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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11/28/2014 TIME: 08:12 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE
ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE
PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE 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 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		1,304,865	-59,095	51,858		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		1,304,865	-59,095	51,858		200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A
VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS
INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 645 SOUTH CENTRAL AVENUE	P.O. Box:		1
2	City: CHICAGO	State: IL	ZIP Code: 60646	County: COOK 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Prov-ider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	LORETTO HOSPITAL	14-0083	16974	1	07/01/1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 2014	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	1	N	23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	11,957				2,898	445	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
	Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
Inpatient Psychiatric Faciltiy PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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WORKSHEET S-2
PART I

				V	XIX	
Title V and XIX Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.			N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.			N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N	109
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'		N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.					118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:					118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.			N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.			N		121
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	1.00		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2013	09/30/2013	170

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y			5
			Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES			1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.		N		11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			Y	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	10/24/2014	Y	10/24/2014	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35

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

COST REORT PREPARER INFORMATION				
41	FIRST NAME: JENNY	LAST NAME: DABROWSKI	TITLE: SENIOR CONSULTANT	41
42	EMPLOYER: S			42
43	PHONE NUMBER: 630-530-7100	E-MAIL ADDRESS: JENNY.DABROWSKI@SRGROUPLLC.COM		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	158	57,670			7,633	11,617	23,109	1
2	HMO AND OTHER (see instructions)							2,898		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		158	57,670			7,633	11,617	23,109	7
8	INTENSIVE CARE UNIT	31	12	4,380			991	785	2,308	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		170	62,050			8,624	12,402	25,417	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		170							27
28	OBSERVATION BED DAYS								560	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,392	2,026	4,655	1
2	HMO AND OTHER (see instructions)								2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)	2.50	462.68			1,392	2,026	4,655	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)	2.50	462.68						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	28,481,207		28,481,207	966,071.00	29.48	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21	117,985		117,985	5,440.00	21.69	7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		413,525		413,525	10,440.00	39.61	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		99,452		99,452	2,034.01	48.89	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		5,229,649		5,229,649			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		77,267		77,267			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)		21,848		21,848			25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		252,811		252,811	7,551.00	33.48	26
27	ADMINISTRATIVE & GENERAL		5,758,616		5,758,616	156,427.00	36.81	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		36,805		36,805	217.50	169.22	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		945,100		945,100	27,088.00	34.89	30
31	LAUNDRY & LINEN SERVICE		34,312		34,312	2,204.00	15.57	31
32	HOUSEKEEPING		623,914		623,914	46,735.00	13.35	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		816,117	-156,143	659,974	42,509.00	15.53	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			156,143	156,143	10,057.00	15.53	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,603,669		1,603,669	38,833.00	41.30	38
39	CENTRAL SERVICES AND SUPPLY		334,963		334,963	13,495.00	24.82	39
40	PHARMACY		674,663		674,663	18,632.00	36.21	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		528,289		528,289	27,347.00	19.32	41
42	SOCIAL SERVICE		792		792	40.00	19.80	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		28,400,027		28,400,027	960,848.50	29.56	1
2	EXCLUDED AREA SALARIES (see instructions)		413,525		413,525	10,440.00	39.61	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		27,986,502		27,986,502	950,408.50	29.45	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		99,452		99,452	2,034.01	48.89	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		5,229,649		5,229,649		18.69%	5

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		33,315,603		33,315,603	952,442.51	34.98	6
7	TOTAL OVERHEAD COST (see instructions)		11,610,051		11,610,051	391,135.50	29.68	7

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HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3**
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	284,590	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,447,766	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	50,883	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	56,604	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	774,112	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	1,922,044	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	618,541	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	174,225	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	5,328,765	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

LORETTO HOSPITAL Provider CCN: 14-0083	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

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

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.772911	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	16,918,862	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	27,519,285	6
7	MEDICAID COST (line 1 times line 6)	21,269,958	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	4,351,096	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	4,351,096	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	5,285,137	776,059	6,061,196	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	4,084,941	599,825	4,684,766	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	4,084,941	599,825	4,684,766	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	2,022,539	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	763,551	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	1,258,988	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	973,086	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	5,657,852	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	10,008,948	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		3,042,754	3,042,754	-1,025,459	2,017,295	-8,331	2,008,964	1
2	00200	CAP REL COSTS-MVBLE EQUIP				1,168,305	1,168,305		1,168,305	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	252,811	3,451,431	3,704,242		3,704,242		3,704,242	4
5.01	01160	COMMUNICATIONS	144,612	353,674	498,286		498,286		498,286	5.01
5.04	00570	ADMITTING	151,436	16,934	168,370		168,370		168,370	5.04
5.05	00580	BUSINESS OFFICE	370,464	93,887	464,351		464,351		464,351	5.05
5.06	00590	OTHER ADMINISTRATIVE	5,092,104	13,593,041	18,685,145	-142,846	18,542,299	-7,199,121	11,343,178	5.06
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	945,100	1,615,238	2,560,338		2,560,338		2,560,338	7
8	00800	LAUNDRY & LINEN SERVICE	34,312	272,997	307,309		307,309		307,309	8
9	00900	HOUSEKEEPING	623,914	363,081	986,995		986,995		986,995	9
10	01000	DIETARY	816,117	882,359	1,698,476	-324,960	1,373,516		1,373,516	10
11	01100	CAFETERIA				324,960	324,960	-66,080	258,880	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,603,669	273,204	1,876,873		1,876,873		1,876,873	13
14	01400	CENTRAL SERVICES & SUPPLY	334,963	246,455	581,418	-81,893	499,525		499,525	14
15	01500	PHARMACY	674,663	1,306,574	1,981,237	-959,951	1,021,286		1,021,286	15
16	01600	MEDICAL RECORDS & LIBRARY	528,289	414,525	942,814		942,814		942,814	16
17	01700	SOCIAL SERVICE	792	70	862		862		862	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD	117,985	15,515	133,500		133,500		133,500	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	7,660,511	775,777	8,436,288		8,436,288		8,436,288	30
31	03100	INTENSIVE CARE UNIT	1,473,618	395,874	1,869,492		1,869,492	-162,000	1,707,492	31
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	481,419	460,508	941,927	-255,898	686,029	-9,604	676,425	50
53	05300	ANESTHESIOLOGY		456,575	456,575	-489	456,086	-454,917	1,169	53
54	05400	RADIOLOGY-DIAGNOSTIC	815,495	975,457	1,790,952		1,790,952	-208,435	1,582,517	54
57	05700	CT SCAN	162,717	74,291	237,008		237,008		237,008	57
60	06000	LABORATORY	891,423	1,124,213	2,015,636		2,015,636		2,015,636	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	691,814	242,731	934,545	-59,748	874,797	-9,000	865,797	65
66	06600	PHYSICAL THERAPY	324,396	40,039	364,435	-1,673	362,762		362,762	66
69	06900	ELECTROCARDIOLOGY	194,881	33,979	228,860		228,860		228,860	69
70	07000	ELECTROENCEPHALOGRAPHY	21,923	2,611	24,534		24,534		24,534	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				591,037	591,037		591,037	71
73	07300	DRUGS CHARGED TO PATIENTS				959,951	959,951		959,951	73
74	07400	RENAL DIALYSIS		366,533	366,533		366,533		366,533	74
75.01	07501	HYBERBARIC CHAMBER								75.01
76	03550	O/P MENTAL HEALTH	676,919	289,084	966,003		966,003	-198,619	767,384	76
76.10	03950	PARTIAL HOSPITALIZATION	100,709	12,218	112,927		112,927		112,927	76.10
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	409,424	70,861	480,285	-5,256	475,029		475,029	90
90.01	09001	CICERO CLINIC								90.01
90.02	09002	YMCA CLINIC								90.02
90.03	09003	NORTH AVENUE CLINIC								90.03
90.04	09004	CLINIC #4								90.04
90.05	09005	WOUND CARE	19,808	2,274	22,082	-325	21,757		21,757	90.05
91	09100	EMERGENCY	2,443,061	1,747,853	4,190,914	-185,755	4,005,159	-1,286,371	2,718,788	91
91.01	09101	GOLDEN LIFE	8,333	560	8,893		8,893		8,893	91.01
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	28,067,682	33,013,177	61,080,859		61,080,859	-9,602,478	51,478,381	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PUBLIC RELATIONS	413,525	76,613	490,138		490,138		490,138	194
194.10	07951	AUSTIN PRIDE		1,575	1,575		1,575		1,575	194.10
200		TOTAL (sum of lines 118-199)	28,481,207	33,091,365	61,572,572		61,572,572	-9,602,478	51,970,094	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DRUGS SOLD	A	DRUGS CHARGED TO PATIENTS	73		959,951	1
500	TOTAL RECLASSIFICATIONS					959,951	500
	CODE LETTER - A						
1	CAFETERIA RECLASS	B	CAFETERIA	11	156,143	168,817	1
500	TOTAL RECLASSIFICATIONS				156,143	168,817	500
	CODE LETTER - B						
1	DEPR EXP	D	CAP REL COSTS-MVBLE EQUIP	2		1,168,305	1
500	TOTAL RECLASSIFICATIONS					1,168,305	500
	CODE LETTER - D						
1	SUPPLIES CHARGED	E	MEDICAL SUPPLIES CHARGED TO P	71		591,037	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	TOTAL RECLASSIFICATIONS					591,037	500
	CODE LETTER - E						
1	CAPITAL INSURANCE EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		142,846	1
500	TOTAL RECLASSIFICATIONS					142,846	500
	CODE LETTER - F						
	GRAND TOTAL (INCREASES)				156,143	3,030,956	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DRUGS SOLD	A	PHARMACY	15		959,951		1
500	TOTAL RECLASSIFICATIONS					959,951		500
	CODE LETTER - A							
1	CAFETERIA RECLASS	B	DIETARY	10	156,143	168,817		1
500	TOTAL RECLASSIFICATIONS				156,143	168,817		500
	CODE LETTER - B							
1	DEPR EXP	D	CAP REL COSTS-BLDG & FIXT	1		1,168,305	9	1
500	TOTAL RECLASSIFICATIONS					1,168,305		500
	CODE LETTER - D							
1	SUPPLIES CHARGED	E	OPERATING ROOM	50		255,898		1
2			ANESTHESIOLOGY	53		489		2
3			RESPIRATORY THERAPY	65		59,748		3
4			PHYSICAL THERAPY	66		1,673		4
5			CLINIC	90		5,256		5
6			EMERGENCY	91		185,755		6
7			WOUND CARE	90.05		325		7
8			CENTRAL SERVICES & SUPPLY	14		81,893		8
500	TOTAL RECLASSIFICATIONS					591,037		500
	CODE LETTER - E							
1	CAPITAL INSURANCE EXPENSE	F	OTHER ADMINISTRATIVE	5.06		142,846	12	1
500	TOTAL RECLASSIFICATIONS					142,846		500
	CODE LETTER - F							
	GRAND TOTAL (DECREASES)				156,143	3,030,956		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	429,028					429,028		1
2	LAND IMPROVEMENTS	224,058					224,058		2
3	BUILDINGS AND FIXTURES	45,088,599	1,747,973		1,747,973		46,836,572		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	20,777,666	752,328		752,328		21,529,994		5
6	MOVABLE EQUIPMENT								6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	66,519,351	2,500,301		2,500,301		69,019,652		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	66,519,351	2,500,301		2,500,301		69,019,652		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	3,042,754						3,042,754	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)	3,042,754						3,042,754	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,866,118			142,846			2,008,964	1
2	CAP REL COSTS-MVBLE EQUIP	1,168,305						1,168,305	2
3	TOTAL (sum of lines 1-2)	3,034,423			142,846			3,177,269	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,
Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,405,177				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-62,094	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-3,986	CAFETERIA	11		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
33.02	TELEPHONE CAPITAL	A	-2,282	CAP REL COSTS-BLDG & FIXT	1	9	33.02
34	MISC	B	-185	RADIOLOGY-DIAGNOSTIC	54		34
35	MED REC COPIES	B	-9,604	OPERATING ROOM	50		35
36	MISC INCOME	B	-456,435	OTHER ADMINISTRATIVE	5.06		36
37	LOBBYING EXPENSES	A	-17,354	OTHER ADMINISTRATIVE	5.06		37
38	RENTAL INCOME	B	-6,049	CAP REL COSTS-BLDG & FIXT	1	9	38
39	MEDICAID TAX ASSESSMENT	A	-6,639,312	OTHER ADMINISTRATIVE	5.06		39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-9,602,478				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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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 CLAIMED HOME OFFICE COSTS:

