LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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: 11/30/2015 Time: 09:07 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 certification 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

(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		1,429,672	-90,417			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		1,429,672	-90,417			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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,
search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence

not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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	Provider 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 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information		1	2	3	
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
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period 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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	8,982				4,748	1,389	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	40

		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 payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. 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, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 nonprovider 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 nonprovider 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, indicate which program year began during this cost reporting period. (see instructions)				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, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 applicable column.		N	92
93	Does this facility operate an ICF/IID 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	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. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			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
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §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	4	
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. (see instructions)		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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
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)	0.75			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 / 2014	06 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

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 Accnountant? 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 in 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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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	08/31/2015	Y	08/31/2015	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 Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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 Cost			
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 capitalization 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	Are 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 servcies to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: EMIL	Last name: MATOV	Title: MANAGER	41
42	Employer: STRATEGIC REIMBURSEMENT LLC			42
43	Phone number: 630-530-7100 X 119	E-mail Address: EMIL.MATOV@SRGROUPLLC.COM		43

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A 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	148	54,020			5,088	8,982	22,046	1
2	HMO and other (see instructions)						526	4,897		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)		148	54,020			5,088	8,982	22,046	7
8	Intensive Care Unit	31	12	4,380			761	1,240	2,231	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)		160	58,400			5,849	10,222	24,277	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)		160							27
28	Observation Bed Days								592	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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)					915	3,662	4,890	1
2	HMO and other (see instructions)					83			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)	3.00	472.00			915	3,662	4,890	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)	3.00	472.00						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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	28,378,378		28,378,378	981,762.00	28.91	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest 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	138,431		138,431	6,328.00	21.88	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)		341,649		341,649	8,506.00	40.17	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							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)		4,893,092		4,893,092			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		59,726		59,726			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)		24,388		24,388			25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		246,242		246,242	7,224.00	34.09	26
27	Administrative & General		5,826,087		5,826,087	161,103.00	36.16	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		1,219,567		1,219,567	36,880.00	33.07	30
31	Laundry & Linen Service		33,265		33,265	2,119.00	15.70	31
32	Housekeeping		643,152		643,152	48,655.00	13.22	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		863,204	-161,586	701,618	45,735.00	15.34	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			161,586	161,586	10,089.00	16.02	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,559,816		1,559,816	43,896.00	35.53	38
39	Central Services and Supply		201,178		201,178	11,274.00	17.84	39
40	Pharmacy		809,592		809,592	21,506.00	37.64	40
41	Medical Records & Medical Records Library		557,626		557,626	28,016.00	19.90	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		28,239,947		28,239,947	975,434.00	28.95	1
2	Excluded area salaries (see instructions)		341,649		341,649	8,506.00	40.17	2
3	Subtotal salarles (line 1 minus line 2)		27,898,298		27,898,298	966,928.00	28.85	3
4	Subtotal other wages & related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)		4,893,092		4,893,092		17.54%	5
6	Total (sum of lines 3 through 5)		32,791,390		32,791,390	966,928.00	33.91	6
7	Total overhead cost (see instructions)		11,959,729		11,959,729	416,497.00	28.72	7

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)	371,376	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)	1,438,550	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	-18,656	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	82,882	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	640,099	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	2,165,007	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	163,292	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	134,656	23
24	Total Wage Related cost (Sum of lines 1-23)	4,977,206	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

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

	STEP 1: 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

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract 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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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)	0.772308	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	13,209,044	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	19,795,618	6
7	Medicaid cost (line 1 times line 6)	15,288,314	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.	2,079,270	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 care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig 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)	2,079,270	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	1,356,486	776,521	2,133,007	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,047,625	599,713	1,647,338	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	1,047,625	599,713	1,647,338	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)	1,259,436	26
27	Medicare bad debts for the entire hospital complex (see instructions)	286,279	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	973,157	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	751,577	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	2,398,915	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,478,185	31

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		1,111,512	1,111,512	-510,069	601,443	-8,331	593,112	1
2	00200	Cap Rel Costs-Mvble Equip				650,693	650,693		650,693	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	246,242	2,809,019	3,055,261		3,055,261		3,055,261	4
5.01	01160	COMMUNICATIONS	148,141	259,499	407,640		407,640		407,640	5.01
5.04	00570	ADMITTING	161,057	18,237	179,294		179,294		179,294	5.04
5.05	00580	BUSINESS OFFICE	437,513	156,777	594,290		594,290		594,290	5.05
5.06	00590	OTHER ADMINISTRATIVE	5,079,376	11,854,051	16,933,427	-140,624	16,792,803	-6,837,052	9,955,751	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,219,567	1,694,847	2,914,414		2,914,414		2,914,414	7
8	00800	Laundry & Linen Service	33,265	127,675	160,940		160,940		160,940	8
9	00900	Housekeeping	643,152	340,391	983,543		983,543		983,543	9
10	01000	Dietary	863,204	858,354	1,721,558	-336,287	1,385,271		1,385,271	10
11	01100	Cafeteria				336,287	336,287	-86,510	249,777	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,559,816	273,075	1,832,891		1,832,891		1,832,891	13
14	01400	Central Services & Supply	201,178	173,908	375,086	-90,719	284,367		284,367	14
15	01500	Pharmacy	809,592	1,178,812	1,988,404	-818,802	1,169,602	-15,950	1,153,652	15
16	01600	Medical Records & Library	557,626	388,641	946,267		946,267		946,267	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	138,431	25,148	163,579		163,579		163,579	21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	7,781,522	886,848	8,668,370		8,668,370		8,668,370	30
31	03100	Intensive Care Unit	1,278,147	440,488	1,718,635		1,718,635	-160,000	1,558,635	31
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	415,974	520,398	936,372	-274,437	661,935	-4,088	657,847	50
53	05300	Anesthesiology		506,075	506,075	-322	505,753	-505,000	753	53
54	05400	Radiology-Diagnostic	805,194	1,005,478	1,810,672		1,810,672	-225,000	1,585,672	54
57	05700	CT Scan	195,885	89,448	285,333		285,333		285,333	57
60	06000	Laboratory	884,852	821,183	1,706,035		1,706,035		1,706,035	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	644,335	130,388	774,723	-46,837	727,886		727,886	65
66	06600	Physical Therapy	337,581	35,717	373,298	-3,235	370,063		370,063	66
69	06900	Electrocardiology	184,312	18,788	203,100		203,100		203,100	69
70	07000	Electroencephalography	9,310	1,307	10,617		10,617		10,617	70
71	07100	Medical Supplies Charged to Patients				565,438	565,438		565,438	71
73	07300	Drugs Charged to Patients				818,802	818,802		818,802	73
74	07400	Renal Dialysis		36,565	36,565		36,565		36,565	74
75.01	07501	HYBERBARIC CHAMBER								75.01
76	03550	O/P MENTAL HEALTH	643,842	289,817	933,659		933,659	-196,035	737,624	76
76.10	03950	PARTIAL HOSPITALIZATION	36,912	3,470	40,382		40,382		40,382	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	306,175	100,400	406,575	-4,489	402,086	-49,403	352,683	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	7,959	5,170	13,129	-4,283	8,846		8,846	90.05
91	09100	Emergency	2,363,648	1,580,722	3,944,370	-141,116	3,803,254	-1,148,733	2,654,521	91
91.01	09101	GOLDEN LIFE	42,921	3,291	46,212		46,212		46,212	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
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								

