LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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: 11/25/2016 Time: 11:59 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 LORETTO HOSPITAL (14-0083) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		1,231,029	47,628	106,256		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		1,231,029	47,628	106,256		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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	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 / 2015	To: 06 / 30 / 2016	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.	4,572				2,888	9,000	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
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
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
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

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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.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118

		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1,318,900			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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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 transition factor. (see instructions)	0.50			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 / 2015	06 / 30 / 2016	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 Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	N			4
5	Are the cost report total expenses and total revenues different from those 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)	Y	11/08/2016	Y	11/08/2016	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)	N		N		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 services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: KENNETH	Last name: MCGHEE	Title: CHIEF FINANCIAL OFFICER	41
42	Employer: LORETTO HOSPITAL			42
43	Phone number: 773-854-5008	E-mail Address: KENNETH.MCGHEE@LORETTOHOSPITAL.ORG		43

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	144	52,704			4,830	13,279	23,165	1
2	HMO and other (see instructions)							2,888		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)		144	52,704			4,830	13,279	23,165	7
8	Intensive Care Unit	31	12	4,392			731	293	2,149	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)		156	57,096			5,561	13,572	25,314	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)		156							27
28	Observation Bed Days								466	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: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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)					807	1,989	4,245	1
2	HMO and other (see instructions)								2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	2.00	475.44			807	1,989	4,245	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	2.00	475.44						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: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	28,264,998		28,264,998	992,710.00	28.47	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	91,920		91,920	4,480.00	20.52	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)		326,181		326,181	8,170.00	39.92	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		344,916		344,916	8,259.50	41.76	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		5,290,269		5,290,269			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		61,967		61,967			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)		17,463		17,463			25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		323,069		323,069	8,621.00	37.47	26
27	Administrative & General		5,099,812		5,099,812	161,870.00	31.51	27
28	Administrative & General under contract (see instructions)		70,850		70,850	391.33	181.05	28
29	Maintenance & Repairs							29
30	Operation of Plant		1,267,489		1,267,489	38,693.00	32.76	30
31	Laundry & Linen Service		30,565		30,565	2,012.00	15.19	31
32	Housekeeping		646,931		646,931	49,154.00	13.16	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		833,347	-156,234	677,113	44,850.00	15.10	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			156,234	156,234	10,619.00	14.71	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,491,023		1,491,023	41,658.00	35.79	38
39	Central Services and Supply		190,081		190,081	12,104.00	15.70	39
40	Pharmacy		799,828		799,828	20,648.00	38.74	40
41	Medical Records & Medical Records Library		548,435		548,435	25,549.00	21.47	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		28,243,928		28,243,928	988,621.33	28.57	1
2	Excluded area salaries (see instructions)		326,181		326,181	8,170.00	39.92	2
3	Subtotal salarles (line 1 minus line 2)		27,917,747		27,917,747	980,451.33	28.47	3
4	Subtotal other wages & related costs (see instructions)		344,916		344,916	8,259.50	41.76	4
5	Subtotal wage-related costs (see instructions)		5,290,269		5,290,269		18.95%	5
6	Total (sum of lines 3 through 5)		33,552,932		33,552,932	988,710.83	33.94	6
7	Total overhead cost (see instructions)		11,301,430		11,301,430	416,169.33	27.16	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)	346,506	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)	1,715,549	8
9	Prescription Drug Plan	-5,690	9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	85,621	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	43,491	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	392,639	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	2,519,187	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	150,686	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	121,710	23
24	Total Wage Related cost (Sum of lines 1-23)	5,369,699	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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)	0.636762	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	8,708,279	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	11,651,108	6
7	Medicaid cost (line 1 times line 6)	7,418,983	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.		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)				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	2,147,643		2,147,643	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,367,537		1,367,537	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	1,367,537		1,367,537	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)	5,317,885	26
27	Medicare bad debts for the entire hospital complex (see instructions)	428,075	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,889,810	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,113,645	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	4,481,182	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,481,182	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		-2,353,510	-2,353,510	992,204	-1,361,306	3,677,421	2,316,115	1
2	00200	Cap Rel Costs-Mvble Equip				-884,797	-884,797	1,718,565	833,768	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	323,069	3,061,718	3,384,787		3,384,787		3,384,787	4
5.01	01160	COMMUNICATIONS	146,865	419,337	566,202		566,202	-17,558	548,644	5.01
5.04	00570	ADMITTING	162,917	19,638	182,555		182,555		182,555	5.04
5.05	00580	BUSINESS OFFICE	466,849	209,900	676,749		676,749		676,749	5.05
5.06	00590	OTHER ADMINISTRATIVE	4,323,181	12,399,831	16,723,012	-107,407	16,615,605	-6,622,106	9,993,499	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,267,489	2,125,723	3,393,212		3,393,212		3,393,212	7
8	00800	Laundry & Linen Service	30,565	146,614	177,179		177,179		177,179	8
9	00900	Housekeeping	646,931	482,123	1,129,054		1,129,054		1,129,054	9
10	01000	Dietary	833,347	1,248,332	2,081,679	-325,149	1,756,530		1,756,530	10
11	01100	Cafeteria				325,149	325,149	-134,421	190,728	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,491,023	491,006	1,982,029		1,982,029		1,982,029	13
14	01400	Central Services & Supply	190,081	374,628	564,709	-155,235	409,474		409,474	14
15	01500	Pharmacy	799,828	1,237,567	2,037,395	-935,921	1,101,474		1,101,474	15
16	01600	Medical Records & Library	548,435	404,162	952,597		952,597		952,597	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	91,920	12,057	103,977		103,977		103,977	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	8,221,293	1,184,013	9,405,306		9,405,306	-83,230	9,322,076	30
31	03100	Intensive Care Unit	1,421,320	470,754	1,892,074		1,892,074	-155,000	1,737,074	31
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	431,222	648,235	1,079,457	-418,884	660,573	-9,552	651,021	50
53	05300	Anesthesiology		499,458	499,458		499,458	-499,458		53
54	05400	Radiology-Diagnostic	819,752	978,816	1,798,568		1,798,568	-228,500	1,570,068	54
57	05700	CT Scan	203,838	170,607	374,445		374,445		374,445	57
60	06000	Laboratory	895,503	945,900	1,841,403		1,841,403		1,841,403	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	646,130	147,059	793,189	-47,635	745,554		745,554	65
66	06600	Physical Therapy	340,029	46,501	386,530		386,530		386,530	66
69	06900	Electrocardiology	164,001	38,788	202,789		202,789		202,789	69
70	07000	Electroencephalography	9,231	1,573	10,804		10,804		10,804	70
71	07100	Medical Supplies Charged to Patients				761,148	761,148		761,148	71
73	07300	Drugs Charged to Patients				935,921	935,921		935,921	73
74	07400	Renal Dialysis		91,877	91,877		91,877		91,877	74
75.01	07501	HYBERBARIC CHAMBER								75.01
76	03550	O/P MENTAL HEALTH	715,385	289,283	1,004,668		1,004,668	-214,019	790,649	76
76.10	03950	PARTIAL HOSPITALIZATION	35,723	3,708	39,431		39,431		39,431	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	308,195	305,228	613,423		613,423	-228,622	384,801	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								90.05
91	09100	Emergency	2,357,270	1,568,274	3,925,544	-139,394	3,786,150	-1,162,829	2,623,321	91
91.01	09101	GOLDEN LIFE	47,425	3,439	50,864		50,864		50,864	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								
118		SUBTOTALS (sum of lines 1-117)	27,938,817	27,672,639	55,611,456		55,611,456	-3,959,309	51,652,147	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PUBLIC RELATIONS	326,181	112,829	439,010		439,010		439,010	194
194.10	07951	AUSTIN PRIDE								194.10
200		TOTAL (sum of lines 118-199)	28,264,998	27,785,468	56,050,466		56,050,466	-3,959,309	52,091,157	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DRUGS SOLD	A	Drugs Charged to Patients	73		935,921	1
500	Total reclassifications					935,921	500
	Code Letter - A						
1	CAFETERIA RECLASS	B	Cafeteria	11	156,234	168,915	1
500	Total reclassifications				156,234	168,915	500
	Code Letter - B						
1	DEPR EXP	D	Cap Rel Costs-Bldg & Fixt	1		884,797	1
500	Total reclassifications					884,797	500
	Code Letter - D						
1	SUPPLIES CHARGED	E	Medical Supplies Charged to P	71		761,148	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					761,148	500
	Code Letter - E						
1	CAPITAL INSURANCE EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		107,407	1
500	Total reclassifications					107,407	500
	Code Letter - F						
	GRAND TOTAL (Increases)				156,234	2,858,188	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DRUGS SOLD	A	Pharmacy	15		935,921		1
500	Total reclassifications					935,921		500
	Code letter - A							
1	CAFETERIA RECLASS	B	Dietary	10	156,234	168,915		1
500	Total reclassifications				156,234	168,915		500
	Code letter - B							
1	DEPR EXP	D	Cap Rel Costs-Mvble Equip	2		884,797	9	1
500	Total reclassifications					884,797		500
	Code letter - D							
1	SUPPLIES CHARGED	E	Operating Room	50		418,884		1
2			Respiratory Therapy	65		47,635		2
3			Emergency	91		139,394		3
4								4
5								5
6								6
7								7
8			Central Services & Supply	14		155,235		8
500	Total reclassifications					761,148		500
	Code letter - E							
1	CAPITAL INSURANCE EXPENSE	F	OTHER ADMINISTRATIVE	5.06		107,407	12	1
500	Total reclassifications					107,407		500
	Code letter - F							
	GRAND TOTAL (Decreases)				156,234	2,858,188		