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1										1
2	31	INTENSIVE CARE UNIT AGGREGATE	162,000	162,000						2
3	53	ANESTHESIOLOGY AGGREGATE	454,917	454,917						3
4	54	RADIOLOGY-DIAGNOSTIC AGGREGATE	208,250	208,250						4
5										5
6	76	O/P MENTAL HEALTH AGGREGATE	198,619	198,619						6
7	91	EMERGENCY AGGREGATE	1,286,371	1,286,371						7
8	65	RESPIRATORY THERAPY AGGREGATE	9,000	9,000						8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE	86,020	86,020						9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,405,177	2,405,177						200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRAC T-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW - ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1										1
2	31	INTENSIVE CARE UNIT AGGREGATE							162,000	2
3	53	ANESTHESIOLOGY AGGREGATE							454,917	3
4	54	RADIOLOGY-DIAGNOSTIC AGGREGATE							208,250	4
5										5
6	76	O/P MENTAL HEALTH AGGREGATE							198,619	6
7	91	EMERGENCY AGGREGATE							1,286,371	7
8	65	RESPIRATORY THERAPY AGGREGATE							9,000	8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE							86,020	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							2,405,177	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	ADMITTING	
		0	1	2	4	5.01	5.04	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	2,008,964	2,008,964					1
2	CAP REL COSTS-MVBLE EQUIP	1,168,305		1,168,305				2
4	EMPLOYEE BENEFITS DEPARTMENT	3,704,242	12,320	7,164	3,723,726			4
5.01	COMMUNICATIONS	498,286	11,950	6,950	18,155	535,341		5.01
5.04	ADMITTING	168,370	1,544	898	23,195	5,123	199,130	5.04
5.05	BUSINESS OFFICE	464,351	36,287	21,103	50,708	7,684		5.05
5.06	OTHER ADMINISTRATIVE	11,343,178	424,269	246,730	599,802	151,129		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,560,338	207,138	120,460	127,936	7,684		7
8	LAUNDRY & LINEN SERVICE	307,309	25,433	14,791	4,461	2,561		8
9	HOUSEKEEPING	986,995	24,650	14,335	80,134	2,561		9
10	DIETARY	1,373,516	72,630	42,238	104,721	12,807		10
11	CAFETERIA	258,880	28,231	16,418		7,684		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,876,873	12,107	7,041	194,182	25,614		13
14	CENTRAL SERVICES & SUPPLY	499,525	119,525	69,509	22,594	7,684		14
15	PHARMACY	1,021,286	16,728	9,728	89,627	5,123		15
16	MEDICAL RECORDS & LIBRARY	942,814	37,820	21,994	72,428	17,930		16
17	SOCIAL SERVICE	862	4,476	2,603	1,555	17,930		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	133,500	1,007	586	24,666			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	8,436,288	305,448	177,632	1,020,896	38,422	92,583	30
31	INTENSIVE CARE UNIT	1,707,492	75,058	43,650	220,164	12,807	18,459	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	676,425	100,794	58,616	69,695	48,667	3,236	50
53	ANESTHESIOLOGY	1,169	4,073	2,369		2,561	343	53
54	RADIOLOGY-DIAGNOSTIC	1,582,517	98,075	57,035	110,671	20,492	4,393	54
57	CT SCAN	237,008			19,799		4,454	57
60	LABORATORY	2,015,636	74,118	43,103	115,511	15,369	27,250	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	865,797	23,073	13,418	97,258	5,123	7,287	65
66	PHYSICAL THERAPY	362,762	49,446	28,755	46,050	17,930	1,572	66
69	ELECTROCARDIOLOGY	228,860	6,445	3,748	23,892	7,684	3,614	69
70	ELECTROENCEPHALOGRAPHY	24,534	4,375	2,544	4,810	2,561	419	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	591,037					6,661	71
73	DRUGS CHARGED TO PATIENTS	959,951					20,820	73
74	RENAL DIALYSIS	366,533					667	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	767,384	45,932	26,712	87,240	17,930		76
76.10	PARTIAL HOSPITALIZATION	112,927	67,058	38,997	17,286	5,123	130	76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	475,029	28,264	16,437	64,080	17,930	130	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE	21,757			2,611			90.05
91	EMERGENCY	2,718,788	42,990	25,000	342,737	43,544	7,112	91
91.01	GOLDEN LIFE	8,893	30,021	17,459	5,479			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	51,478,381	1,991,285	1,158,023	3,662,343	527,657	199,130	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	490,138	895	521	61,383	2,561		194
194.10	AUSTIN PRIDE	1,575	16,784	9,761		5,123		194.10