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	
118		SUBTOTALS (sum of lines 1-117)	28,036,729	27,745,499	55,782,228		55,782,228	-9,236,102	46,546,126	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PUBLIC RELATIONS	341,649	77,852	419,501		419,501		419,501	194
194.10	07951	AUSTIN PRIDE		805	805		805		805	194.10
200		TOTAL (sum of lines 118-199)	28,378,378	27,824,156	56,202,534		56,202,534	-9,236,102	46,966,432	200

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		818,802	1
500	Total reclassifications					818,802	500
	Code Letter - A						
1	CAFETERIA RECLASS	B	Cafeteria	11	161,586	174,701	1
500	Total reclassifications				161,586	174,701	500
	Code Letter - B						
1	DEPR EXP	D	Cap Rel Costs-Mvble Equip	2		650,693	1
500	Total reclassifications					650,693	500
	Code Letter - D						
1	SUPPLIES CHARGED	E	Medical Supplies Charged to P	71		565,438	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					565,438	500
	Code Letter - E						
1	CAPITAL INSURANCE EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		140,624	1
500	Total reclassifications					140,624	500
	Code Letter - F						
	GRAND TOTAL (Increases)				161,586	2,350,258	

(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.

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		818,802		1
500	Total reclassifications					818,802		500
	Code letter - A							
1	CAFETERIA RECLASS	B	Dietary	10	161,586	174,701		1
500	Total reclassifications				161,586	174,701		500
	Code letter - B							
1	DEPR EXP	D	Cap Rel Costs-Bldg & Fixt	1		650,693	9	1
500	Total reclassifications					650,693		500
	Code letter - D							
1	SUPPLIES CHARGED	E	Operating Room	50		274,437		1
2			Anesthesiology	53		322		2
3			Respiratory Therapy	65		46,837		3
4			Physical Therapy	66		3,235		4
5			Clinic	90		4,489		5
6			Emergency	91		141,116		6
7			WOUND CARE	90.05		4,283		7
8			Central Services & Supply	14		90,719		8
500	Total reclassifications					565,438		500
	Code letter - E							
1	CAPITAL INSURANCE EXPENSE	F	OTHER ADMINISTRATIVE	5.06		140,624	12	1
500	Total reclassifications					140,624		500
	Code letter - F							
	GRAND TOTAL (Decreases)				161,586	2,350,258		

(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.

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 Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	429,028					429,028		1
2	Land Improvements	224,058				187,115	36,943		2
3	Buildings and Fixtures	46,836,572				11,713,003	35,123,569		3
4	Building Improvements								4
5	Fixed Equipment	21,529,994		54,878	54,878		21,584,872		5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	69,019,652		54,878	54,878	11,900,118	57,174,412		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	69,019,652		54,878	54,878	11,900,118	57,174,412		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,089,900		21,612				1,111,512	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	1,089,900		21,612				1,111,512	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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
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	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	430,876		21,612	140,624			593,112	1
2	Cap Rel Costs-Mvble Equip	650,693						650,693	2
3	Total (sum of lines 1-2)	1,081,569		21,612	140,624			1,243,805	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.)

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	-2,571,922				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	-82,023	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	-4,487	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						32
33							33
33.02	TELEPHONE CAPITAL	A	-2,282	Cap Rel Costs-Bldg & Fixt	1	9	33.02
34							34
35	MED REC COPIES	B	-4,088	Operating Room	50		35
36	MISC INCOME	B	-1,167	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	-6,530,780	OTHER ADMINISTRATIVE	5.06		39
40	PHARMACY RENT	B	-15,950	Pharmacy	15	10	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)		-9,236,102				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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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.

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 Adjustments (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:

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2	31	Intensive Care Unit AGGREGATE	160,000	160,000						2
3	53	Anesthesiology AGGREGATE	505,000	505,000						3
4	54	Radiology-Diagnostic AGGREGATE	225,000	225,000						4
5										5
6	76	O/P MENTAL HEALTH AGGREGATE	196,035	196,035						6
7	91	Emergency AGGREGATE	1,148,733	1,148,733						7
8	90	Clinic AGGREGATE	49,403	49,403						8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE	287,751	287,751						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	2,571,922	2,571,922						200

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2	31	Intensive Care Unit AGGREGATE							160,000	2
3	53	Anesthesiology AGGREGATE							505,000	3
4	54	Radiology-Diagnostic AGGREGATE							225,000	4
5										5
6	76	O/P MENTAL HEALTH AGGREGATE							196,035	6
7	91	Emergency AGGREGATE							1,148,733	7
8	90	Clinic AGGREGATE							49,403	8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE							287,751	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							2,571,922	200

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST 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	593,112	593,112					1
2	Cap Rel Costs-Mvble Equip	650,693		650,693				2
4	Employee Benefits Department	3,055,261	3,637	3,990	3,062,888			4
5.01	COMMUNICATIONS	407,640	3,528	3,871	14,933	429,972		5.01
5.04	ADMITTING	179,294	456	500	19,079	4,115	203,444	5.04
5.05	BUSINESS OFFICE	594,290	10,713	11,753	41,709	6,172		5.05
5.06	OTHER ADMINISTRATIVE	9,955,751	125,256	137,416	493,359	121,379		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	2,914,414	61,154	67,091	105,232	6,172		7
8	Laundry & Linen Service	160,940	7,509	8,238	3,670	2,057		8
9	Housekeeping	983,543	7,278	7,984	65,913	2,057		9
10	Dietary	1,385,271	21,443	23,525	86,137	10,286		10
11	Cafeteria	249,777	8,335	9,144		6,172		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,832,891	3,574	3,921	159,721	20,573		13
14	Central Services & Supply	284,367	35,288	38,714	18,584	6,172		14
15	Pharmacy	1,153,652	4,939	5,418	73,721	4,115		15
16	Medical Records & Library	946,267	11,166	12,250	59,574	14,401		16
17	Social Service		1,321	1,450	1,279	14,401		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	163,579	297	326	20,289			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,668,370	90,178	98,933	839,713	30,859	94,584	30
31	Intensive Care Unit	1,558,635	22,160	24,311	181,093	10,286	18,860	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	657,847	29,758	32,647	57,327	39,088	3,306	50
53	Anesthesiology	753	1,202	1,319		2,057	350	53
54	Radiology-Diagnostic	1,585,672	28,955	31,766	91,031	16,458	4,488	54
57	CT Scan	285,333			16,286		4,551	57
60	Laboratory	1,706,035	21,882	24,007	95,012	12,344	27,841	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	727,886	6,812	7,473	79,998	4,115	7,445	65
66	Physical Therapy	370,063	14,598	16,015	37,878	14,401	1,607	66
69	Electrocardiology	203,100	1,903	2,088	19,652	6,172	3,692	69
70	Electroencephalography	10,617	1,292	1,417	3,956	2,057	428	70
71	Medical Supplies Charged to Patients	565,438					6,805	71
73	Drugs Charged to Patients	818,802					21,272	73
74	Renal Dialysis	36,565					682	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	737,624	13,561	14,877	71,758	14,401		76
76.10	PARTIAL HOSPITALIZATION	40,382	19,798	21,720	14,218	4,115	133	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	352,683	8,345	9,155	52,708	14,401	133	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	8,846			2,148			90.05
91	Emergency	2,654,521	12,692	13,924	281,913	34,974	7,267	91
91.01	GOLDEN LIFE	46,212	8,863	9,724	4,507			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)	46,546,126	587,893	644,967	3,012,398	423,800	203,444	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	419,501	264	290	50,490	2,057		194