(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					224,058		2
3	Buildings and Fixtures	46,836,572	1,956,314		1,956,314		48,792,886		3
4	Building Improvements								4
5	Fixed Equipment	21,529,994	1,686,235		1,686,235		23,216,229		5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	69,019,652	3,642,549		3,642,549		72,662,201		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	69,019,652	3,642,549		3,642,549		72,662,201		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						-2,353,510	-2,353,510	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)						-2,353,510	-2,353,510	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	4,562,218			107,407		-2,353,510	2,316,115	1
2	Cap Rel Costs-Mvble Equip	833,768						833,768	2
3	Total (sum of lines 1-2)	5,395,986			107,407		-2,353,510	3,149,883	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	-2,728,734				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	-127,577	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	-6,844	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	-9,552	Operating Room	50		35
36							36
37	LOBBYING EXPENSES	A	-32,771	OTHER ADMINISTRATIVE	5.06		37
38	RENTAL INCOME	B	-18,964	Cap Rel Costs-Bldg & Fixt	1	9	38
39	MEDICAID TAX ASSESSMENT	A	-6,428,759	OTHER ADMINISTRATIVE	5.06		39
40							40
41	MISC INCOME	B	-3,500	Radiology-Diagnostic	54		41
42	MISC INCOME	B	-17,558	COMMUNICATIONS	5.01		42
43							43
44	DEPR ADJ HISTORICAL	A	3,698,667	Cap Rel Costs-Bldg & Fixt	1	9	44
45	DEPR ADJ HISTORICAL	A	1,718,565	Cap Rel Costs-Mvble Equip	2	9	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)		-3,959,309				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
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net 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	30	Adults & Pediatrics AGGREGATE	83,230	83,230						1
2	31	Intensive Care Unit AGGREGATE	155,000	155,000						2
3	53	Anesthesiology AGGREGATE	499,458	499,458						3
4	54	Radiology-Diagnostic AGGREGATE	225,000	225,000						4
5										5
6	76	O/P MENTAL HEALTH AGGREGATE	214,019	214,019						6
7	91	Emergency AGGREGATE	1,162,829	1,162,829						7
8	90	Clinic AGGREGATE	228,622	228,622						8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE	160,576	160,576						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	2,728,734	2,728,734						200

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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	30	Adults & Pediatrics AGGREGATE							83,230	1
2	31	Intensive Care Unit AGGREGATE							155,000	2
3	53	Anesthesiology AGGREGATE							499,458	3
4	54	Radiology-Diagnostic AGGREGATE							225,000	4
5										5
6	76	O/P MENTAL HEALTH AGGREGATE							214,019	6
7	91	Emergency AGGREGATE							1,162,829	7
8	90	Clinic AGGREGATE							228,622	8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE							160,576	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							2,728,734	200