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	ADMITTING	
		0	1	2	4	5.01	5.04	
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	51,970,094	2,008,964	1,168,305	3,723,726	535,341	199,130	202

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	BUSINESS OFFICE	SUBTOTAL (cols.0-4)	OTHER ADMINISTRV & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.05	4A	5.06	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE	580,133						5.05
5.06	OTHER ADMINISTRATIVE		12,765,108	12,765,108				5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		3,023,556	984,467	4,008,023			7
8	LAUNDRY & LINEN SERVICE		354,555	115,443	77,544	547,542		8
9	HOUSEKEEPING		1,108,675	360,983	75,156		1,544,814	9
10	DIETARY		1,605,912	522,883	221,444		13,787	10
11	CAFETERIA		311,213	101,331	86,073		80,323	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,115,817	688,908	36,913			13
14	CENTRAL SERVICES & SUPPLY		718,837	234,053	364,422		41,314	14
15	PHARMACY		1,142,492	371,994	51,003		18,352	15
16	MEDICAL RECORDS & LIBRARY		1,092,986	355,875	115,310		13,787	16
17	SOCIAL SERVICE		27,426	8,930	13,646		6,871	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		159,759	52,017	3,070			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	189,569	10,260,838	3,340,922	928,590	357,422	399,404	30
31	INTENSIVE CARE UNIT	37,617	2,115,247	688,722	228,847	26,050	73,453	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	12,264	969,697	315,732	307,312	164,070	117,072	50
53	ANESTHESIOLOGY	1,192	11,707	3,812	12,418			53
54	RADIOLOGY-DIAGNOSTIC	20,119	1,893,302	616,457	299,022		80,323	54
57	CT SCAN	21,461	282,722	92,054				57
60	LABORATORY	89,387	2,380,374	775,047	225,981		80,323	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	25,057	1,037,013	337,650	70,346		41,314	65
66	PHYSICAL THERAPY	7,163	513,678	167,253	150,756		70,017	66
69	ELECTROCARDIOLOGY	9,596	283,839	92,418	19,651			69
70	ELECTROENCEPHALOGRAPHY	966	40,209	13,092	13,339			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,756	623,454	202,996				71
73	DRUGS CHARGED TO PATIENTS	50,159	1,030,930	335,670				73
74	RENAL DIALYSIS	1,360	368,560	120,003				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	9,150	954,348	310,735	140,044		61,972	76
76.10	PARTIAL HOSPITALIZATION	18,555	260,076	84,680	204,454			76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	14,230	616,100	200,602	86,176		114,767	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE	945	25,313	8,242				90.05
91	EMERGENCY	45,587	3,225,758	1,050,304	131,072		321,384	91
91.01	GOLDEN LIFE		61,852	20,139	91,532			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	580,133	51,381,353	12,573,414	3,954,121	547,542	1,534,463	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		555,498	180,870	2,729			194
194.10	AUSTIN PRIDE		33,243	10,824	51,173		10,351	194.10
200	CROSS FOOT ADJUSTMENTS							200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	BUSINESS OFFICE	SUBTOTAL (cols.0-4)	OTHER ADMINISTRV & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.05	4A	5.06	7	8	9	
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	580,133	51,970,094	12,765,108	4,008,023	547,542	1,544,814	202

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY	2,364,026						10
11	CAFETERIA		578,940					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		33,384	2,875,022				13
14	CENTRAL SERVICES & SUPPLY		11,595		1,370,221			14
15	PHARMACY					1,583,841		15
16	MEDICAL RECORDS & LIBRARY		23,512				1,601,470	16
17	SOCIAL SERVICE		36					17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		4,685					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,558,286	129,694	1,663,711		54,322	558,582	30
31	INTENSIVE CARE UNIT	132,237	32,971	260,442		16,319	76,573	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	673,503	10,356	76,287		32,111	18,181	50
53	ANESTHESIOLOGY						2,301	53
54	RADIOLOGY-DIAGNOSTIC		20,587			442	48,317	54
57	CT SCAN		3,841				63,315	57
60	LABORATORY		29,525				228,897	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		20,138			77	86,987	65
66	PHYSICAL THERAPY		9,638			403	21,323	66
69	ELECTROCARDIOLOGY		6,318				40,575	69
70	ELECTROENCEPHALOGRAPHY		879				1,902	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				1,370,221		66,152	71
73	DRUGS CHARGED TO PATIENTS		16,010			1,286,444	175,151	73
74	RENAL DIALYSIS						3,166	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		25,702	168,922		55,417	21,843	76
76.10	PARTIAL HOSPITALIZATION		108,300	33,438			43,246	76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		14,843	122,605		124,234	28,055	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE		323				1,556	90.05
91	EMERGENCY		66,301	473,577		14,072	115,348	91
91.01	GOLDEN LIFE		1,328	7,926				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,364,026	569,966	2,806,908	1,370,221	1,583,841	1,601,470	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		8,974	68,114				194
194.10	AUSTIN PRIDE							194.10
200	CROSS FOOT ADJUSTMENTS							200

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,364,026	578,940	2,875,022	1,370,221	1,583,841	1,601,470	202

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I/R-SALARY AND FRINGES	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	21	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE	56,909						17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		219,531					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	53,880	219,531	19,525,182	-219,531	19,305,651		30
31	INTENSIVE CARE UNIT			3,650,861		3,650,861		31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			2,684,321		2,684,321		50
53	ANESTHESIOLOGY			30,238		30,238		53
54	RADIOLOGY-DIAGNOSTIC			2,958,450		2,958,450		54
57	CT SCAN			441,932		441,932		57
60	LABORATORY			3,720,147		3,720,147		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			1,593,525		1,593,525		65
66	PHYSICAL THERAPY			933,068		933,068		66
69	ELECTROCARDIOLOGY			442,801		442,801		69
70	ELECTROENCEPHALOGRAPHY			69,421		69,421		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			2,262,823		2,262,823		71
73	DRUGS CHARGED TO PATIENTS			2,844,205		2,844,205		73
74	RENAL DIALYSIS			491,729		491,729		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			1,738,983		1,738,983		76
76.10	PARTIAL HOSPITALIZATION			734,194		734,194		76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,298		1,308,680		1,308,680		90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE			35,434		35,434		90.05
91	EMERGENCY	1,731		5,399,547		5,399,547		91
91.01	GOLDEN LIFE			182,777		182,777		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	56,909	219,531	51,048,318	-219,531	50,828,787		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			816,185		816,185		194
194.10	AUSTIN PRIDE			105,591		105,591		194.10
200	CROSS FOOT ADJUSTMENTS							200

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I/R-SALARY AND FRINGES	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	21	24	25	26		
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	56,909	219,531	51,970,094	-219,531	51,750,563		202