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST 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	
194.10	AUSTIN PRIDE	805	4,955	5,436		4,115		194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	46,966,432	593,112	650,693	3,062,888	429,972	203,444	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	664,637						5.05
5.06	OTHER ADMINISTRATIVE		10,833,161	10,833,161				5.06
6	Maintenance & Repairs							6
7	Operation of Plant		3,154,063	945,623	4,099,686			7
8	Laundry & Linen Service		182,414	54,690	79,318	316,422		8
9	Housekeeping		1,066,775	319,831	76,875		1,463,481	9
10	Dietary		1,526,662	457,710	226,508		13,061	10
11	Cafeteria		273,428	81,977	88,042		76,095	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,020,680	605,822	37,757			13
14	Central Services & Supply		383,125	114,865	372,756		39,139	14
15	Pharmacy		1,241,845	372,319	52,169		17,386	15
16	Medical Records & Library		1,043,658	312,900	117,947		13,061	16
17	Social Service		18,451	5,532	13,958		6,509	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		184,491	55,312	3,141			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	217,150	10,039,787	3,010,047	949,826	206,553	378,371	30
31	Intensive Care Unit	43,100	1,858,445	557,182	234,080	15,054	69,586	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,051	834,024	250,050	314,340	94,815	110,909	50
53	Anesthesiology	1,366	7,047	2,113	12,702			53
54	Radiology-Diagnostic	23,051	1,781,421	534,090	305,861		76,095	54
57	CT Scan	24,589	330,759	99,165				57
60	Laboratory	102,415	1,989,536	596,485	231,149		76,095	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	28,709	862,438	258,568	71,955		39,139	65
66	Physical Therapy	8,207	462,769	138,743	154,204		66,331	66
69	Electrocardiology	10,994	247,601	74,234	20,100			69
70	Electroencephalography	1,107	20,874	6,258	13,644			70
71	Medical Supplies Charged to Patients	29,510	601,753	180,412				71
73	Drugs Charged to Patients	57,469	897,543	269,093				73
74	Renal Dialysis	1,558	38,805	11,634				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	10,483	862,704	258,648	143,247		58,709	76
76.10	PARTIAL HOSPITALIZATION	21,259	121,625	36,465	209,130			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	16,304	453,729	136,033	88,147		108,725	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	1,083	12,077	3,621				90.05
91	Emergency	52,232	3,057,523	916,679	134,069		304,464	91
91.01	GOLDEN LIFE		69,306	20,779	93,625			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)	664,637	46,478,519	10,686,880	4,044,550	316,422	1,453,675	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		472,602	141,691	2,792			194
194.10	AUSTIN PRIDE		15,311	4,590	52,344		9,806	194.10

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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	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	664,637	46,966,432	10,833,161	4,099,686	316,422	1,463,481	202

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	2,223,941						10
11	Cafeteria		519,542					11
12	Maintenance of Personnel							12
13	Nursing Administration		29,959	2,694,218				13
14	Central Services & Supply		10,405		920,290			14
15	Pharmacy					1,683,719		15
16	Medical Records & Library		21,100				1,508,666	16
17	Social Service		32					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		4,204					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,465,947	116,387	1,559,082		57,747	526,241	30
31	Intensive Care Unit	124,401	29,588	244,064		17,348	72,134	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	633,593	9,294	71,490		34,136	17,127	50
53	Anesthesiology						2,168	53
54	Radiology-Diagnostic		18,475			470	45,516	54
57	CT Scan		3,447				59,644	57
60	Laboratory		26,496				215,626	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,072			82	81,944	65
66	Physical Therapy		8,649			428	20,087	66
69	Electrocardiology		5,670				38,223	69
70	Electroencephalography		789				1,792	70
71	Medical Supplies Charged to Patients				920,290		62,317	71
73	Drugs Charged to Patients		14,367			1,367,568	164,996	73
74	Renal Dialysis						2,982	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		23,065	158,299		58,912	20,576	76
76.10	PARTIAL HOSPITALIZATION		97,189	31,335			40,739	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		13,320	114,895		132,068	26,428	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		290				1,466	90.05
91	Emergency		59,499	443,795		14,960	108,660	91
91.01	GOLDEN LIFE		1,192	7,428				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)	2,223,941	511,489	2,630,388	920,290	1,683,719	1,508,666	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		8,053	63,830				194
194.10	AUSTIN PRIDE							194.10

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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	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,223,941	519,542	2,694,218	920,290	1,683,719	1,508,666	202

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	44,482						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		247,148					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,114	247,148	18,599,250	-247,148	18,352,102		30
31	Intensive Care Unit			3,221,882		3,221,882		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			2,369,778		2,369,778		50
53	Anesthesiology			24,030		24,030		53
54	Radiology-Diagnostic			2,761,928		2,761,928		54
57	CT Scan			493,015		493,015		57
60	Laboratory			3,135,387		3,135,387		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			1,332,198		1,332,198		65
66	Physical Therapy			851,211		851,211		66
69	Electrocardiology			385,828		385,828		69
70	Electroencephalography			43,357		43,357		70
71	Medical Supplies Charged to Patients			1,764,772		1,764,772		71
73	Drugs Charged to Patients			2,713,567		2,713,567		73
74	Renal Dialysis			53,421		53,421		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			1,584,160		1,584,160		76
76.10	PARTIAL HOSPITALIZATION			536,483		536,483		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	1,015		1,074,360		1,074,360		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			17,454		17,454		90.05
91	Emergency	1,353		5,041,002		5,041,002		91
91.01	GOLDEN LIFE			192,330		192,330		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)	44,482	247,148	46,195,413	-247,148	45,948,265		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			688,968		688,968		194
194.10	AUSTIN PRIDE			82,051		82,051		194.10

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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		
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	44,482	247,148	46,966,432	-247,148	46,719,284		202

