13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD				14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)				15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)				16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT				17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	4A	25	26	27
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6.01 COMMUNICATIONS					6.01
6.04 ADMITTING					6.04
6.05 BUSINESS OFFICE					6.05
6.06 OTHER ADMINISTRATIVE					6.06
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE					18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES A					22
23 I&R SERVICES-OTHER PRGM COSTS A					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS					25
26 INTENSIVE CARE UNIT					26
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN CO					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
54 ELECTROENCEPHALOGRAPHY					54
55 MEDICAL SUPPLIES CHARGED TO PAT					55
56 DRUGS CHARGED TO PATIENTS					56
57 RENAL DIALYSIS					57
58.01 HYPERBARIC CHAMBER					58.01
59 O/P MENTAL HEALTH					59
59.10 PARTIAL HOSPITALIZATION					59.10
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
60.01 CICERO CLINIC					60.01
60.02 YMCA CLINIC					60.02
60.03 NORTH AVENUE CLINIC					60.03
60.04 CLINIC #4					60.04
61 EMERGENCY					61
61.01 GOLDEN LIFE					61.01
62 OBSERVATION BEDS (NON-DISTINCT)					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03
95 SUBTOTALS					95
NONREIMBURSABLE COST CENTERS					
96 GIFT, FLOWER, COFFEE SHOP & CAN					96
98 PHYSICIANS' PRIVATE OFFICES					98
00 PUBLIC RELATIONS					00
00.10 AUSTIN PRIDE					00.10

PROVIDER NO. 14-0083 LORETTO HOSPITAL
PERIOD FROM 07/01/2007 TO 06/30/2008

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

VERSION: 2008.05
12/04/2008 09:52

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	0	4A	25	26	27	
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 TOTAL						103
104 TOTAL STATISTICAL BASIS						104
105 UNIT COST MULTIPLIER						105
105 UNIT COST MULTIPLIER						105

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	38.20		52.47				90.67 25
26 INTENSIVE CARE UNIT	50.36		19.58				69.94 26
UTILIZATION PERCENTAGES BASED ON CHARGES							
37 OPERATING ROOM	38.12	11.32					49.44 37
40 ANESTHESIOLOGY	34.85	13.49					48.34 40
41 RADIOLOGY-DIAGNOSTIC	23.93	7.85					31.78 41
44 LABORATORY	29.96						29.96 44
49 RESPIRATORY THERAPY	45.56	2.17					47.73 49
50 PHYSICAL THERAPY	18.22						18.22 50
53 ELECTROCARDIOLOGY	36.86	5.61					42.47 53
54 ELECTROENCEPHALOGRAPHY	45.69	2.48					48.17 54
55 MEDICAL SUPPLIES CHARGED TO PAT	31.61	9.16					40.77 55
56 DRUGS CHARGED TO PATIENTS	38.50	2.35					40.85 56
59 O/P MENTAL HEALTH		6.01					6.01 59
59.10 PARTIAL HOSPITALIZATION	0.21						0.21 59.10
60 CLINIC	1.24	38.05					39.29 60
61 EMERGENCY	12.13	6.71					18.84 61
61.01 GOLDEN LIFE	0.25						0.25 61.01
101 TOTAL CHARGES	15.03	2.52					17.55 101

COST CENTER		---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT	1167071	2.39	-1167071	-4.97			3
4	NEW CAP REL COSTS-MVBLE EQUIP	717338	1.47	-717338	-3.05			4
5	EMPLOYEE BENEFITS	3343190	6.85	-3343190	-14.23			5
6.01	COMMUNICATIONS	512172	1.05	-512172	-2.18			6.01
6.04	ADMITTING	216360	.44	-216360	-.92			6.04
6.05	BUSINESS OFFICE	416506	.85	-416506	-1.77			6.05
6.06	OTHER ADMINISTRATIVE	7664216	15.70	-7664216	-32.63			6.06
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	2548160	5.22	-2548160	-10.85			8
9	LAUNDRY & LINEN SERVICE	256748	.53	-256748	-1.09			9
10	HOUSEKEEPING	1155431	2.37	-1155431	-4.92			10
11	DIETARY	1155996	2.37	-1155996	-4.92			11
12	CAFETERIA	212885	.44	-212885	-.91			12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION	1734025	3.55	-1734025	-7.38			14
15	CENTRAL SERVICES & SUPPLY	479561	.98	-479561	-2.04			15
16	PHARMACY	866095	1.77	-866095	-3.69			16
17	MEDICAL RECORDS & LIBRARY	913308	1.87	-913308	-3.89			17
18	SOCIAL SERVICE	94762	.19	-94762	-.40			18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES A	31248	.06	-31248	-.13			22
23	I&R SERVICES-OTHER PRGM COSTS A	2099		-2099	-.01			23
24	PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	10410170	21.33	10147314	43.20	20557484	42.11	25
26	INTENSIVE CARE UNIT	1867074	3.82	1586834	6.76	3453908	7.08	26
ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	1101079	2.26	1070672	4.56	2171751	4.45	37
40	ANESTHESIOLOGY	9154	.02	29869	.13	39023	.08	40
41	RADIOLOGY-DIAGNOSTIC	1711889	3.51	1146584	4.88	2858473	5.86	41
44	LABORATORY	2060574	4.22	1292389	5.50	3352963	6.87	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	1115878	2.29	636828	2.71	1752706	3.59	49
50	PHYSICAL THERAPY	521323	1.07	495177	2.11	1016500	2.08	50
53	ELECTROCARDIOLOGY	263546	.54	181064	.77	444610	.91	53
54	ELECTROENCEPHALOGRAPHY	38150	.08	36216	.15	74366	.15	54
55	MEDICAL SUPPLIES CHARGED TO PAT	217705	.45	1205069	5.13	1422774	2.91	55
56	DRUGS CHARGED TO PATIENTS	1440500	2.95	1484770	6.32	2925270	5.99	56
57	RENAL DIALYSIS	276780	.57	63762	.27	340542	.70	57
58.01	HYPERBARIC CHAMBER							58.01
59	O/P MENTAL HEALTH	756667	1.55	730143	3.11	1486810	3.05	59
59.10	PARTIAL HOSPITALIZATION	138229	.28	392403	1.67	530632	1.09	59.10
60	CLINIC	585293	1.20	609022	2.59	1194315	2.45	60