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		12,320	7,164	19,484	19,484		4
5.01	COMMUNICATIONS		11,950	6,950	18,900	95	18,995	5.01
5.04	ADMITTING	934	1,544	898	3,376	121	182	5.04
5.05	BUSINESS OFFICE	1,363	36,287	21,103	58,753	265	273	5.05
5.06	OTHER ADMINISTRATIVE	68,955	424,269	246,730	739,954	3,137	5,361	5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	12,744	207,138	120,460	340,342	669	273	7
8	LAUNDRY & LINEN SERVICE		25,433	14,791	40,224	23	91	8
9	HOUSEKEEPING		24,650	14,335	38,985	419	91	9
10	DIETARY	416	72,630	42,238	115,284	548	454	10
11	CAFETERIA		28,231	16,418	44,649		273	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	934	12,107	7,041	20,082	1,016	909	13
14	CENTRAL SERVICES & SUPPLY	2,014	119,525	69,509	191,048	118	273	14
15	PHARMACY	163,135	16,728	9,728	189,591	469	182	15
16	MEDICAL RECORDS & LIBRARY	3,755	37,820	21,994	63,569	379	636	16
17	SOCIAL SERVICE		4,476	2,603	7,079	8	636	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		1,007	586	1,593	129		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,839	305,448	177,632	488,919	5,346	1,363	30
31	INTENSIVE CARE UNIT	7,348	75,058	43,650	126,056	1,152	454	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,556	100,794	58,616	161,966	365	1,727	50
53	ANESTHESIOLOGY		4,073	2,369	6,442		91	53
54	RADIOLOGY-DIAGNOSTIC	14,194	98,075	57,035	169,304	579	727	54
57	CT SCAN					104		57
60	LABORATORY	934	74,118	43,103	118,155	604	545	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	41,236	23,073	13,418	77,727	509	182	65
66	PHYSICAL THERAPY		49,446	28,755	78,201	241	636	66
69	ELECTROCARDIOLOGY	-162	6,445	3,748	10,031	125	273	69
70	ELECTROENCEPHALOGRAPHY		4,375	2,544	6,919	25	91	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		45,932	26,712	72,644	456	636	76
76.10	PARTIAL HOSPITALIZATION	1,425	67,058	38,997	107,480	90	182	76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	530	28,264	16,437	45,231	335	636	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE					14		90.05
91	EMERGENCY	898	42,990	25,000	68,888	1,793	1,545	91
91.01	GOLDEN LIFE		30,021	17,459	47,480	29		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	329,048	1,991,285	1,158,023	3,478,356	19,163	18,722	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	1,892	895	521	3,308	321	91	194
194.10	AUSTIN PRIDE		16,784	9,761	26,545		182	194.10

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		0	1	2	2A	4	5.01	
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	330,940	2,008,964	1,168,305	3,508,209	19,484	18,995	202

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ADMITTING	BUSINESS OFFICE	OTHER ADMINISTRV & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.04	5.05	5.06	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING	3,679						5.04
5.05	BUSINESS OFFICE		59,291					5.05
5.06	OTHER ADMINISTRATIVE			748,452				5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT			57,723	399,007			7
8	LAUNDRY & LINEN SERVICE			6,769	7,720	54,827		8
9	HOUSEKEEPING			21,166	7,482		68,143	9
10	DIETARY			30,658	22,045		608	10
11	CAFETERIA			5,941	8,569		3,543	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			40,393	3,675			13
14	CENTRAL SERVICES & SUPPLY			13,723	36,279		1,822	14
15	PHARMACY			21,811	5,077		810	15
16	MEDICAL RECORDS & LIBRARY			20,866	11,479		608	16
17	SOCIAL SERVICE			524	1,359		303	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			3,050	306			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,711	19,377	195,881	92,443	35,790	17,618	30
31	INTENSIVE CARE UNIT	341	3,844	40,382	22,782	2,608	3,240	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	60	1,253	18,512	30,594	16,429	5,164	50
53	ANESTHESIOLOGY	6	122	223	1,236			53
54	RADIOLOGY-DIAGNOSTIC	81	2,056	36,145	29,768		3,543	54
57	CT SCAN	82	2,193	5,397				57
60	LABORATORY	504	9,135	45,444	22,497		3,543	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	135	2,561	19,798	7,003		1,822	65
66	PHYSICAL THERAPY	29	732	9,807	15,008		3,089	66
69	ELECTROCARDIOLOGY	67	981	5,419	1,956			69
70	ELECTROENCEPHALOGRAPHY	8	99	768	1,328			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	123	2,632	11,902				71
73	DRUGS CHARGED TO PATIENTS	385	5,126	19,681				73
74	RENAL DIALYSIS	12	139	7,036				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		935	18,219	13,942		2,734	76
76.10	PARTIAL HOSPITALIZATION	2	1,896	4,965	20,354			76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2	1,454	11,762	8,579		5,062	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE		97	483				90.05
91	EMERGENCY	131	4,659	61,583	13,048		14,177	91
91.01	GOLDEN LIFE			1,181	9,112			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,679	59,291	737,212	393,641	54,827	67,686	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			10,605	272			194
194.10	AUSTIN PRIDE			635	5,094		457	194.10
200	CROSS FOOT ADJUSTMENTS							200

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ADMITTING	BUSINESS OFFICE	OTHER ADMINISTRV & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.04	5.05	5.06	7	8	9	
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,679	59,291	748,452	399,007	54,827	68,143	202

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY	169,597						10
11	CAFETERIA		62,975					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		3,631	69,706				13
14	CENTRAL SERVICES & SUPPLY		1,261		244,524			14
15	PHARMACY					217,940		15
16	MEDICAL RECORDS & LIBRARY		2,558				100,095	16
17	SOCIAL SERVICE		4					17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		510					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	111,792	14,108	40,336		7,475	34,918	30
31	INTENSIVE CARE UNIT	9,487	3,586	6,315		2,246	4,786	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	48,318	1,127	1,850		4,419	1,136	50
53	ANESTHESIOLOGY						144	53
54	RADIOLOGY-DIAGNOSTIC		2,239			61	3,020	54
57	CT SCAN		418				3,957	57
60	LABORATORY		3,212				14,305	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		2,191			11	5,436	65
66	PHYSICAL THERAPY		1,048			55	1,333	66
69	ELECTROCARDIOLOGY		687				2,536	69
70	ELECTROENCEPHALOGRAPHY		96				119	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				244,524		4,134	71
73	DRUGS CHARGED TO PATIENTS		1,741			177,016	10,946	73
74	RENAL DIALYSIS						198	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		2,796	4,096		7,626	1,365	76
76.10	PARTIAL HOSPITALIZATION		11,780	811			2,703	76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		1,615	2,973		17,095	1,753	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE		35				97	90.05
91	EMERGENCY		7,212	11,482		1,936	7,209	91
91.01	GOLDEN LIFE		144	192				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	169,597	61,999	68,055	244,524	217,940	100,095	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		976	1,651				194
194.10	AUSTIN PRIDE							194.10
200	CROSS FOOT ADJUSTMENTS							200

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10	11	13	14	15	16	
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	169,597	62,975	69,706	244,524	217,940	100,095	202

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I/R-SALARY AND FRINGES	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	21	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE	9,913						17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		5,588					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	9,386		1,076,463		1,076,463		30
31	INTENSIVE CARE UNIT			227,279		227,279		31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			292,920		292,920		50
53	ANESTHESIOLOGY			8,264		8,264		53
54	RADIOLOGY-DIAGNOSTIC			247,523		247,523		54
57	CT SCAN			12,151		12,151		57
60	LABORATORY			217,944		217,944		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			117,375		117,375		65
66	PHYSICAL THERAPY			110,179		110,179		66
69	ELECTROCARDIOLOGY			22,075		22,075		69
70	ELECTROENCEPHALOGRAPHY			9,453		9,453		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			263,315		263,315		71
73	DRUGS CHARGED TO PATIENTS			214,895		214,895		73
74	RENAL DIALYSIS			7,385		7,385		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			125,449		125,449		76
76.10	PARTIAL HOSPITALIZATION			150,263		150,263		76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	226		96,723		96,723		90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE			726		726		90.05
91	EMERGENCY	301		193,964		193,964		91
91.01	GOLDEN LIFE			58,138		58,138		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	9,913		3,452,484		3,452,484		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			17,224		17,224		194
194.10	AUSTIN PRIDE			32,913		32,913		194.10
200	CROSS FOOT ADJUSTMENTS		5,588	5,588		5,588		200

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I/R-SALARY AND FRINGES	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	21	24	25	26		
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	9,913	5,588	3,508,209		3,508,209		202