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	6,875	3,637	3,990	14,502	14,502		4
5.01	COMMUNICATIONS		3,528	3,871	7,399	71	7,470	5.01
5.04	ADMITTING		456	500	956	90	71	5.04
5.05	BUSINESS OFFICE	563	10,713	11,753	23,029	197	107	5.05
5.06	OTHER ADMINISTRATIVE	24,434	125,256	137,416	287,106	2,336	2,112	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,094	61,154	67,091	129,339	498	107	7
8	Laundry & Linen Service		7,509	8,238	15,747	17	36	8
9	Housekeeping		7,278	7,984	15,262	312	36	9
10	Dietary		21,443	23,525	44,968	408	179	10
11	Cafeteria		8,335	9,144	17,479		107	11
12	Maintenance of Personnel							12
13	Nursing Administration		3,574	3,921	7,495	756	357	13
14	Central Services & Supply	113	35,288	38,714	74,115	88	107	14
15	Pharmacy	174,859	4,939	5,418	185,216	349	71	15
16	Medical Records & Library		11,166	12,250	23,416	282	250	16
17	Social Service		1,321	1,450	2,771	6	250	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		297	326	623	96		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,954	90,178	98,933	201,065	3,978	536	30
31	Intensive Care Unit	2,368	22,160	24,311	48,839	857	179	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		29,758	32,647	62,405	271	679	50
53	Anesthesiology		1,202	1,319	2,521		36	53
54	Radiology-Diagnostic		28,955	31,766	60,721	431	286	54
57	CT Scan					77		57
60	Laboratory	19,311	21,882	24,007	65,200	450	214	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,578	6,812	7,473	22,863	379	71	65
66	Physical Therapy		14,598	16,015	30,613	179	250	66
69	Electrocardiology		1,903	2,088	3,991	93	107	69
70	Electroencephalography		1,292	1,417	2,709	19	36	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		13,561	14,877	28,438	340	250	76
76.10	PARTIAL HOSPITALIZATION		19,798	21,720	41,518	67	71	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		8,345	9,155	17,500	250	250	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					10		90.05
91	Emergency		12,692	13,924	26,616	1,335	608	91
91.01	GOLDEN LIFE		8,863	9,724	18,587	21		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)	250,149	587,893	644,967	1,483,009	14,263	7,363	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		264	290	554	239	36	194

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	
194.10	AUSTIN PRIDE		4,955	5,436	10,391		71	194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	250,149	593,112	650,693	1,493,954	14,502	7,470	202

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	1,117						5.04
5.05	BUSINESS OFFICE		23,333					5.05
5.06	OTHER ADMINISTRATIVE			291,554				5.06
6	Maintenance & Repairs							6
7	Operation of Plant			25,450	155,394			7
8	Laundry & Linen Service			1,472	3,006	20,278		8
9	Housekeeping			8,608	2,914		27,132	9
10	Dietary			12,319	8,586		242	10
11	Cafeteria			2,206	3,337		1,411	11
12	Maintenance of Personnel							12
13	Nursing Administration			16,305	1,431			13
14	Central Services & Supply			3,091	14,129		726	14
15	Pharmacy			10,020	1,977		322	15
16	Medical Records & Library			8,421	4,471		242	16
17	Social Service			149	529		121	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			1,489	119			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	521	7,637	81,007	36,002	13,237	7,013	30
31	Intensive Care Unit	103	1,512	14,996	8,873	965	1,290	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18	493	6,730	11,915	6,076	2,056	50
53	Anesthesiology	2	48	57	481			53
54	Radiology-Diagnostic	25	808	14,374	11,593		1,411	54
57	CT Scan	25	862	2,669				57
60	Laboratory	152	3,592	16,054	8,761		1,411	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41	1,007	6,959	2,727		726	65
66	Physical Therapy	9	288	3,734	5,845		1,230	66
69	Electrocardiology	20	386	1,998	762			69
70	Electroencephalography	2	39	168	517			70
71	Medical Supplies Charged to Patients	37	1,035	4,856				71
73	Drugs Charged to Patients	116	2,015	7,242				73
74	Renal Dialysis	4	55	313				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		368	6,961	5,430		1,088	76
76.10	PARTIAL HOSPITALIZATION	1	746	981	7,927			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	572	3,661	3,341		2,016	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		38	97				90.05
91	Emergency	40	1,832	24,671	5,082		5,645	91
91.01	GOLDEN LIFE			559	3,549			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)	1,117	23,333	287,617	153,304	20,278	26,950	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			3,813	106			194
194.10	AUSTIN PRIDE			124	1,984		182	194.10

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	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,117	23,333	291,554	155,394	20,278	27,132	202

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	66,702						10
11	Cafeteria		24,540					11
12	Maintenance of Personnel							12
13	Nursing Administration		1,415	27,759				13
14	Central Services & Supply		491		92,747			14
15	Pharmacy					197,955		15
16	Medical Records & Library		997				38,079	16
17	Social Service		2					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		199					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	43,968	5,496	16,062		6,789	13,287	30
31	Intensive Care Unit	3,731	1,398	2,515		2,040	1,820	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,003	439	737		4,013	432	50
53	Anesthesiology						55	53
54	Radiology-Diagnostic		873			55	1,149	54
57	CT Scan		163				1,505	57
60	Laboratory		1,251				5,441	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		854			10	2,068	65
66	Physical Therapy		409			50	507	66
69	Electrocardiology		268				965	69
70	Electroencephalography		37				45	70
71	Medical Supplies Charged to Patients				92,747		1,573	71
73	Drugs Charged to Patients		679			160,786	4,164	73
74	Renal Dialysis						75	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		1,089	1,631		6,926	519	76
76.10	PARTIAL HOSPITALIZATION		4,591	323			1,028	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		629	1,184		15,527	667	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				37	90.05
91	Emergency		2,810	4,572		1,759	2,742	91
91.01	GOLDEN LIFE		56	77				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)	66,702	24,160	27,101	92,747	197,955	38,079	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		380	658				194
194.10	AUSTIN PRIDE							194.10

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	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	66,702	24,540	27,759	92,747	197,955	38,079	202

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	3,828						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		2,526					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,625		440,223		440,223		30
31	Intensive Care Unit			89,118		89,118		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			115,267		115,267		50
53	Anesthesiology			3,200		3,200		53
54	Radiology-Diagnostic			91,726		91,726		54
57	CT Scan			5,301		5,301		57
60	Laboratory			102,526		102,526		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			37,705		37,705		65
66	Physical Therapy			43,114		43,114		66
69	Electrocardiology			8,590		8,590		69
70	Electroencephalography			3,572		3,572		70
71	Medical Supplies Charged to Patients			100,248		100,248		71
73	Drugs Charged to Patients			175,002		175,002		73
74	Renal Dialysis			447		447		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			53,040		53,040		76
76.10	PARTIAL HOSPITALIZATION			57,253		57,253		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	87		45,685		45,685		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			196		196		90.05
91	Emergency	116		77,828		77,828		91
91.01	GOLDEN LIFE			22,849		22,849		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)	3,828		1,472,890		1,472,890		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			5,786		5,786		194
194.10	AUSTIN PRIDE			12,752		12,752		194.10

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		
200	Cross Foot Adjustments		2,526	2,526		2,526		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,828	2,526	1,493,954		1,493,954		202