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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	COMMUNI CATIONS	ADMITTING	
		0	1	2	4	5.01	5.04	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,316,115	2,316,115					1
2	Cap Rel Costs-Mvble Equip	833,768		833,768				2
4	Employee Benefits Department	3,384,787	14,278	5,140	3,404,205			4
5.01	COMMUNICATIONS	548,644	13,850	4,986	16,597	584,077		5.01
5.04	ADMITTING	182,555	1,790	644	21,205	5,589	211,783	5.04
5.05	BUSINESS OFFICE	676,749	38,217	13,758	46,357	8,384		5.05
5.06	OTHER ADMINISTRATIVE	9,993,499	491,714	177,012	548,337	164,884		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	3,393,212	240,067	86,421	116,959	8,384		7
8	Laundry & Linen Service	177,179	29,477	10,611	4,079	2,795		8
9	Housekeeping	1,129,054	28,569	10,284	73,258	2,795		9
10	Dietary	1,756,530	75,799	27,287	95,736	13,973		10
11	Cafeteria	190,728	32,719	11,778		8,384		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,982,029	8,624	3,104	177,520	27,946		13
14	Central Services & Supply	409,474	138,526	49,867	20,655	8,384		14
15	Pharmacy	1,101,474	15,717	5,658	81,936	5,589		15
16	Medical Records & Library	952,597	39,151	14,094	66,213	19,562		16
17	Social Service				1,422	19,562		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	103,977	1,167	420	22,550			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,322,076	354,005	127,437	933,285	41,919	98,457	30
31	Intensive Care Unit	1,737,074	82,659	29,756	201,274	13,973	19,634	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	651,021	116,817	42,053	63,715	53,098	3,442	50
53	Anesthesiology		4,720	1,699		2,795	365	53
54	Radiology-Diagnostic	1,570,068	113,666	40,918	101,175	22,357	4,672	54
57	CT Scan	374,445			18,101		4,737	57
60	Laboratory	1,841,403	85,901	30,923	105,600	16,768	28,983	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	745,554	26,740	9,626	88,913	5,589	7,751	65
66	Physical Therapy	386,530	41,044	14,775	42,099	19,562	1,672	66
69	Electrocardiology	202,789	7,470	2,689	21,842	8,384	3,844	69
70	Electroencephalography	10,804	5,071	1,825	4,397	2,795	446	70
71	Medical Supplies Charged to Patients	761,148					7,084	71
73	Drugs Charged to Patients	935,921					22,144	73
74	Renal Dialysis	91,877					710	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	790,649	46,504	16,741	79,754	19,562		76
76.10	PARTIAL HOSPITALIZATION	39,431	77,718	27,977	15,802	5,589	138	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	384,801	32,758	11,792	58,582	19,562	139	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE				2,387			90.05
91	Emergency	2,623,321	115,546	41,595	313,329	47,509	7,565	91
91.01	GOLDEN LIFE	50,864	34,794	12,525	5,009			91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	51,652,147	2,315,078	833,395	3,348,088	575,693	211,783	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	439,010	1,037	373	56,117	2,795		194
194.10	AUSTIN PRIDE					5,589		194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	52,091,157	2,316,115	833,768	3,404,205	584,077	211,783	202