KPMG LLP

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	COMMUNICATIONS (PHONES	ADMITTING INPATIENT REVENUE	BUSINESS OFFICE GROSS REVENUE	
		1	2	4	5.01	5.04	5.05	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	179,542						1
2	CAP REL COSTS-MVBLE EQUIP		179,542					2
4	EMPLOYEE BENEFITS DEPARTMENT	1,101	1,101	27,783,405				4
5.01	COMMUNICATIONS	1,068	1,068	135,457	209			5.01
5.04	ADMITTING	138	138	173,063	2	42,794,514		5.04
5.05	BUSINESS OFFICE	3,243	3,243	378,338	3		61,180,643	5.05
5.06	OTHER ADMINISTRATIVE	37,917	37,917	4,475,233	59			5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	18,512	18,512	954,555	3			7
8	LAUNDRY & LINEN SERVICE	2,273	2,273	33,288	1			8
9	HOUSEKEEPING	2,203	2,203	597,895	1			9
10	DIETARY	6,491	6,491	781,343	5			10
11	CAFETERIA	2,523	2,523		3			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,082	1,082	1,448,825	10			13
14	CENTRAL SERVICES & SUPPLY	10,682	10,682	168,576	3			14
15	PHARMACY	1,495	1,495	668,721	2			15
16	MEDICAL RECORDS & LIBRARY	3,380	3,380	540,396	7			16
17	SOCIAL SERVICE	400	400	11,602	7			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	90	90	184,037				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	27,298	27,298	7,617,086	15	19,895,799	19,990,712	30
31	INTENSIVE CARE UNIT	6,708	6,708	1,642,687	5	3,967,200	3,967,200	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	9,008	9,008	520,010	19	695,408	1,293,381	50
53	ANESTHESIOLOGY	364	364		1	73,707	125,704	53
54	RADIOLOGY-DIAGNOSTIC	8,765	8,765	825,739	8	944,098	2,121,786	54
57	CT SCAN			147,727		957,216	2,263,339	57
60	LABORATORY	6,624	6,624	861,848	6	5,856,373	9,427,038	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,062	2,062	725,662	2	1,566,112	2,642,555	65
66	PHYSICAL THERAPY	4,419	4,419	343,591	7	337,930	755,469	66
69	ELECTROCARDIOLOGY	576	576	178,263	3	776,713	1,011,994	69
70	ELECTROENCEPHALOGRAPHY	391	391	35,886	1	90,052	101,883	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					1,431,451	2,716,266	71
73	DRUGS CHARGED TO PATIENTS					4,474,509	5,289,898	73
74	RENAL DIALYSIS					143,446	143,446	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	4,105	4,105	650,913	7		964,951	76
76.10	PARTIAL HOSPITALIZATION	5,993	5,993	128,971	2	27,953	1,956,815	76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,526	2,526	478,114	7	28,039	1,500,770	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE			19,483			99,676	90.05
91	EMERGENCY	3,842	3,842	2,557,223	17	1,528,508	4,807,760	91
91.01	GOLDEN LIFE	2,683	2,683	40,880				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	177,962	177,962	27,325,412	206	42,794,514	61,180,643	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	80	80	457,993	1			194

KPMG LLP COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	COMMUNICATIONS (PHONES	ADMITTING INPATIENT REVENUE	BUSINESS OFFICE GROSS REVENUE	
		1	2	4	5.01	5.04	5.05	
194.10	AUSTIN PRIDE	1,500	1,500		2			194.10
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,008,964	1,168,305	3,723,726	535,341	199,130	580,133	202
203	UNIT COST MULT-WS B PT I	11.189382	6.507140	0.134027	2,561.440191	0.004653	0.009482	203
204	COST TO BE ALLOC PER B PT II			19,484	18,995	3,679	59,291	204
205	UNIT COST MULT-WS B PT II			0.000701	90.885167	0.000086	0.000969	205

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	RECON-CILIATION	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)	
		5A.06	5.06	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE	-12,765,108	39,204,986					5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		3,023,556	117,484				7
8	LAUNDRY & LINEN SERVICE		354,555	2,273	251,345			8
9	HOUSEKEEPING		1,108,675	2,203		34,176		9
10	DIETARY		1,605,912	6,491		305	75,996	10
11	CAFETERIA		311,213	2,523		1,777		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,115,817	1,082				13
14	CENTRAL SERVICES & SUPPLY		718,837	10,682		914		14
15	PHARMACY		1,142,492	1,495		406		15
16	MEDICAL RECORDS & LIBRARY		1,092,986	3,380		305		16
17	SOCIAL SERVICE		27,426	400		152		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		159,759	90				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		10,260,838	27,219	164,072	8,836	50,094	30
31	INTENSIVE CARE UNIT		2,115,247	6,708	11,958	1,625	4,251	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		969,697	9,008	75,315	2,590	21,651	50
53	ANESTHESIOLOGY		11,707	364				53
54	RADIOLOGY-DIAGNOSTIC		1,893,302	8,765		1,777		54
57	CT SCAN		282,722					57
60	LABORATORY		2,380,374	6,624		1,777		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		1,037,013	2,062		914		65
66	PHYSICAL THERAPY		513,678	4,419		1,549		66
69	ELECTROCARDIOLOGY		283,839	576				69
70	ELECTROENCEPHALOGRAPHY		40,209	391				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		623,454					71
73	DRUGS CHARGED TO PATIENTS		1,030,930					73
74	RENAL DIALYSIS		368,560					74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		954,348	4,105		1,371		76
76.10	PARTIAL HOSPITALIZATION		260,076	5,993				76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		616,100	2,526		2,539		90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE		25,313					90.05
91	EMERGENCY		3,225,758	3,842		7,110		91
91.01	GOLDEN LIFE		61,852	2,683				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	-12,765,108	38,616,245	115,904	251,345	33,947	75,996	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		555,498	80				194
194.10	AUSTIN PRIDE		33,243	1,500		229		194.10

KPMG LLP COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	RECON-CILIATION	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)	
		5A.06	5.06	7	8	9	10	
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I		12,765,108	4,008,023	547,542	1,544,814	2,364,026	202
203	UNIT COST MULT-WS B PT I		0.325599	34.115480	2.178448	45.201721	31.107242	203
204	COST TO BE ALLOC PER B PT II		748,452	399,007	54,827	68,143	169,597	204
205	UNIT COST MULT-WS B PT II		0.019091	3.396267	0.218134	1.993885	2.231657	205

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAFETERIA (MEALS SERVED)	NURSING ADMINI-STRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE (TIME SPENT)	
		11	13	14	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA	32,256						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,860	23,215					13
14	CENTRAL SERVICES & SUPPLY	646		100				14
15	PHARMACY				967,040			15
16	MEDICAL RECORDS & LIBRARY	1,310				86,134,390		16
17	SOCIAL SERVICE	2					13,680	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	261						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	7,226	13,434		33,167	30,043,968	12,952	30
31	INTENSIVE CARE UNIT	1,837	2,103		9,964	4,118,400		31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	577	616		19,606	977,848		50
53	ANESTHESIOLOGY					123,755		53
54	RADIOLOGY-DIAGNOSTIC	1,147			270	2,598,664		54
57	CT SCAN	214				3,405,317		57
60	LABORATORY	1,645				12,310,946		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,122			47	4,678,490		65
66	PHYSICAL THERAPY	537			246	1,146,832		66
69	ELECTROCARDIOLOGY	352				2,182,276		69
70	ELECTROENCEPHALOGRAPHY	49				102,317		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			100		3,557,907		71
73	DRUGS CHARGED TO PATIENTS	892			785,459	9,420,249		73
74	RENAL DIALYSIS					170,271		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	1,432	1,364		33,836	1,174,784		76
76.10	PARTIAL HOSPITALIZATION	6,034	270			2,325,950		76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	827	990		75,853	1,508,894	312	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE	18				83,674		90.05
91	EMERGENCY	3,694	3,824		8,592	6,203,848	416	91
91.01	GOLDEN LIFE	74	64					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	31,756	22,665	100	967,040	86,134,390	13,680	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	500	550					194
194.10	AUSTIN PRIDE							194.10

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAFETERIA (MEALS SERVED)	NURSING ADMINI-STRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE (TIME SPENT)	
		11	13	14	15	16	17	
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	578,940	2,875,022	1,370,221	1,583,841	1,601,470	56,909	202
203	UNIT COST MULT-WS B PT I	17.948289	123.843291	13,702.210000	1.637824	0.018593	4.160015	203
204	COST TO BE ALLOC PER B PT II	62,975	69,706	244,524	217,940	100,095	9,913	204
205	UNIT COST MULT-WS B PT II	1.952350	3.002628	2,445.240000	0.225368	0.001162	0.724635	205