	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

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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	593,112	650,693	3,062,888	429,972	203,444	664,637	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.303472	3.624183	0.110242	2,057.282297	0.004754	0.010864	203
204	Cost to be allocated (Per Wkst. B, Part II)			14,502	7,470	1,117	23,333	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000522	35.741627	0.000026	0.000381	205

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	-10,833,161	36,133,271					5.06
6	Maintenance & Repairs							6
7	Operation of Plant		3,154,063	117,484				7
8	Laundry & Linen Service		182,414	2,273	251,345			8
9	Housekeeping		1,066,775	2,203		34,176		9
10	Dietary		1,526,662	6,491		305	75,996	10
11	Cafeteria		273,428	2,523		1,777		11
12	Maintenance of Personnel							12
13	Nursing Administration		2,020,680	1,082				13
14	Central Services & Supply		383,125	10,682		914		14
15	Pharmacy		1,241,845	1,495		406		15
16	Medical Records & Library		1,043,658	3,380		305		16
17	Social Service		18,451	400		152		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		184,491	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		10,039,787	27,219	164,072	8,836	50,094	30
31	Intensive Care Unit		1,858,445	6,708	11,958	1,625	4,251	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		834,024	9,008	75,315	2,590	21,651	50
53	Anesthesiology		7,047	364				53
54	Radiology-Diagnostic		1,781,421	8,765		1,777		54
57	CT Scan		330,759					57
60	Laboratory		1,989,536	6,624		1,777		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		862,438	2,062		914		65
66	Physical Therapy		462,769	4,419		1,549		66
69	Electrocardiology		247,601	576				69
70	Electroencephalography		20,874	391				70
71	Medical Supplies Charged to Patients		601,753					71
73	Drugs Charged to Patients		897,543					73
74	Renal Dialysis		38,805					74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		862,704	4,105		1,371		76
76.10	PARTIAL HOSPITALIZATION		121,625	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		453,729	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		12,077					90.05
91	Emergency		3,057,523	3,842		7,110		91
91.01	GOLDEN LIFE		69,306	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)	-10,833,161	35,645,358	115,904	251,345	33,947	75,996	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		472,602	80				194

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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	
194.10	AUSTIN PRIDE		15,311	1,500		229		194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		10,833,161	4,099,686	316,422	1,463,481	2,223,941	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.299811	34.895696	1.258915	42.821893	29.263922	203
204	Cost to be allocated (Per Wkst. B, Part II)		291,554	155,394	20,278	27,132	66,702	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.008069	1.322682	0.080678	0.793890	0.877704	205

	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

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	
194.10	AUSTIN PRIDE							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	519,542	2,694,218	920,290	1,683,719	1,508,666	44,482	202
203	Unit Cost Multiplier (Wkst. B, Part I)	16.106833	116.055051	9,202.900000	1.741106	0.017515	3.251608	203
204	Cost to be allocated (Per Wkst. B, Part II)	24,540	27,759	92,747	197,955	38,079	3,828	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.760789	1.195736	927.470000	0.204702	0.000442	0.279825	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							

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

	COST CENTER DESCRIPTIONS	I/R-SALARY AND FRINGES (ASSIGNED TIME)						
		21						
194	PUBLIC RELATIONS							194
194.10	AUSTIN PRIDE							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	247,148						202
203	Unit Cost Multiplier (Wkst. B, Part I)	24.714800						203
204	Cost to be allocated (Per Wkst. B, Part II)	2,526						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.252600						205

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POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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 Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	18,352,102		18,352,102		18,352,102	30
31	Intensive Care Unit	3,221,882		3,221,882		3,221,882	31
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,369,778		2,369,778		2,369,778	50
53	Anesthesiology	24,030		24,030		24,030	53
54	Radiology-Diagnostic	2,761,928		2,761,928		2,761,928	54
57	CT Scan	493,015		493,015		493,015	57
60	Laboratory	3,135,387		3,135,387		3,135,387	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,332,198		1,332,198		1,332,198	65
66	Physical Therapy	851,211		851,211		851,211	66
69	Electrocardiology	385,828		385,828		385,828	69
70	Electroencephalography	43,357		43,357		43,357	70
71	Medical Supplies Charged to Patients	1,764,772		1,764,772		1,764,772	71
73	Drugs Charged to Patients	2,713,567		2,713,567		2,713,567	73
74	Renal Dialysis	53,421		53,421		53,421	74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	1,584,160		1,584,160		1,584,160	76
76.10	PARTIAL HOSPITALIZATION	536,483		536,483		536,483	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	1,074,360		1,074,360		1,074,360	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	17,454		17,454		17,454	90.05
91	Emergency	5,041,002		5,041,002		5,041,002	91
91.01	GOLDEN LIFE	192,330		192,330		192,330	91.01
92	Observation Beds (Non-Distinct Part)	479,923		479,923		479,923	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 (sum of lines 30 thru 199)	46,428,188		46,428,188		46,428,188	200
201	Less Observation Beds	479,923		479,923		479,923	201
202	Total (line 200 minus line 201)	45,948,265		45,948,265		45,948,265	202

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 SERVICE COST CENTERS							
30	Adults & Pediatrics	21,561,000		21,561,000				30
31	Intensive Care Unit	4,017,600		4,017,600				31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	553,990	638,301	1,192,291	1.987584	1.987584	1.987584	50
53	Anesthesiology	16,264	49,696	65,960	0.364312	0.364312	0.364312	53
54	Radiology-Diagnostic	664,972	854,094	1,519,066	1.818175	1.818175	1.818175	54
57	CT Scan	731,869	1,467,649	2,199,518	0.224147	0.224147	0.224147	57
60	Laboratory	5,357,858	3,796,003	9,153,861	0.342521	0.342521	0.342521	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,428,442	979,437	2,407,879	0.553266	0.553266	0.553266	65
66	Physical Therapy	390,500	561,825	952,325	0.893824	0.893824	0.893824	66
69	Electrocardiology	673,850	318,672	992,522	0.388735	0.388735	0.388735	69
70	Electroencephalography	63,218	10,260	73,478	0.590068	0.590068	0.590068	70
71	Medical Supplies Charged to Patients	1,105,293	1,148,276	2,253,569	0.783101	0.783101	0.783101	71
73	Drugs Charged to Patients	3,448,010	803,014	4,251,024	0.638333	0.638333	0.638333	73
74	Renal Dialysis	153,117		153,117	0.348890	0.348890	0.348890	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		203,268	203,268	7.793455	7.793455	7.793455	76
76.10	PARTIAL HOSPITALIZATION	550	2,596,000	2,596,550	0.206614	0.206614	0.206614	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	73,718	344,175	417,893	2.570897	2.570897	2.570897	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	1,495		1,495	11.674916	11.674916	11.674916	90.05
91	Emergency	1,641,343	3,669,906	5,311,249	0.949118	0.949118	0.949118	91
91.01	GOLDEN LIFE							91.01
92	Observation Beds (Non-Distinct Part)	2,138	168,975	171,113	2.804714	2.804714	2.804714	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 (sum of lines 30 thru 199)	41,885,227	17,609,551	59,494,778				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	41,885,227	17,609,551	59,494,778				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes: **[ ] Title V** **[XX] PPS** **[XX] Title XVIII, Part A** **[ ] TEFRA** **[ ] Title XIX**