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	783,465						5.05
5.06	OTHER ADMINISTRATIVE		11,375,446	11,375,446				5.06
6	Maintenance & Repairs							6
7	Operation of Plant		3,845,043	1,074,255	4,919,298			7
8	Laundry & Linen Service		224,141	62,622	95,637	382,400		8
9	Housekeeping		1,243,960	347,546	92,692		1,684,198	9
10	Dietary		1,969,325	550,204	245,929		15,132	10
11	Cafeteria		243,609	68,061	106,156		88,162	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,199,223	614,434	27,980			13
14	Central Services & Supply		626,906	175,149	449,447		45,346	14
15	Pharmacy		1,210,374	338,163	50,995		20,143	15
16	Medical Records & Library		1,091,617	304,984	127,025		15,132	16
17	Social Service		20,984	5,863			7,541	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		128,114	35,793	3,787			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	255,985	11,133,164	3,110,469	1,148,565	249,622	438,375	30
31	Intensive Care Unit	50,804	2,135,174	596,540	268,187	18,193	80,620	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,563	946,709	264,498	379,013	114,585	128,497	50
53	Anesthesiology	1,610	11,189	3,126	15,315			53
54	Radiology-Diagnostic	27,172	1,880,028	525,255	368,789		88,162	54
57	CT Scan	28,984	426,267	119,093				57
60	Laboratory	120,723	2,230,301	623,117	278,706		88,162	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	33,841	918,014	256,481	86,759		45,346	65
66	Physical Therapy	9,675	515,357	143,984	133,168		76,850	66
69	Electrocardiology	12,960	259,978	72,634	24,235			69
70	Electroencephalography	1,305	26,643	7,444	16,451			70
71	Medical Supplies Charged to Patients	34,785	803,017	224,353				71
73	Drugs Charged to Patients	67,742	1,025,807	286,597				73
74	Renal Dialysis	1,837	94,424	26,381				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	12,357	965,567	269,767	150,881		68,019	76
76.10	PARTIAL HOSPITALIZATION	25,059	191,714	53,562	252,156			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	19,219	526,853	147,196	106,282		125,966	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	1,276	3,663	1,023				90.05
91	Emergency	61,568	3,210,433	896,953	374,889		352,745	91
91.01	GOLDEN LIFE		103,192	28,831	112,888			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)	783,465	51,586,236	11,234,378	4,915,932	382,400	1,684,198	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		499,332	139,507	3,366			194
194.10	AUSTIN PRIDE		5,589	1,561				194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	783,465	52,091,157	11,375,446	4,919,298	382,400	1,684,198	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	2,780,590						10
11	Cafeteria		505,988					11
12	Maintenance of Personnel							12
13	Nursing Administration		32,358	2,873,995				13
14	Central Services & Supply		9,407		1,306,255			14
15	Pharmacy					1,619,675		15
16	Medical Records & Library		16,041				1,554,799	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		3,487					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,040,461	227,791	1,789,272		25,492	542,312	30
31	Intensive Care Unit	236,055	27,865	218,881		9,851	74,341	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	504,074	7,623	59,880		12,911	17,651	50
53	Anesthesiology						2,234	53
54	Radiology-Diagnostic		17,209			576	46,908	54
57	CT Scan		4,947				61,469	57
60	Laboratory		25,935			37,900	222,225	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		17,014			121	84,451	65
66	Physical Therapy		8,872				20,701	66
69	Electrocardiology		4,542				39,392	69
70	Electroencephalography		292				1,847	70
71	Medical Supplies Charged to Patients				1,306,255		64,224	71
73	Drugs Charged to Patients					1,509,669	170,045	73
74	Renal Dialysis						3,074	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		25,205	197,987			21,206	76
76.10	PARTIAL HOSPITALIZATION		1,508	11,849			41,986	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		10,997	86,380		10,781	27,237	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						1,510	90.05
91	Emergency		57,418	451,013		12,374	111,986	91
91.01	GOLDEN LIFE		1,135	8,918				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)	2,780,590	499,646	2,824,180	1,306,255	1,619,675	1,554,799	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		6,342	49,815				194
194.10	AUSTIN PRIDE							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,780,590	505,988	2,873,995	1,306,255	1,619,675	1,554,799	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	34,388						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		171,181					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	32,558	171,181	20,909,262	-171,181	20,738,081		30
31	Intensive Care Unit			3,665,707		3,665,707		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			2,435,441		2,435,441		50
53	Anesthesiology			31,864		31,864		53
54	Radiology-Diagnostic			2,926,927		2,926,927		54
57	CT Scan			611,776		611,776		57
60	Laboratory			3,506,346		3,506,346		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			1,408,186		1,408,186		65
66	Physical Therapy			898,932		898,932		66
69	Electrocardiology			400,781		400,781		69
70	Electroencephalography			52,677		52,677		70
71	Medical Supplies Charged to Patients			2,397,849		2,397,849		71
73	Drugs Charged to Patients			2,992,118		2,992,118		73
74	Renal Dialysis			123,879		123,879		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			1,698,632		1,698,632		76
76.10	PARTIAL HOSPITALIZATION			552,775		552,775		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	784		1,042,476		1,042,476		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			6,196		6,196		90.05
91	Emergency	1,046		5,468,857		5,468,857		91
91.01	GOLDEN LIFE			254,964		254,964		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)	34,388	171,181	51,385,645	-171,181	51,214,464		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			698,362		698,362		194
194.10	AUSTIN PRIDE			7,150		7,150		194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	34,388	171,181	52,091,157	-171,181	51,919,976		202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	COMMUNI CATIONS	
		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	7,666	14,278	5,140	27,084	27,084		4
5.01	COMMUNICATIONS		13,850	4,986	18,836	132	18,968	5.01
5.04	ADMITTING		1,790	644	2,434	169	182	5.04
5.05	BUSINESS OFFICE	563	38,217	13,758	52,538	369	272	5.05
5.06	OTHER ADMINISTRATIVE	3,934	491,714	177,012	672,660	4,363	5,353	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	-250	240,067	86,421	326,238	931	272	7
8	Laundry & Linen Service		29,477	10,611	40,088	32	91	8
9	Housekeeping		28,569	10,284	38,853	583	91	9
10	Dietary		75,799	27,287	103,086	762	454	10
11	Cafeteria		32,719	11,778	44,497		272	11
12	Maintenance of Personnel							12
13	Nursing Administration		8,624	3,104	11,728	1,413	908	13
14	Central Services & Supply	484	138,526	49,867	188,877	164	272	14
15	Pharmacy	179,935	15,717	5,658	201,310	652	182	15
16	Medical Records & Library	-154	39,151	14,094	53,091	527	635	16
17	Social Service					11	635	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		1,167	420	1,587	179		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,844	354,005	127,437	501,286	7,421	1,361	30
31	Intensive Care Unit	1,107	82,659	29,756	113,522	1,602	454	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,468	116,817	42,053	162,338	507	1,724	50
53	Anesthesiology		4,720	1,699	6,419		91	53
54	Radiology-Diagnostic	32,147	113,666	40,918	186,731	805	726	54
57	CT Scan					144		57
60	Laboratory		85,901	30,923	116,824	840	545	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,553	26,740	9,626	37,919	708	182	65
66	Physical Therapy		41,044	14,775	55,819	335	635	66
69	Electrocardiology		7,470	2,689	10,159	174	272	69
70	Electroencephalography		5,071	1,825	6,896	35	91	70
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		46,504	16,741	63,245	635	635	76
76.10	PARTIAL HOSPITALIZATION		77,718	27,977	105,695	126	182	76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		32,758	11,792	44,550	466	635	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		90.05
91	Emergency		115,546	41,595	157,141	2,493	1,543	91
91.01	GOLDEN LIFE		34,794	12,525	47,319	40		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)	250,297	2,315,078	833,395	3,398,770	26,637	18,695	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	683	1,037	373	2,093	447	91	194
194.10	AUSTIN PRIDE						182	194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	250,980	2,316,115	833,768	3,400,863	27,084	18,968	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	2,785						5.04
5.05	BUSINESS OFFICE		53,179					5.05
5.06	OTHER ADMINISTRATIVE			682,376				5.06
6	Maintenance & Repairs							6
7	Operation of Plant			64,443	391,884			7
8	Laundry & Linen Service			3,757	7,619	51,587		8
9	Housekeeping			20,849	7,384		67,760	9
10	Dietary			33,006	19,591		609	10
11	Cafeteria			4,083	8,457		3,547	11
12	Maintenance of Personnel							12
13	Nursing Administration			36,859	2,229			13
14	Central Services & Supply			10,507	35,804		1,824	14
15	Pharmacy			20,286	4,062		810	15
16	Medical Records & Library			18,296	10,119		609	16
17	Social Service			352			303	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			2,147	302			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,297	17,385	186,569	91,498	33,675	17,637	30
31	Intensive Care Unit	258	3,447	35,786	21,364	2,454	3,244	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	45	1,124	15,867	30,193	15,458	5,170	50
53	Anesthesiology	5	109	188	1,220			53
54	Radiology-Diagnostic	61	1,844	31,509	29,379		3,547	54
57	CT Scan	62	1,967	7,144				57
60	Laboratory	381	8,192	37,380	22,202		3,547	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	102	2,296	15,386	6,911		1,824	65
66	Physical Therapy	22	657	8,637	10,608		3,092	66
69	Electrocardiology	50	879	4,357	1,931			69
70	Electroencephalography	6	89	447	1,311			70
71	Medical Supplies Charged to Patients	93	2,360	13,459				71
73	Drugs Charged to Patients	291	4,597	17,193				73
74	Renal Dialysis	9	125	1,583				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		839	16,183	12,020		2,737	76
76.10	PARTIAL HOSPITALIZATION	2	1,700	3,213	20,087			76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2	1,304	8,830	8,467		5,068	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		87	61				90.05
91	Emergency	99	4,178	53,807	29,865		14,192	91
91.01	GOLDEN LIFE			1,729	8,993			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)	2,785	53,179	673,913	391,616	51,587	67,760	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			8,369	268			194
194.10	AUSTIN PRIDE			94				194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,785	53,179	682,376	391,884	51,587	67,760	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	157,508						10
11	Cafeteria		60,856					11
12	Maintenance of Personnel							12
13	Nursing Administration		3,892	57,029				13
14	Central Services & Supply		1,131		238,579			14
15	Pharmacy					227,302		15
16	Medical Records & Library		1,929				85,206	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		419					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	115,583	27,398	35,506		3,578	29,733	30
31	Intensive Care Unit	13,371	3,351	4,343		1,382	4,073	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,554	917	1,188		1,812	967	50
53	Anesthesiology						122	53
54	Radiology-Diagnostic		2,070			81	2,570	54
57	CT Scan		595				3,368	57
60	Laboratory		3,119			5,319	12,176	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,046			17	4,627	65
66	Physical Therapy		1,067				1,134	66
69	Electrocardiology		546				2,158	69
70	Electroencephalography		35				101	70
71	Medical Supplies Charged to Patients				238,579		3,519	71
73	Drugs Charged to Patients					211,864	9,317	73
74	Renal Dialysis						168	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		3,031	3,929			1,162	76
76.10	PARTIAL HOSPITALIZATION		181	235			2,300	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		1,323	1,714		1,513	1,492	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						83	90.05
91	Emergency		6,906	8,949		1,736	6,136	91
91.01	GOLDEN LIFE		137	177				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)	157,508	60,093	56,041	238,579	227,302	85,206	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		763	988				194
194.10	AUSTIN PRIDE							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	157,508	60,856	57,029	238,579	227,302	85,206	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	1,301						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		4,634					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,231		1,071,158		1,071,158		30
31	Intensive Care Unit			208,651		208,651		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			265,864		265,864		50
53	Anesthesiology			8,154		8,154		53
54	Radiology-Diagnostic			259,323		259,323		54
57	CT Scan			13,280		13,280		57
60	Laboratory			210,525		210,525		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			72,018		72,018		65
66	Physical Therapy			82,006		82,006		66
69	Electrocardiology			20,526		20,526		69
70	Electroencephalography			9,011		9,011		70
71	Medical Supplies Charged to Patients			258,010		258,010		71
73	Drugs Charged to Patients			243,262		243,262		73
74	Renal Dialysis			1,885		1,885		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			104,416		104,416		76
76.10	PARTIAL HOSPITALIZATION			133,721		133,721		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	30		75,394		75,394		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			250		250		90.05
91	Emergency	40		287,085		287,085		91
91.01	GOLDEN LIFE			58,395		58,395		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)	1,301		3,382,934		3,382,934		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			13,019		13,019		194
194.10	AUSTIN PRIDE			276		276		194.10
200	Cross Foot Adjustments		4,634	4,634		4,634		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,301	4,634	3,400,863		3,400,863		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	COMMUNI CATIONS (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	178,600						1
2	Cap Rel Costs-Mvble Equip		178,600					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	2,947	2,947	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	5,845	5,845	781,343	5			10
11	Cafeteria	2,523	2,523		3			11
12	Maintenance of Personnel							12
13	Nursing Administration	665	665	1,448,825	10			13
14	Central Services & Supply	10,682	10,682	168,576	3			14
15	Pharmacy	1,212	1,212	668,721	2			15
16	Medical Records & Library	3,019	3,019	540,396	7			16
17	Social Service			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	6,374	6,374	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	3,165	3,165	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	3,586	3,586	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	8,910	8,910	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)	178,520	178,520	27,325,412	206	42,794,514	61,180,643	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	80	80	457,993	1			194
194.10	AUSTIN PRIDE				2			194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,316,115	833,768	3,404,205	584,077	211,783	783,465	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.968169	4.668354	0.122527	2,794.626794	0.004949	0.012806	203
204	Cost to be allocated (Per Wkst. B, Part II)			27,084	18,968	2,785	53,179	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000975	90.755981	0.000065	0.000869	205