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	I/R-SALARY AND FRINGES (ASSIGNED TIME)						
		21						
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	10,000						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	10,000						30
31	INTENSIVE CARE UNIT							31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH							76
76.10	PARTIAL HOSPITALIZATION							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE							90.05
91	EMERGENCY							91
91.01	GOLDEN LIFE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,000						118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS							194

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	I/R-SALARY AND FRINGES (ASSIGNED TIME)						
		21						
194.10	AUSTIN PRIDE							194.10
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	219,531						202
203	UNIT COST MULT-WS B PT I	21.953100						203
204	COST TO BE ALLOC PER B PT II	5,588						204
205	UNIT COST MULT-WS B PT II	0.558800						205

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	19,305,651		19,305,651		19,305,651	30
31	INTENSIVE CARE UNIT	3,650,861		3,650,861		3,650,861	31
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,684,321		2,684,321		2,684,321	50
53	ANESTHESIOLOGY	30,238		30,238		30,238	53
54	RADIOLOGY-DIAGNOSTIC	2,958,450		2,958,450		2,958,450	54
57	CT SCAN	441,932		441,932		441,932	57
60	LABORATORY	3,720,147		3,720,147		3,720,147	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,593,525		1,593,525		1,593,525	65
66	PHYSICAL THERAPY	933,068		933,068		933,068	66
69	ELECTROCARDIOLOGY	442,801		442,801		442,801	69
70	ELECTROENCEPHALOGRAPHY	69,421		69,421		69,421	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,262,823		2,262,823		2,262,823	71
73	DRUGS CHARGED TO PATIENTS	2,844,205		2,844,205		2,844,205	73
74	RENAL DIALYSIS	491,729		491,729		491,729	74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	1,738,983		1,738,983		1,738,983	76
76.10	PARTIAL HOSPITALIZATION	734,194		734,194		734,194	76.10
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,308,680		1,308,680		1,308,680	90
90.01	CICERO CLINIC						90.01
90.02	YMCA CLINIC						90.02
90.03	NORTH AVENUE CLINIC						90.03
90.04	CLINIC #4						90.04
90.05	WOUND CARE	35,434		35,434		35,434	90.05
91	EMERGENCY	5,399,547		5,399,547		5,399,547	91
91.01	GOLDEN LIFE	182,777		182,777		182,777	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	456,764		456,764		456,764	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	51,285,551		51,285,551		51,285,551	200
201	LESS OBSERVATION BEDS	456,764		456,764		456,764	201
202	TOTAL (SEE INSTRUCTIONS)	50,828,787		50,828,787		50,828,787	202

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	22,567,572		22,567,572				30
31	INTENSIVE CARE UNIT	4,152,600		4,152,600				31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	555,410	489,195	1,044,605	2.569700	2.569700	2.569700	50
53	ANESTHESIOLOGY	57,277	38,520	95,797	0.315647	0.315647	0.315647	53
54	RADIOLOGY-DIAGNOSTIC	918,927	1,303,212	2,222,139	1.331352	1.331352	1.331352	54
57	CT SCAN	894,580	1,486,348	2,380,928	0.185613	0.185613	0.185613	57
60	LABORATORY	5,962,269	3,703,621	9,665,890	0.384874	0.384874	0.384874	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,530,816	1,213,397	2,744,213	0.580686	0.580686	0.580686	65
66	PHYSICAL THERAPY	375,284	544,974	920,258	1.013920	1.013920	1.013920	66
69	ELECTROCARDIOLOGY	774,712	325,953	1,100,665	0.402303	0.402303	0.402303	69
70	ELECTROENCEPHALOGRAPHY	101,707	8,124	109,831	0.632071	0.632071	0.632071	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,373,911	1,462,569	2,836,480	0.797757	0.797757	0.797757	71
73	DRUGS CHARGED TO PATIENTS	4,743,038	896,031	5,639,069	0.504375	0.504375	0.504375	73
74	RENAL DIALYSIS	167,718		167,718	2.931880	2.931880	2.931880	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		826,114	826,114	2.105016	2.105016	2.105016	76
76.10	PARTIAL HOSPITALIZATION		2,359,094	2,359,094	0.311219	0.311219	0.311219	76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	25,691	1,268,696	1,294,387	1.011042	1.011042	1.011042	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE	2,040	42,579	44,619	0.794146	0.794146	0.794146	90.05
91	EMERGENCY	1,643,496	3,832,755	5,476,251	0.985993	0.985993	0.985993	91
91.01	GOLDEN LIFE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		114,563	114,563	3.987012	3.987012	3.987012	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	45,847,048	19,915,745	65,762,793				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	45,847,048	19,915,745	65,762,793				202

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII, PART A** **[ ] TITLE XIX** **[XX] PPS** **[ ] TEFRA**

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,076,463		1,076,463	23,669	45.48	7,633	347,149	30
31	INTENSIVE CARE UNIT	227,279		227,279	2,308	98.47	991	97,584	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,303,742		1,303,742	25,977		8,624	444,733	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0083** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII, PART A** **[ ] TITLE XIX** **[XX] HOSPITAL** **[ ] IPF** **[ ] IRF** **[ ] SUB (OTHER)** **[XX] PPS** **[ ] TEFRA**

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	292,920	1,044,605	0.280412	248,964	69,812	50
53	ANESTHESIOLOGY	8,264	95,797	0.086266	25,162	2,171	53
54	RADIOLOGY-DIAGNOSTIC	247,523	2,222,139	0.111390	379,385	42,260	54
57	CT SCAN	12,151	2,380,928	0.005103	360,152	1,838	57
60	LABORATORY	217,944	9,665,890	0.022548	2,121,588	47,838	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	117,375	2,744,213	0.042772	617,955	26,431	65
66	PHYSICAL THERAPY	110,179	920,258	0.119726	176,245	21,101	66
69	ELECTROCARDIOLOGY	22,075	1,100,665	0.020056	315,805	6,334	69
70	ELECTROENCEPHALOGRAPHY	9,453	109,831	0.086069	42,366	3,646	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	263,315	2,836,480	0.092832	508,883	47,241	71
73	DRUGS CHARGED TO PATIENTS	214,895	5,639,069	0.038108	1,519,341	57,899	73
74	RENAL DIALYSIS	7,385	167,718	0.044032			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	125,449	826,114	0.151854			76
76.10	PARTIAL HOSPITALIZATION	150,263	2,359,094	0.063695			76.10
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	96,723	1,294,387	0.074725	7,205	538	90
90.01	CICERO CLINIC						90.01
90.02	YMCA CLINIC						90.02
90.03	NORTH AVENUE CLINIC						90.03
90.04	CLINIC #4						90.04
90.05	WOUND CARE	726	44,619	0.016271			90.05
91	EMERGENCY	193,964	5,476,251	0.035419	504,354	17,864	91
91.01	GOLDEN LIFE	58,138					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	25,469	114,563	0.222314			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,174,211	39,042,621		6,827,405	344,973	200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: **[ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] PPS [ ] TEFRA**