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
60.01 CICERO CLINIC							60.01
60.02 YMCA CLINIC							60.02
60.03 NORTH AVENUE CLINIC							60.03
60.04 CLINIC #4							60.04
61 EMERGENCY	2327249	4.77	2022898	8.61	4350147	8.91	61
61.01 GOLDEN LIFE	5877	.01	114749	.49	120626	.25	61.01
62 OBSERVATION BEDS (NON-DISTINCT							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
69.10 CMHC							69.10
69.20 OUTPATIENT PHYSICAL THERAPY							69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
NONREIMBURSABLE COST CENTERS							
96 GIFT, FLOWER, COFFEE SHOP & CAN			6469	.03	6469	.01	96
98 PHYSICIANS' PRIVATE OFFICES	34171	.07	13075	.06	47246	.10	98
100 PUBLIC RELATIONS	133588	.27	34857	.15	168445	.35	100
100.10 AUSTIN PRIDE	312923	.64	187007	.80	499930	1.02	100.10
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	48814990	100.00	0	.00	48814990	100.00	103

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE	
	RELATED		CAPITAL		PROGRAM	
	COSTS	CHARGES	COST TO	CHARGES	PPS CAPITAL	
	1	2	CHARGES	4	COSTS	5
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	136508	1988542	.068647	758129	52043	37
40 ANESTHESIOLOGY	5135	402704	.012751	140334	1789	40
41 RADIOLOGY-DIAGNOSTIC	139218	4735278	.029400	1132948	33309	41
44 LABORATORY	122916	13035346	.009429	3905334	36823	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	46112	4834707	.009538	2202668	21009	49
50 PHYSICAL THERAPY	65806	1096016	.060041	199690	11990	50
53 ELECTROCARDIOLOGY	13239	2327891	.005687	858160	4880	53
54 ELECTROENCEPHALOGRAPHY	5581	92254	.060496	42148	2550	54
55 MEDICAL SUPPLIES CHARGED TO PAT	144362	1721074	.083879	543950	45626	55
56 DRUGS CHARGED TO PATIENTS	47022	9133990	.005148	3516826	18105	56
57 RENAL DIALYSIS	2977	203060	.014661			57
58.01 HYPERBARIC CHAMBER						58.01
59 O/P MENTAL HEALTH	67661	1669286	.040533			59
59.10 PARTIAL HOSPITALIZATION	80005	2763314	.028953	5929	172	59.10
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	46239	1431478	.032302	17793	575	60
60.01 CICERO CLINIC	12800					60.01
60.02 YMCA CLINIC	10663					60.02
60.03 NORTH AVENUE CLINIC	9625					60.03
60.04 CLINIC #4	2425					60.04
61 EMERGENCY	107067	7059841	.015166	856623	12992	61
61.01 GOLDEN LIFE	33607	8548	3.931563	21	83	61.01
62 OBSERVATION BEDS (NON-DISTINCT		115106				62
OTHER REIMBURSABLE COST CENTERS						
63.50 RHC						63.50
63.60 FQHC						63.60
101 TOTAL	1098968	52618435		14180553	241946	101

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	SWING-BED	TOTAL	TOTAL	PER	INPATIENT	MEDICARE
	RELATED	ADJUSTMENT		PATIENT			INPATIENT
	COSTS	AMOUNT	COST	DAYS	DIEM	PROGRAM	PPS CAPITAL
	1	2	3	4	5	6	7
INPATIENT ROUTINE SERVICE COST CENTERS							
25 ADULTS & PEDIATRICS	663368		663368	37175	17.84	14199	253310 25
26 INTENSIVE CARE UNIT	128859		128859	3217	40.06	1620	64897 26
101 TOTAL	792227		792227			15819	318207 101

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS 318207

MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS 241946

TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS 560153

MEDICARE DISCHARGES (WORKSHEET S-3, LINE 8, COLUMN 13)

MEDICARE PATIENT DAYS (WORKSHEET S-3, LINE 8, COLUMN 4)

PER DISCHARGE CAPITAL COSTS

PER DIEM CAPITAL COSTS

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	14843598
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-4 FOR HOSPITAL TITLE XVIII COMPONENT)	30271282
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.490

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 25-30, COLS 10 & 12 + WKST D PART II, LINE 101, COLS 6 & 8)	560153
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	.019

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	1575091
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	2380094
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.662