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

	COST CENTER DESCRIPTIONS	RECON-CILIATION	OTHER ADMINISTRV & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	
		5A.06	5.06	6	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							5.05
5.06	OTHER ADMINISTRATIVE	-11,375,446	40,715,711					5.06
6	Maintenance & Repairs			135,429				6
7	Operation of Plant		3,845,043	18,512	116,917			7
8	Laundry & Linen Service		224,141	2,273	2,273	251,345		8
9	Housekeeping		1,243,960	2,203	2,203		33,947	9
10	Dietary		1,969,325	5,845	5,845		305	10
11	Cafeteria		243,609	2,523	2,523		1,777	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,199,223	665	665			13
14	Central Services & Supply		626,906	10,682	10,682		914	14
15	Pharmacy		1,210,374	1,212	1,212		406	15
16	Medical Records & Library		1,091,617	3,019	3,019		305	16
17	Social Service		20,984				152	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		128,114	90	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		11,133,164	27,298	27,298	164,072	8,836	30
31	Intensive Care Unit		2,135,174	6,374	6,374	11,958	1,625	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		946,709	9,008	9,008	75,315	2,590	50
53	Anesthesiology		11,189	364	364			53
54	Radiology-Diagnostic		1,880,028	8,765	8,765		1,777	54
57	CT Scan		426,267					57
60	Laboratory		2,230,301	6,624	6,624		1,777	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		918,014	2,062	2,062		914	65
66	Physical Therapy		515,357	3,165	3,165		1,549	66
69	Electrocardiology		259,978	576	576			69
70	Electroencephalography		26,643	391	391			70
71	Medical Supplies Charged to Patients		803,017					71
73	Drugs Charged to Patients		1,025,807					73
74	Renal Dialysis		94,424					74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		965,567	3,586	3,586		1,371	76
76.10	PARTIAL HOSPITALIZATION		191,714	5,993	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		526,853	2,526	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		3,663					90.05
91	Emergency		3,210,433	8,910	8,910		7,110	91
91.01	GOLDEN LIFE		103,192	2,683	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)	-11,375,446	40,210,790	135,349	116,837	251,345	33,947	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		499,332	80	80			194
194.10	AUSTIN PRIDE		5,589					194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		11,375,446		4,919,298	382,400	1,684,198	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.279387		42.075130	1.521415	49.612573	203
204	Cost to be allocated (Per Wkst. B, Part II)		682,376		391,884	51,587	67,760	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.016760		3.351814	0.205244	1.996053	205

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

	COST CENTER DESCRIPTIONS	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINI-STRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		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	75,942						10
11	Cafeteria		31,196					11
12	Maintenance of Personnel							12
13	Nursing Administration		1,995	22,558				13
14	Central Services & Supply		580		100			14
15	Pharmacy					1,004,119		15
16	Medical Records & Library		989				86,134,390	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		215					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	55,728	14,044	14,044		15,804	30,043,968	30
31	Intensive Care Unit	6,447	1,718	1,718		6,107	4,118,400	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,767	470	470		8,004	977,848	50
53	Anesthesiology						123,755	53
54	Radiology-Diagnostic		1,061			357	2,598,664	54
57	CT Scan		305				3,405,317	57
60	Laboratory		1,599			23,496	12,310,946	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,049			75	4,678,490	65
66	Physical Therapy		547				1,146,832	66
69	Electrocardiology		280				2,182,276	69
70	Electroencephalography		18				102,317	70
71	Medical Supplies Charged to Patients				100		3,557,907	71
73	Drugs Charged to Patients					935,921	9,420,249	73
74	Renal Dialysis						170,271	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		1,554	1,554			1,174,784	76
76.10	PARTIAL HOSPITALIZATION		93	93			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		678	678		6,684	1,508,894	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						83,674	90.05
91	Emergency		3,540	3,540		7,671	6,203,848	91
91.01	GOLDEN LIFE		70	70				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)	75,942	30,805	22,167	100	1,004,119	86,134,390	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		391	391				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)	2,780,590	505,988	2,873,995	1,306,255	1,619,675	1,554,799	202
203	Unit Cost Multiplier (Wkst. B, Part I)	36.614653	16.219644	127.404690	13,062.550000	1.613031	0.018051	203
204	Cost to be allocated (Per Wkst. B, Part II)	157,508	60,856	57,029	238,579	227,302	85,206	204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.074057	1.950763	2.528105	2,385.790000	0.226370	0.000989	205