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] PPS**
[XX] TITLE XVIII, PART A **[ ] TEFRA**
[ ] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	23,669		7,633		30
31	INTENSIVE CARE UNIT	2,308		991		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	25,977		8,624		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0083** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH							76
76.10	PARTIAL HOSPITALIZATION							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE							90.05
91	EMERGENCY							91
91.01	GOLDEN LIFE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0083** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,044,605			248,964		188,467		50
53	ANESTHESIOLOGY	95,797			25,162		13,967		53
54	RADIOLOGY-DIAGNOSTIC	2,222,139			379,385		260,071		54
57	CT SCAN	2,380,928			360,152		271,450		57
60	LABORATORY	9,665,890			2,121,588		259,339		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	2,744,213			617,955		108,322		65
66	PHYSICAL THERAPY	920,258			176,245				66
69	ELECTROCARDIOLOGY	1,100,665			315,805		90,709		69
70	ELECTROENCEPHALOGRAPHY	109,831			42,366		3,413		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,836,480			508,883		235,682		71
73	DRUGS CHARGED TO PATIENTS	5,639,069			1,519,341		223,745		73
74	RENAL DIALYSIS	167,718							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	826,114					63,216		76
76.10	PARTIAL HOSPITALIZATION	2,359,094							76.10
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,294,387			7,205		583,120		90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	44,619					10,484		90.05
91	EMERGENCY	5,476,251			504,354		398,182		91
91.01	GOLDEN LIFE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	114,563							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	39,042,621			6,827,405		2,710,167		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0083** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	2.569700	188,467			484,304			50
53	ANESTHESIOLOGY	0.315647	13,967			4,409			53
54	RADIOLOGY-DIAGNOSTIC	1.331352	260,071			346,246			54
57	CT SCAN	0.185613	271,450			50,385			57
60	LABORATORY	0.384874	259,339			99,813			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.580686	108,322			62,901			65
66	PHYSICAL THERAPY	1.013920							66
69	ELECTROCARDIOLOGY	0.402303	90,709			36,493			69
70	ELECTROENCEPHALOGRAPHY	0.632071	3,413			2,157			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.797757	235,682			188,017			71
73	DRUGS CHARGED TO PATIENTS	0.504375	223,745		4,443	112,851		2,241	73
74	RENAL DIALYSIS	2.931880							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	2.105016	63,216			133,071			76
76.10	PARTIAL HOSPITALIZATION	0.311219							76.10
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.011042	583,120	6		589,559	6		90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	0.794146	10,484			8,326			90.05
91	EMERGENCY	0.985993	398,182			392,605			91
91.01	GOLDEN LIFE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	3.987012							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		2,710,167	6	4,443	2,511,137	6	2,241	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		2,710,167	6	4,443	2,511,137	6	2,241	202

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26) 1	SWING BED ADJUST-MENT 2	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2) 3	TOTAL PATIENT DAYS 4	PER DIEM (col. 3 ÷ col. 4) 5	INPATIENT PROGRAM DAYS 6	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6) 7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,076,463		1,076,463	23,669	45.48	11,617	528,341	30
31	INTENSIVE CARE UNIT	227,279		227,279	2,308	98.47	785	77,299	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,303,742		1,303,742	25,977		12,402	605,640	200

(A) Worksheet A line numbers

KPMG LLP

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0083** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] HOSPITAL** **[ ] SUB (OTHER)** **[ ] TITLE XVIII, PART A** **[ ] IPF** **[XX] TITLE XIX** **[ ] IRF**

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	292,920	1,044,605	0.280412			50
53	ANESTHESIOLOGY	8,264	95,797	0.086266			53
54	RADIOLOGY-DIAGNOSTIC	247,523	2,222,139	0.111390			54
57	CT SCAN	12,151	2,380,928	0.005103			57
60	LABORATORY	217,944	9,665,890	0.022548			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	117,375	2,744,213	0.042772			65
66	PHYSICAL THERAPY	110,179	920,258	0.119726			66
69	ELECTROCARDIOLOGY	22,075	1,100,665	0.020056			69
70	ELECTROENCEPHALOGRAPHY	9,453	109,831	0.086069			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	263,315	2,836,480	0.092832			71
73	DRUGS CHARGED TO PATIENTS	214,895	5,639,069	0.038108			73
74	RENAL DIALYSIS	7,385	167,718	0.044032			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	125,449	826,114	0.151854			76
76.10	PARTIAL HOSPITALIZATION	150,263	2,359,094	0.063695			76.10
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	96,723	1,294,387	0.074725			90
90.01	CICERO CLINIC						90.01
90.02	YMCA CLINIC						90.02
90.03	NORTH AVENUE CLINIC						90.03
90.04	CLINIC #4						90.04
90.05	WOUND CARE	726	44,619	0.016271			90.05
91	EMERGENCY	193,964	5,476,251	0.035419			91
91.01	GOLDEN LIFE	58,138					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	25,469	114,563	0.222314			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,174,211	39,042,621				200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[ ] TITLE XVIII, PART A** **[XX] TITLE XIX**

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	23,669		11,617		30
31	INTENSIVE CARE UNIT	2,308		785		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	25,977		12,402		200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0083** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH							76
76.10	PARTIAL HOSPITALIZATION							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE							90.05
91	EMERGENCY							91
91.01	GOLDEN LIFE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0083** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR

(A)		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,044,605							50
53	ANESTHESIOLOGY	95,797							53
54	RADIOLOGY-DIAGNOSTIC	2,222,139							54
57	CT SCAN	2,380,928							57
60	LABORATORY	9,665,890							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	2,744,213							65
66	PHYSICAL THERAPY	920,258							66
69	ELECTROCARDIOLOGY	1,100,665							69
70	ELECTROENCEPHALOGRAPHY	109,831							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,836,480							71
73	DRUGS CHARGED TO PATIENTS	5,639,069							73
74	RENAL DIALYSIS	167,718							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	826,114							76
76.10	PARTIAL HOSPITALIZATION	2,359,094							76.10
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1,294,387							90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	44,619							90.05
91	EMERGENCY	5,476,251							91
91.01	GOLDEN LIFE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	114,563							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	39,042,621							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0083** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	2.569700							50
53	ANESTHESIOLOGY	0.315647							53
54	RADIOLOGY-DIAGNOSTIC	1.331352							54
57	CT SCAN	0.185613							57
60	LABORATORY	0.384874							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.580686							65
66	PHYSICAL THERAPY	1.013920							66
69	ELECTROCARDIOLOGY	0.402303							69
70	ELECTROENCEPHALOGRAPHY	0.632071							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.797757							71
73	DRUGS CHARGED TO PATIENTS	0.504375							73
74	RENAL DIALYSIS	2.931880							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	2.105016							76
76.10	PARTIAL HOSPITALIZATION	0.311219							76.10
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.011042							90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	0.794146							90.05
91	EMERGENCY	0.985993							91
91.01	GOLDEN LIFE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	3.987012							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0083** **WORKSHEET D-1 PART I**

CHECK	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**
APPLICABLE	**[XX] TITLE XVIII, PART A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
BOXES:	**[ ] TITLE XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] OTHER**

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	23,669	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	23,669	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	23,109	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	7,633	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	19,305,651	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	19,305,651	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	19,305,651	37

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0083** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	815.65	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	6,225,856	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	6,225,856	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	3,650,861	2,308	1,581.83	991	1,567,594	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	4,404,414	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	12,197,864	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	444,733	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	344,973	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	789,706	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	11,408,158	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0083** **WORKSHEET D-1**
PARTS III & IV

CHECK	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**
APPLICABLE	**[XX] TITLE XVIII, PART A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
BOXES:	**[ ] TITLE XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] OTHER**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					560	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					815.65	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					456,764	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	1,076,463	19,305,651	0.055759	456,764	25,469	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0083** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	23,669	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	23,669	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	23,109	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,617	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	19,305,651	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	19,305,651	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	19,305,651	37

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0083** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] PPS [ ] TEFRA [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					815.65	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					9,475,406	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					9,475,406	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	3,650,861	2,308	1,581.83	785	1,241,737	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					10,717,143	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					605,640	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					605,640	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0083** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					560	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

KPMG LLP COMPU-MAX

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0083** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		7,311,450		30
31	INTENSIVE CARE UNIT		1,749,600		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	2.569700	248,964	639,763	50
53	ANESTHESIOLOGY	0.315647	25,162	7,942	53
54	RADIOLOGY-DIAGNOSTIC	1.331352	379,385	505,095	54
57	CT SCAN	0.185613	360,152	66,849	57
60	LABORATORY	0.384874	2,121,588	816,544	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.580686	617,955	358,838	65
66	PHYSICAL THERAPY	1.013920	176,245	178,698	66
69	ELECTROCARDIOLOGY	0.402303	315,805	127,049	69
70	ELECTROENCEPHALOGRAPHY	0.632071	42,366	26,778	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.797757	508,883	405,965	71
73	DRUGS CHARGED TO PATIENTS	0.504375	1,519,341	766,318	73
74	RENAL DIALYSIS	2.931880			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	2.105016			76
76.10	PARTIAL HOSPITALIZATION	0.311219			76.10
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.011042	7,205	7,285	90
90.01	CICERO CLINIC				90.01
90.02	YMCA CLINIC				90.02
90.03	NORTH AVENUE CLINIC				90.03
90.04	CLINIC #4				90.04
90.05	WOUND CARE	0.794146			90.05
91	EMERGENCY	0.985993	504,354	497,290	91
91.01	GOLDEN LIFE				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	3.987012			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		6,827,405	4,404,414	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		6,827,405		202