		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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	440,223		440,223	22,638	19.45	5,088	98,962	30
31	Intensive Care Unit	89,118		89,118	2,231	39.95	761	30,402	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)	529,341		529,341	24,869		5,849	129,364	200

(A) Worksheet A line numbers

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	115,267	1,192,291	0.096677	205,386	19,856	50
53	Anesthesiology	3,200	65,960	0.048514			53
54	Radiology-Diagnostic	91,726	1,519,066	0.060383	265,692	16,043	54
57	CT Scan	5,301	2,199,518	0.002410	246,935	595	57
60	Laboratory	102,526	9,153,861	0.011200	1,485,483	16,637	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	37,705	2,407,879	0.015659	351,965	5,511	65
66	Physical Therapy	43,114	952,325	0.045272	142,112	6,434	66
69	Electrocardiology	8,590	992,522	0.008655	211,513	1,831	69
70	Electroencephalography	3,572	73,478	0.048613	24,560	1,194	70
71	Medical Supplies Charged to Pat	100,248	2,253,569	0.044484	427,934	19,036	71
73	Drugs Charged to Patients	175,002	4,251,024	0.041167	996,438	41,020	73
74	Renal Dialysis	447	153,117	0.002919			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	53,040	203,268	0.260936			76
76.10	PARTIAL HOSPITALIZATION	57,253	2,596,550	0.022050			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	45,685	417,893	0.109322			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	196	1,495	0.131104			90.05
91	Emergency	77,828	5,311,249	0.014653	374,762	5,491	91
91.01	GOLDEN LIFE	22,849					91.01
92	Observation Beds (Non-Distinct	11,512	171,113	0.067277			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	955,061	33,916,178		4,732,780	133,648	200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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** **[ ] Other**

		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 SERVICE 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

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** **[ ] Other**

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	22,638		5,088		30
31	Intensive Care Unit	2,231		761		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)	24,869		5,849		200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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/IID** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient 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 Pat							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							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

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/IID** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

		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	1,192,291			205,386		218,912		50
53	Anesthesiology	65,960							53
54	Radiology-Diagnostic	1,519,066			265,692		207,697		54
57	CT Scan	2,199,518			246,935		208,355		57
60	Laboratory	9,153,861			1,485,483		231,161		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,407,879			351,965		54,004		65
66	Physical Therapy	952,325			142,112				66
69	Electrocardiology	992,522			211,513		73,775		69
70	Electroencephalography	73,478			24,560		6,048		70
71	Medical Supplies Charged to Pat	2,253,569			427,934		198,548		71
73	Drugs Charged to Patients	4,251,024			996,438		141,362		73
74	Renal Dialysis	153,117							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	203,268					51,639		76
76.10	PARTIAL HOSPITALIZATION	2,596,550							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	417,893					37,721		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	1,495							90.05
91	Emergency	5,311,249			374,762		293,799		91
91.01	GOLDEN LIFE								91.01
92	Observation Beds (Non-Distinct	171,113							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	33,916,178			4,732,780		1,723,021		200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF** **[XX] Title XVIII, Part B** **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF** **[ ] Title XIX - O/P** **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			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	1.987584	218,912			435,106			50
53	Anesthesiology	0.364312							53
54	Radiology-Diagnostic	1.818175	207,697			377,629			54
57	CT Scan	0.224147	208,355			46,702			57
60	Laboratory	0.342521	231,161			79,177			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.553266	54,004			29,879			65
66	Physical Therapy	0.893824							66
69	Electrocardiology	0.388735	73,775			28,679			69
70	Electroencephalography	0.590068	6,048			3,569			70
71	Medical Supplies Charged to Pat	0.783101	198,548			155,483			71
73	Drugs Charged to Patients	0.638333	141,362		1,175	90,236		750	73
74	Renal Dialysis	0.348890							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	7.793455	51,639			402,446			76
76.10	PARTIAL HOSPITALIZATION	0.206614							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	2.570897	37,721	6		96,977	15		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	11.674916							90.05
91	Emergency	0.949118	293,799			278,850			91
91.01	GOLDEN LIFE								91.01
92	Observation Beds (Non-Distinct	2.804714							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		1,723,021	6	1,175	2,024,733	15	750	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		1,723,021	6	1,175	2,024,733	15	750	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	440,223		440,223	22,638	19.45	8,982	174,700	30
31	Intensive Care Unit	89,118		89,118	2,231	39.95	1,240	49,538	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)	529,341		529,341	24,869		10,222	224,238	200

(A) Worksheet A line numbers

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**

		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	115,267	1,192,291	0.096677			50
53	Anesthesiology	3,200	65,960	0.048514			53
54	Radiology-Diagnostic	91,726	1,519,066	0.060383			54
57	CT Scan	5,301	2,199,518	0.002410			57
60	Laboratory	102,526	9,153,861	0.011200			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	37,705	2,407,879	0.015659			65
66	Physical Therapy	43,114	952,325	0.045272			66
69	Electrocardiology	8,590	992,522	0.008655			69
70	Electroencephalography	3,572	73,478	0.048613			70
71	Medical Supplies Charged to Pat	100,248	2,253,569	0.044484			71
73	Drugs Charged to Patients	175,002	4,251,024	0.041167			73
74	Renal Dialysis	447	153,117	0.002919			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	53,040	203,268	0.260936			76
76.10	PARTIAL HOSPITALIZATION	57,253	2,596,550	0.022050			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	45,685	417,893	0.109322			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	196	1,495	0.131104			90.05
91	Emergency	77,828	5,311,249	0.014653			91
91.01	GOLDEN LIFE	22,849					91.01
92	Observation Beds (Non-Distinct	11,512	171,113	0.067277			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	955,061	33,916,178				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		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 SERVICE 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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	22,638		8,982		30
31	Intensive Care Unit	2,231		1,240		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)	24,869		10,222		200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient 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 Pat							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							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		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	1,192,291							50
53	Anesthesiology	65,960							53
54	Radiology-Diagnostic	1,519,066							54
57	CT Scan	2,199,518							57
60	Laboratory	9,153,861							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,407,879							65
66	Physical Therapy	952,325							66
69	Electrocardiology	992,522							69
70	Electroencephalography	73,478							70
71	Medical Supplies Charged to Pat	2,253,569							71
73	Drugs Charged to Patients	4,251,024							73
74	Renal Dialysis	153,117							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	203,268							76
76.10	PARTIAL HOSPITALIZATION	2,596,550							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	417,893							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	1,495							90.05
91	Emergency	5,311,249							91
91.01	GOLDEN LIFE								91.01
92	Observation Beds (Non-Distinct	171,113							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	33,916,178							200