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE (TIME SPENT)	I/R-SALARY AND FRINGES (ASSIGNED TIME)					
		17	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	13,680						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	12,952	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	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							90.05
91	Emergency	416						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)	13,680	10,000					118
	NONREIMBURSABLE COST CENTERS							
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)	34,388	171,181					202
203	Unit Cost Multiplier (Wkst. B, Part I)	2.513743	17.118100					203

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE (TIME SPENT)	I/R-SALARY AND FRINGES (ASSIGNED TIME)					
		17	21					
204	Cost to be allocated (Per Wkst. B, Part II)	1,301	4,634					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.095102	0.463400					205

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POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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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	20,738,081		20,738,081		20,738,081	30
31	Intensive Care Unit	3,665,707		3,665,707		3,665,707	31
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,435,441		2,435,441		2,435,441	50
53	Anesthesiology	31,864		31,864		31,864	53
54	Radiology-Diagnostic	2,926,927		2,926,927		2,926,927	54
57	CT Scan	611,776		611,776		611,776	57
60	Laboratory	3,506,346		3,506,346		3,506,346	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,408,186		1,408,186		1,408,186	65
66	Physical Therapy	898,932		898,932		898,932	66
69	Electrocardiology	400,781		400,781		400,781	69
70	Electroencephalography	52,677		52,677		52,677	70
71	Medical Supplies Charged to Patients	2,397,849		2,397,849		2,397,849	71
73	Drugs Charged to Patients	2,992,118		2,992,118		2,992,118	73
74	Renal Dialysis	123,879		123,879		123,879	74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	1,698,632		1,698,632		1,698,632	76
76.10	PARTIAL HOSPITALIZATION	552,775		552,775		552,775	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	1,042,476		1,042,476		1,042,476	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	6,196		6,196		6,196	90.05
91	Emergency	5,468,857		5,468,857		5,468,857	91
91.01	GOLDEN LIFE	254,964		254,964		254,964	91.01
92	Observation Beds (Non-Distinct Part)	408,952		408,952		408,952	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)	51,623,416		51,623,416		51,623,416	200
201	Less Observation Beds	408,952		408,952		408,952	201
202	Total (line 200 minus line 201)	51,214,464		51,214,464		51,214,464	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	30,606,450		30,606,450				30
31	Intensive Care Unit	4,578,686		4,578,686				31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,173,849	1,626,944	2,800,793	0.869554	0.869554	0.869554	50
53	Anesthesiology	95,610	207,545	303,155	0.105108	0.105108	0.105108	53
54	Radiology-Diagnostic	1,132,291	2,090,665	3,222,956	0.908150	0.908150	0.908150	54
57	CT Scan	570,014	1,616,460	2,186,474	0.279800	0.279800	0.279800	57
60	Laboratory	4,481,966	3,933,248	8,415,214	0.416667	0.416667	0.416667	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,061,766	838,302	4,900,068	0.287381	0.287381	0.287381	65
66	Physical Therapy	320,910	393,501	714,411	1.258284	1.258284	1.258284	66
69	Electrocardiology	1,239,937	782,607	2,022,544	0.198157	0.198157	0.198157	69
70	Electroencephalography	48,938	8,651	57,589	0.914706	0.914706	0.914706	70
71	Medical Supplies Charged to Patients	882,288	1,162,646	2,044,934	1.172580	1.172580	1.172580	71
73	Drugs Charged to Patients	2,673,184	1,020,913	3,694,097	0.809973	0.809973	0.809973	73
74	Renal Dialysis	96,475		96,475	1.284053	1.284053	1.284053	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		420,297	420,297	4.041504	4.041504	4.041504	76
76.10	PARTIAL HOSPITALIZATION		2,755,500	2,755,500	0.200608	0.200608	0.200608	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	54,718	1,228,896	1,283,614	0.812141	0.812141	0.812141	90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE		2,976	2,976	2.081989	2.081989	2.081989	90.05
91	Emergency	2,647,766	7,202,858	9,850,624	0.555179	0.555179	0.555179	91
91.01	GOLDEN LIFE		5,844	5,844	43.628337	43.628337	43.628337	91.01
92	Observation Beds (Non-Distinct Part)	3,604	463,216	466,820	0.876038	0.876038	0.876038	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)	54,668,452	25,761,069	80,429,521				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	54,668,452	25,761,069	80,429,521				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,071,158		1,071,158	23,631	45.33	4,830	218,944	30
31	Intensive Care Unit	208,651		208,651	2,149	97.09	731	70,973	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,279,809		1,279,809	25,780		5,561	289,917	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	265,864	2,800,793	0.094925	356,970	33,885	50
53	Anesthesiology	8,154	303,155	0.026897			53
54	Radiology-Diagnostic	259,323	3,222,956	0.080461	391,192	31,476	54
57	CT Scan	13,280	2,186,474	0.006074	186,679	1,134	57
60	Laboratory	210,525	8,415,214	0.025017	1,343,333	33,606	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	72,018	4,900,068	0.014697	1,234,692	18,146	65
66	Physical Therapy	82,006	714,411	0.114788	128,758	14,780	66
69	Electrocardiology	20,526	2,022,544	0.010149	436,385	4,429	69
70	Electroencephalography	9,011	57,589	0.156471	17,456	2,731	70
71	Medical Supplies Charged to Pat	258,010	2,044,934	0.126170	313,073	39,500	71
73	Drugs Charged to Patients	243,262	3,694,097	0.065852	878,325	57,839	73
74	Renal Dialysis	1,885	96,475	0.019539			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	104,416	420,297	0.248434			76
76.10	PARTIAL HOSPITALIZATION	133,721	2,755,500	0.048529			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	75,394	1,283,614	0.058736			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	250	2,976	0.084005			90.05
91	Emergency	287,085	9,850,624	0.029144	706,415	20,588	91
91.01	GOLDEN LIFE	58,395	5,844	9.992300			91.01
92	Observation Beds (Non-Distinct	21,123	466,820	0.045249			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,124,248	45,244,385		5,993,278	258,114	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] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] 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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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)	23,631		4,830		30
31	Intensive Care Unit	2,149		731		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	25,780		5,561		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