(A) Worksheet A line numbers

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0083** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	2.569700			50
53	ANESTHESIOLOGY	0.315647			53
54	RADIOLOGY-DIAGNOSTIC	1.331352			54
57	CT SCAN	0.185613			57
60	LABORATORY	0.384874			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.580686			65
66	PHYSICAL THERAPY	1.013920			66
69	ELECTROCARDIOLOGY	0.402303			69
70	ELECTROENCEPHALOGRAPHY	0.632071			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.797757			71
73	DRUGS CHARGED TO PATIENTS	0.504375			73
74	RENAL DIALYSIS	2.931880			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	2.105016			76
76.10	PARTIAL HOSPITALIZATION	0.311219			76.10
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.011042			90
90.01	CICERO CLINIC				90.01
90.02	YMCA CLINIC				90.02
90.03	NORTH AVENUE CLINIC				90.03
90.04	CLINIC #4				90.04
90.05	WOUND CARE	0.794146			90.05
91	EMERGENCY	0.985993			91
91.01	GOLDEN LIFE				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	3.987012			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	2,121,702			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	6,365,106			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	76,069			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	168.47			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS	2.50			11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	2.50			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	2.00			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	3.00			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	2.50			15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	2.50			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.014839			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.017534			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.014839			21
22	IME PAYMENT ADJUSTMENT (see instructions)	68,548			22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)	68,548			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.2432			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.6020			31
32	SUM OF LINES 30 AND 31	0.8452			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.5894			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	2,188,429			34
		PRIOR TO	ON OR AFTER		

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		5,062,333		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		3,786,347		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	3,786,347			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	14,606,201			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	14,606,201			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	814,179			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)	61,787			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	15,482,167			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	15,482,167			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	927,520			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	222,808			63
64	ALLOWABLE BAD DEBTS (see instructions)	1,016,585			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	660,780			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	747,080			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	14,992,619			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (OTHER ADJUSTMENTS)				70
71	AMOUNT DUE PROVIDER (see instructions)	14,992,619			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	299,852			71.01
72	INTERIM PAYMENTS	13,387,902			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	1,304,865			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	173,485			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0083** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	2,247			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	2,511,137			2
3	PPS PAYMENTS	1,198,962			3
4	OUTLIER PAYMENT (see instructions)	3,229			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	2,247			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	4,449			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	4,449			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	4,449			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	2,202			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	2,247			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	1,202,191			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	302,561			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	901,877			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	12,731			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	914,608			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	914,608			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	158,109			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	102,771			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	104,547			36
37	SUBTOTAL (see instructions)	1,017,379			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS ()				39
40	SUBTOTAL (see instructions)	1,017,379			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	20,348			40.01
41	INTERIM PAYMENTS	1,056,126			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-59,095			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0083** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				13,315,509		1,020,342	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							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	02/21/2014	84,462	02/21/2014	38,653	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	06/25/2014	12,069	06/25/2014	2,869	3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		72,393		35,784	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				13,387,902		1,056,126	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		1,604,717			6.01
	BASED ON THE COST REPORT (1)		.02				-38,747	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				14,992,619		1,017,379	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/28/2014 Run Time: 08:12 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT **WORKSHEET E-1 PART II**

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	4,655	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	8,624	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	25,417	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	65,762,793	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	6,061,196	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,009,438	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	20,189	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	989,249	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	937,391	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	51,858	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0083** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[ ] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[XX] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	10,717,143		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	10,717,143		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	10,717,143		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	10,717,143		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)	10,717,143		30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	0.00	0.00	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		2.00		10
11	TOTAL WEIGHTED FTE COUNT	0.00	2.00		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	2.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	3.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	2.33		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	2.33		17
18	PER RESIDENT AMOUNT	92,574.30	94,259.15		18
19	APPROVED AMOUNT FOR RESIDENT COSTS		219,624	219,624	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			219,624	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	8,624			26
27	TOTAL INPATIENT DAYS (see instructions)	25,417			27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.339300	0.000000		28
29	PROGRAM DIRECT GME AMOUNT	74,518			29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT			74,518	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			167,718	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			12,197,864	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			12,197,864	41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			2,513,384	42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			2,513,384	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			14,711,248	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.829152	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			0.170848	47

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	TOTAL PROGRAM GME PAYMENT (line 31)	74,518	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)	61,787	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)	12,731	50

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX: **[ ] TITLE V** **[ ] TITLE XVIII** **[XX] TITLE XIX**

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	0.00	0.00	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00		17
18	PER RESIDENT AMOUNT	0.00	0.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	12,402	2,898		26
27	TOTAL INPATIENT DAYS (see instructions)	25,417	25,417		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.487941	0.114018		28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)				37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)				42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)				44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)				46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)				47

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX:
[ ] TITLE V
[ ] TITLE XVIII
[XX] TITLE XIX

	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	TOTAL PROGRAM GME PAYMENT (line 31)		48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)		49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)		50

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BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,478,221				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	10,580,575				4
5	OTHER RECEIVABLES	320				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-6,081,350				6
7	INVENTORY	322,311				7
8	PREPAID EXPENSES	406,856				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS	13,537,735				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	21,244,668				11
	FIXED ASSETS					
12	LAND	429,028				12
13	LAND IMPROVEMENTS	224,058				13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	48,051,361				15
16	ACCUMULATED DEPRECIATION	-44,286,411				16
17	LEASEHOLD IMPROVEMENTS	197,413				17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	21,529,994				19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS	1,214,789				21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	27,360,232				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	-645,259				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	-645,259				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	47,959,641				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	3,807,768				37
38	SALARIES, WAGES & FEES PAYABLE	1,488,279				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	434,551				43
44	OTHER CURRENT LIABILITIES	9,548,829				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	15,279,427				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	2,596,787				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	2,596,787				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	17,876,214				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	30,083,427				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57

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BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	30,083,427				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	47,959,641				60

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STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		27,685,729			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		2,394,794			2
3	TOTAL (sun of line 1 and line 2)		30,080,523			3
4	ADDITIONS (credit adjustments)	2,904				4
5	NET ASSETS RELEASED					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		2,904			10
11	SUBTOTAL (line 3 plus line 10)		30,083,427			11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS					13
14	OTHER					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		30,083,427			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	NET ASSETS RELEASED					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS					13
14	OTHER					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	22,611,952		22,611,952	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	22,611,952		22,611,952	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	4,152,600		4,152,600	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	4,152,600		4,152,600	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	26,764,552		26,764,552	17
18	ANCILLARY SERVICES	18,959,282	19,871,993	38,831,275	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	45,723,834	19,871,993	65,595,827	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		61,572,572	29
30	ADD (SPECIFY)			30
31	BAD DEBTS	2,022,539		31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		2,022,539	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		63,595,111	43

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STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	65,595,827	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	9,104,356	2
3	NET PATIENT REVENUES (line 1 minus line 2)	56,491,471	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	63,595,111	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-7,103,640	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	62,094	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES 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	9,604	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	3,986	21
22	RENTAL OF HOSPITAL SPACE	6,049	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER INCOME)	9,416,701	24
24.01	OTHER (OTHER MISC)		24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	9,498,434	25
26	TOTAL (line 5 plus line 25)	2,394,794	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	2,394,794	29

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CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0083** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	677,448	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	3,341	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	69.64	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	2.50	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	1.02	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	6,910	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.2432	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.6020	8
9	SUM OF LINES 7 AND 8	0.8452	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1867	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	126,480	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	814,179	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		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 (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH							76
76.10	PARTIAL HOSPITALIZATION							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE							90.05
91	EMERGENCY							91
91.01	GOLDEN LIFE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS							194
194.10	AUSTIN PRIDE							194.10
200	CROSS FOOT ADJUSTMENTS							200

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES **WORKSHEET L-1**
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202