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V - O/P [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF
[ ] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF
[XX] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/IID

			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	1.987584							50
53	Anesthesiology	0.364312							53
54	Radiology-Diagnostic	1.818175							54
57	CT Scan	0.224147							57
60	Laboratory	0.342521							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.553266							65
66	Physical Therapy	0.893824							66
69	Electrocardiology	0.388735							69
70	Electroencephalography	0.590068							70
71	Medical Supplies Charged to Pat	0.783101							71
73	Drugs Charged to Patients	0.638333							73
74	Renal Dialysis	0.348890							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	7.793455							76
76.10	PARTIAL HOSPITALIZATION	0.206614							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	2.570897							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	11.674916							90.05
91	Emergency	0.949118							91
91.01	GOLDEN LIFE								91.01
92	Observation Beds (Non-Distinct	2.804714							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

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] 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)	22,638	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,638	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)	22,046	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,088	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 XIX only)		15
16	Nursery days (title V or 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)	18,352,102	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 (line 21 minus line 26)	18,352,102	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 minus line 36)	18,352,102	37

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)					810.68	38
39	Program general inpatient routine service cost (line 9 x line 38)					4,124,740	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)					4,124,740	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	3,221,882	2,231	1,444.14	761	1,098,991	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 (Wkst. D-3, col. 3, line 200)	3,200,792	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	8,424,523	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	129,364	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	133,648	51
52	Total Program excludable cost (sum of lines 50 and 51)	263,012	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	8,161,511	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 etner 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

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** **[ ] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					592	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					810.68	88
89	Observation bed cost (line 87 x line 88) (see instructions)					479,923	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	440,223	18,352,102	0.023988	479,923	11,512	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

Check Applicable Boxes:

[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[ ] PPS
[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
[XX] Title XIX - I/P	[ ] IRF	[ ] NF		[XX] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	22,638	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,638	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)	22,046	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,982	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 XIX only)		15
16	Nursery days (title V or 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)	18,352,102	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 (line 21 minus line 26)	18,352,102	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 minus line 36)	18,352,102	37

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [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)					810.68	38
39	Program general inpatient routine service cost (line 9 x line 38)					7,281,528	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)					7,281,528	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	3,221,882	2,231	1,444.14	1,240	1,790,734	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 (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					9,072,262	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					224,238	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					224,238	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 etner 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

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/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					592	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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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

Check Applicable Boxes:
[ ] Title V **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF** **[XX] PPS**
[XX] Title XVIII, Part A **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF** **[ ] TEFRA**
[ ] Title XIX **[ ] IRF** **[ ] NF** **[ ] ICF/IID** **[ ] 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		4,903,675		30
31	Intensive Care Unit		1,369,800		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	1.987584	205,386	408,222	50
53	Anesthesiology	0.364312			53
54	Radiology-Diagnostic	1.818175	265,692	483,075	54
57	CT Scan	0.224147	246,935	55,350	57
60	Laboratory	0.342521	1,485,483	508,809	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.553266	351,965	194,730	65
66	Physical Therapy	0.893824	142,112	127,023	66
69	Electrocardiology	0.388735	211,513	82,223	69
70	Electroencephalography	0.590068	24,560	14,492	70
71	Medical Supplies Charged to Patients	0.783101	427,934	335,116	71
73	Drugs Charged to Patients	0.638333	996,438	636,059	73
74	Renal Dialysis	0.348890			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	7.793455			76
76.10	PARTIAL HOSPITALIZATION	0.206614			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	2.570897			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	11.674916			90.05
91	Emergency	0.949118	374,762	355,693	91
91.01	GOLDEN LIFE				91.01
92	Observation Beds (Non-Distinct Part)	2.804714			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,732,780	3,200,792	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,732,780		202

(A) Worksheet A line numbers

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	1.987584			50
53	Anesthesiology	0.364312			53
54	Radiology-Diagnostic	1.818175			54
57	CT Scan	0.224147			57
60	Laboratory	0.342521			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.553266			65
66	Physical Therapy	0.893824			66
69	Electrocardiology	0.388735			69
70	Electroencephalography	0.590068			70
71	Medical Supplies Charged to Patients	0.783101			71
73	Drugs Charged to Patients	0.638333			73
74	Renal Dialysis	0.348890			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	7.793455			76
76.10	PARTIAL HOSPITALIZATION	0.206614			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	2.570897			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	11.674916			90.05
91	Emergency	0.949118			91
91.01	GOLDEN LIFE				91.01
92	Observation Beds (Non-Distinct Part)	2.804714			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

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E**
PART A

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 (see instructions)	1,451,732			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,355,196			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	64,385			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	492,664			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	158.38			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) 64 FR 26340 (May 12, 1998), and 67 FR 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 line 8 plus lines (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 podiatric programs	3.00			11
12	Current year allowable FTE (see instructions)	3.00			12
13	Total allowable FTE count for the prior year	2.50			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	2.83			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	2.83			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.017868			19
20	Prior year resident to bed ratio (see instructions)	0.015785			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.015785			21
22	IME payment adjustment (see instructions)	54,113			22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	54,113			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.2788			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.6228			31
32	Sum of lines 30 and 31	0.9016			32
33	Allowable disproportionate share percentage (see instructions)	0.6350			33
34	Disproportionate share adjustment (see instructions)	921,850			34
		Prior to	**On or after**		
	Uncompensated Care Adjustment	**October 1**	**October 1**		
35	Total uncompensated care amount (see instructions)	9,046,380,143			35
35.01	Factor 3 (see instructions)	0.000559598			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	5,062,336	2,999,140		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,275,987	2,243,192		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,519,179			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
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)	10,366,455			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 (see instructions)	10,366,455			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	567,215			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	46,103			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 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	10,979,773			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	10,979,773			61
62	Deductibles billed to program beneficiaries	606,956			62
63	Coinsurance billed to program beneficiaries	105,457			63
64	Allowable bad debts (see instructions)	416,219			64
65	Adjusted reimbursable bad debts (see instructions)	270,542			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	416,219			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,537,902			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJUSTMENTS)				70
70.93	HVBP payment adjustment amount (see instructions)	-3,533			70.93
70.94	HRR adjustment amount (see instructions)	-13,688			70.94
70.99	HAC adjustment amount (see instructions)	77,916			70.99
71	Amount due provider (see instructions)	10,442,765			71
71.01	Sequestration adjustment (see instructions)	208,855			71.01
72	Interim payments	8,804,238			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	1,429,672			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	64,422			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,451,732	1,451,732				1,451,732	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	4,355,196			4,355,196		4,355,196	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	64,385	16,052		48,333		64,385	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	492,664	122,829		369,835		492,664	4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21	0.015785	0.015785		0.015785			5
6	IME payment adjustment	54,113	13,525		40,588		54,113	6
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)	54,113	13,525		40,588		54,113	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.6350	0.6350	0.6350	0.6350	0.6350		10
11	Disproportionate share adjustment	921,850	230,463		691,387		921,850	11
11.01	Uncompensated care payments	3,519,179	1,275,987		2,243,192		3,519,179	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	10,366,455	2,987,759		7,378,696		10,366,455	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only	10,366,455	2,987,759		7,378,696		10,366,455	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	567,215	141,414		425,801		567,215	16
17	Special add-on payments for new technologies							17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	**SUBTOTAL**		3,129,173		7,804,497		10,933,670	19
20	Capital DRG other than outlier	464,204	115,733		348,471		464,204	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	4,414	1,100		3,314		4,414	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage	1.2100	1.2100		1.2100			22
23	Indirect medical education adjustment	5,617	1,400		4,217		5,617	23
24	Allowable disproportionate share percentage	0.2003	0.2003		0.2003			24
25	Disproportionate share adjustment	92,980	23,181		69,799		92,980	25
26	Total prospective capital payments	567,215	141,414		425,801		567,215	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1							29
30	HVBP payment adjustment	-3,533	-881		-2,652		-3,533	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-13,688	-3,413		-10,275		-13,688	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				77,916		77,916	32