		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	2,800,793			356,970		579,892		50
53	Anesthesiology	303,155							53
54	Radiology-Diagnostic	3,222,956			391,192		373,550		54
57	CT Scan	2,186,474			186,679		226,461		57
60	Laboratory	8,415,214			1,343,333		315,201		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,900,068			1,234,692		63,081		65
66	Physical Therapy	714,411			128,758				66
69	Electrocardiology	2,022,544			436,385		192,434		69
70	Electroencephalography	57,589			17,456		3,536		70
71	Medical Supplies Charged to Pat	2,044,934			313,073		204,023		71
73	Drugs Charged to Patients	3,694,097			878,325		221,212		73
74	Renal Dialysis	96,475							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	420,297					8,899		76
76.10	PARTIAL HOSPITALIZATION	2,755,500							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	1,283,614					158,661		90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	2,976							90.05
91	Emergency	9,850,624			706,415		541,162		91
91.01	GOLDEN LIFE	5,844							91.01
92	Observation Beds (Non-Distinct	466,820					100,350		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	45,244,385			5,993,278		2,988,462		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] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed 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	0.869554	579,892			504,247			50
53	Anesthesiology	0.105108							53
54	Radiology-Diagnostic	0.908150	373,550			339,239			54
57	CT Scan	0.279800	226,461			63,364			57
60	Laboratory	0.416667	315,201			131,334			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.287381	63,081			18,128			65
66	Physical Therapy	1.258284							66
69	Electrocardiology	0.198157	192,434			38,132			69
70	Electroencephalography	0.914706	3,536			3,234			70
71	Medical Supplies Charged to Pat	1.172580	204,023			239,233			71
73	Drugs Charged to Patients	0.809973	221,212		2,383	179,176		1,930	73
74	Renal Dialysis	1.284053							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	4.041504	8,899			35,965			76
76.10	PARTIAL HOSPITALIZATION	0.200608							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	0.812141	158,661	6		128,855	5		90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	2.081989							90.05
91	Emergency	0.555179	541,162			300,442			91
91.01	GOLDEN LIFE	43.628337							91.01
92	Observation Beds (Non-Distinct	0.876038	100,350			87,910			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		2,988,462	6	2,383	2,069,259	5	1,930	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,988,462	6	2,383	2,069,259	5	1,930	202

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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)	1,071,158		1,071,158	23,631	45.33	13,279	601,937	30
31	Intensive Care Unit	208,651		208,651	2,149	97.09	293	28,447	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,279,809		1,279,809	25,780		13,572	630,384	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** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		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	265,864	2,800,793	0.094925			50
53	Anesthesiology	8,154	303,155	0.026897			53
54	Radiology-Diagnostic	259,323	3,222,956	0.080461			54
57	CT Scan	13,280	2,186,474	0.006074			57
60	Laboratory	210,525	8,415,214	0.025017			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	72,018	4,900,068	0.014697			65
66	Physical Therapy	82,006	714,411	0.114788			66
69	Electrocardiology	20,526	2,022,544	0.010149			69
70	Electroencephalography	9,011	57,589	0.156471			70
71	Medical Supplies Charged to Pat	258,010	2,044,934	0.126170			71
73	Drugs Charged to Patients	243,262	3,694,097	0.065852			73
74	Renal Dialysis	1,885	96,475	0.019539			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	104,416	420,297	0.248434			76
76.10	PARTIAL HOSPITALIZATION	133,721	2,755,500	0.048529			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	75,394	1,283,614	0.058736			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	250	2,976	0.084005			90.05
91	Emergency	287,085	9,850,624	0.029144			91
91.01	GOLDEN LIFE	58,395	5,844	9.992300			91.01
92	Observation Beds (Non-Distinct	21,123	466,820	0.045249			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,124,248	45,244,385				200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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)	23,631		13,279		30
31	Intensive Care Unit	2,149		293		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	25,780		13,572		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] 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

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	2,800,793							50
53	Anesthesiology	303,155							53
54	Radiology-Diagnostic	3,222,956							54
57	CT Scan	2,186,474							57
60	Laboratory	8,415,214							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,900,068							65
66	Physical Therapy	714,411							66
69	Electrocardiology	2,022,544							69
70	Electroencephalography	57,589							70
71	Medical Supplies Charged to Pat	2,044,934							71
73	Drugs Charged to Patients	3,694,097							73
74	Renal Dialysis	96,475							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	420,297							76
76.10	PARTIAL HOSPITALIZATION	2,755,500							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	1,283,614							90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	2,976							90.05
91	Emergency	9,850,624							91
91.01	GOLDEN LIFE	5,844							91.01
92	Observation Beds (Non-Distinct	466,820							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	45,244,385							200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed 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	0.869554							50
53	Anesthesiology	0.105108							53
54	Radiology-Diagnostic	0.908150							54
57	CT Scan	0.279800							57
60	Laboratory	0.416667							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.287381							65
66	Physical Therapy	1.258284							66
69	Electrocardiology	0.198157							69
70	Electroencephalography	0.914706							70
71	Medical Supplies Charged to Pat	1.172580							71
73	Drugs Charged to Patients	0.809973							73
74	Renal Dialysis	1.284053							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	4.041504							76
76.10	PARTIAL HOSPITALIZATION	0.200608							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	0.812141							90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	2.081989							90.05
91	Emergency	0.555179							91
91.01	GOLDEN LIFE	43.628337							91.01
92	Observation Beds (Non-Distinct	0.876038							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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,631	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,631	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	23,165	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)	4,830	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)	20,738,081	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)	20,738,081	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)	20,738,081	37

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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)					877.58	38
39	Program general inpatient routine service cost (line 9 x line 38)					4,238,711	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)					4,238,711	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	3,665,707	2,149	1,705.77	731	1,246,918	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)					3,367,613	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					8,853,242	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					289,917	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					258,114	51
52	Total Program excludable cost (sum of lines 50 and 51)					548,031	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					8,305,211	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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					466	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					877.58	88
89	Observation bed cost (line 87 x line 88) (see instructions)					408,952	89
		Cost	Routine Cost (from line 21)	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	1,071,158	20,738,081	0.051652	408,952	21,123	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: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[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)	23,631	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,631	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	23,165	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)	13,279	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)	20,738,081	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)	20,738,081	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)	20,738,081	37