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)	765			1
2	Medical and other services reimbursed under OPPS (see instructions)	2,024,733			2
3	PPS payments	751,756			3
4	Outlier payment (see instructions)				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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	765			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,181			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	1,181			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)	1,181			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	416			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)	765			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	751,756			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	180,342			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	572,179			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	11,084			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	583,263			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	583,263			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)	24,211			34
35	Adjusted reimbursable bad debts (see instructions)	15,737			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	24,211			36
37	Subtotal (see instructions)	599,000			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	599,000			40
40.01	Sequestration adjustment (see instructions)	11,980			40.01
41	Interim payments	677,437			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-90,417			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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

Check Applicable Boxes: **[XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] 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				8,923,142		717,627	1
2	Interim payments payable on individual bills, eitehr 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					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	02/27/2015	118,904	02/27/2015	40,190	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		-118,904		-40,190	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)				8,804,238		677,437	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		1,429,672			6.01
	based on the cost report (1)		.02				-90,417	6.02
7	Total Medicare program liability (see instructions)				10,233,910		587,020	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.

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 (Wkst. S-3, Pt. I, col. 15, line 14)	4,890	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	5,849	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	526	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	24,277	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	59,494,778	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,133,007	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	561,458	8
9	Sequestration adjustment amount (see instructions)	11,229	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	550,229	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	550,229	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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/IID**	**[ ] 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	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	9,072,262		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	9,072,262		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	9,072,262		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 cahrge 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)	1.000000	1.000000	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)	9,072,262		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	9,072,262		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 Wkst. 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 line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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) (see instructions)				2
3	Amount of reduction to Direct GME cap under §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 §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §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 teh 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 through 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	92,880.00	94,570.00		18
19	Approved amount for resident costs		220,348	220,348	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct 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)			220,348	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	5,849	526		26
27	Total inpatient days (see instructions)	24,277	24,277		27
28	Ratio of inpatient days to total inpatient days	0.240928	0.021667		28
29	Program direct GME amount	53,088	4,774		29
30	Reduction for direct GME payments for Medicare Advantage		675		30
31	Net Program direct GME amount			57,187	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 Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			153,117	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)			8,424,523	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			8,424,523	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			2,025,498	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			2,025,498	44
45	Total reasonable cost (sum of lines 41 and 44)			10,450,021	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.806173	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.193827	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			57,187	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			46,103	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			11,084	50

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) (see instructions)				2
3	Amount of reduction to Direct GME cap under §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 §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §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 teh 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 through 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 §413.79(c)(4)				20
21	Direct 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 (see instructions)	10,222	4,897		26
27	Total inpatient days (see instructions)	24,277	24,277		27
28	Ratio of inpatient days to total inpatient days	0.421057	0.201714		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				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 Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 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 (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 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
	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

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	273,935				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	2,293,981				4
5	Other receivables	1,280,000				5
6	Allowances for uncollectible notes and accounts receivable	-5,830,238				6
7	Inventory	426,275				7
8	Prepaid expenses	999,896				8
9	Other current assets	2,298,128				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	1,741,977				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 depreciation					18
19	Fixed equipment	24,993,620				19
20	Accumulated depreciation					20
21	Audomobiles 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)	30,823,858				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,286,567				34
35	Total other assets (sum of lines 31-34)	8,286,567				35
36	Total assets (sum of lines 11, 30 and 35)	40,852,402				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	2,956,777				37
38	Salaries, wages and fees payable	1,373,840				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	302,578				43
44	Other current liabilities	3,087,108				44
45	Total current liabilities (sum of lines 37 thru 44)	7,720,303				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	714,140				47
48	Unsecured loans					48
49	Other long term liabilities	2,288,961				49
50	Total long term liabilities (sum of lines 46 thru 49)	3,003,101				50
51	Total liabilities (sum of lines 45 and 50)	10,723,404				51
	CAPITAL ACCOUNTS					
52	General fund balance	30,128,998				52
53	Specific purpose fund					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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	30,128,998				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	40,852,402				60

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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		30,083,427			1
2	Net income (loss) (from Worksheet G-3, line 29)		45,571			2
3	Total (sum of line 1 and line 2)		30,128,998			3
4	Additions (credit adjustments) (specify)					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)		30,128,998			11
12	Deductions (debit adjustments) (specify)					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)		30,128,998			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 (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					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) (specify)					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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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	25,664,573		25,664,573	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)	25,664,573		25,664,573	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)	29,817,173		29,817,173	17
18	Ancillary services	13,647,582	16,409,406	30,056,988	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (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)	43,464,755	16,409,406	59,874,161	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		56,202,534	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)		58,225,073	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	59,874,161	1
2	Less contractual allowances and discounts on patients' accounts	9,371,130	2
3	Net patient revenues (line 1 minus line 2)	50,503,031	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	58,225,073	4
5	Net income from service to patients (line 3 minus line 4)	-7,722,042	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 otehr 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, flowers, coffee shops and canteen		20
21	Rental of vending machines	3,986	21
22	Rental of hosptial space	6,049	22
23	Governmental appropriations		23
24	Other (OTHER INCOME)	7,685,880	24
24.01	Other (OTHER MISC)		24.01
25	Total other income (sum of lines 6-24)	7,767,613	25
26	Total (line 5 plus line 25)	45,571	26
29	Net income (or loss) for the period (line 26 minus line 28)	45,571	29

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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	464,204	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	4,414	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)	66.51	3
4	Number of interns & residents (see instructions)	2.83	4
5	Indirect medical education percentage (see instructions)	1.21	5
6	Indirect medical education adjustment (see instructions)	5,617	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2788	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.6228	8
9	Sum of lines 7 and 8	0.9016	9
10	Allowable disproportionate share percentage (see instructions)	0.2003	10
11	Disproportionate share adjustment (see instructions)	92,980	11
12	Total prospective capital payments (see instructions)	567,215	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

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 SERVICE 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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/30/2015 Run Time: 09:07 Version: 2015.10 (11/24/2015)

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		
194.10	AUSTIN PRIDE							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202