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					877.58	38
39	Program general inpatient routine service cost (line 9 x line 38)					11,653,385	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)					11,653,385	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	3,665,707	2,149	1,705.77	293	499,791	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)					12,153,176	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					630,384	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)					630,384	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 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)					466	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 21)	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: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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		6,404,434		30
31	Intensive Care Unit		1,777,300		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.869554	356,970	310,405	50
53	Anesthesiology	0.105108			53
54	Radiology-Diagnostic	0.908150	391,192	355,261	54
57	CT Scan	0.279800	186,679	52,233	57
60	Laboratory	0.416667	1,343,333	559,723	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.287381	1,234,692	354,827	65
66	Physical Therapy	1.258284	128,758	162,014	66
69	Electrocardiology	0.198157	436,385	86,473	69
70	Electroencephalography	0.914706	17,456	15,967	70
71	Medical Supplies Charged to Patients	1.172580	313,073	367,103	71
73	Drugs Charged to Patients	0.809973	878,325	711,420	73
74	Renal Dialysis	1.284053			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	4.041504			76
76.10	PARTIAL HOSPITALIZATION	0.200608			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	0.812141			90
90.01	CICERO CLINIC				90.01
90.02	YMCA CLINIC				90.02
90.03	NORTH AVENUE CLINIC				90.03
90.04	CLINIC #4				90.04
90.05	WOUND CARE	2.081989			90.05
91	Emergency	0.555179	706,415	392,187	91
91.01	GOLDEN LIFE	43.628337			91.01
92	Observation Beds (Non-Distinct Part)	0.876038			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,993,278	3,367,613	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,993,278		202

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	0.869554			50
53	Anesthesiology	0.105108			53
54	Radiology-Diagnostic	0.908150			54
57	CT Scan	0.279800			57
60	Laboratory	0.416667			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.287381			65
66	Physical Therapy	1.258284			66
69	Electrocardiology	0.198157			69
70	Electroencephalography	0.914706			70
71	Medical Supplies Charged to Patients	1.172580			71
73	Drugs Charged to Patients	0.809973			73
74	Renal Dialysis	1.284053			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	4.041504			76
76.10	PARTIAL HOSPITALIZATION	0.200608			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	0.812141			90
90.01	CICERO CLINIC				90.01
90.02	YMCA CLINIC				90.02
90.03	NORTH AVENUE CLINIC				90.03
90.04	CLINIC #4				90.04
90.05	WOUND CARE	2.081989			90.05
91	Emergency	0.555179			91
91.01	GOLDEN LIFE	43.628337			91.01
92	Observation Beds (Non-Distinct Part)	0.876038			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)	1,303,433			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,910,299			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)	367,757			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				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	154.73			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	2.00			11
12	Current year allowable FTE (see instructions)	2.00			12
13	Total allowable FTE count for the prior year	3.00			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	2.50			14
15	Sum of lines 12 through 14 divided by 3	2.50			15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	2.50			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.016157			19
20	Prior year resident to bed ratio (see instructions)	0.017868			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.016157			21
22	IME payment adjustment (see instructions)	45,834			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)	45,834			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)	0.2525			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.6502			31
32	Sum of lines 30 and 31	0.9027			32
33	Allowable disproportionate share percentage (see instructions)	0.6369			33
34	Disproportionate share adjustment (see instructions)	830,156			34
	Uncompensated Care Adjustment	**Prior to October 1 (1.00)**	**(1.01)**	**On or after October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)	7,647,644,885			35
35.01	Factor 3 (see instructions)	0.000392165		0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,999,139		2,456,434	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	755,948		1,838,970	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,594,918			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
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

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

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	9,052,397			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)	9,052,397			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	519,747			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)	39,641			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)	9,611,785			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	9,611,785			61
62	Deductibles billed to program beneficiaries	585,368			62
63	Coinsurance billed to program beneficiaries	110,502			63
64	Allowable bad debts (see instructions)	556,577			64
65	Adjusted reimbursable bad debts (see instructions)	361,775			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	316,896			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,277,690			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)	25,960			70.93
70.94	HRR adjustment amount (see instructions)	-10,559			70.94
70.99	HAC adjustment amount (see instructions)	70,834			70.99
71	Amount due provider (see instructions)	9,222,257			71
71.01	Sequestration adjustment (see instructions)	184,445			71.01
72	Interim payments	7,806,783			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	1,231,029			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	55,005			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

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	1,303,433	1,303,433				1,303,433	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	3,910,299			3,910,299		3,910,299	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	367,757	91,939		275,818		367,757	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments							4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21	0.016157	0.016157		0.016157			5
6	IME payment adjustment	45,834	11,458		34,376		45,834	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)	45,834	11,458		34,376		45,834	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	0.6369	0.6369	0.6369	0.6369	0.6369		10
11	Disproportionate share adjustment	830,156	207,539		622,617		830,156	11
11.01	Uncompensated care payments	2,594,918	755,948		1,838,970		2,594,918	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	9,052,397	2,370,317		6,682,080		9,052,397	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	9,052,397	2,370,317		6,682,080		9,052,397	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	519,747	129,937		389,810		519,747	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**		2,500,254		7,071,890		9,572,144	19
20	Capital DRG other than outlier	417,821	104,455		313,366		417,821	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	13,807	3,452		10,355		13,807	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage	1.0300	1.0300		1.0300			22
23	Indirect medical education adjustment	4,304	1,076		3,228		4,304	23
24	Allowable disproportionate share percentage	0.2006	0.2006		0.2006			24
25	Disproportionate share adjustment	83,815	20,954		62,861		83,815	25
26	Total prospective capital payments	519,747	129,937		389,810		519,747	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	25,960	6,490		19,470		25,960	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-10,559	-2,640		-7,919		-10,559	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				70,834		70,834	32

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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)	1,935			1
2	Medical and other services reimbursed under OPPS (see instructions)	2,069,259			2
3	PPS payments	824,773			3
4	Outlier payment (see instructions)	245,467			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)	1,935			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	2,389			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)	2,389			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)	2,389			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	454			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)	1,935			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)	1,070,240			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	192,731			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)	879,444			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	9,274			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	888,718			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	888,718			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)	102,000			34
35	Adjusted reimbursable bad debts (see instructions)	66,300			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	69,776			36
37	Subtotal (see instructions)	955,018			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)	955,018			40
40.01	Sequestration adjustment (see instructions)	19,100			40.01
41	Interim payments	888,290			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	47,628			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: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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				8,011,149		934,757	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	02/16/2016	204,366	02/16/2016	46,467	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		-204,366		-46,467	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)				7,806,783		888,290	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		1,231,029		47,628	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				9,037,812		935,918	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)	4,245	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	5,561	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	25,314	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	80,429,521	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,147,643	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)	295,577	8
9	Sequestration adjustment amount (see instructions)	5,912	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	289,665	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	183,409	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	106,256	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.

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	12,153,176		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	12,153,176		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	12,153,176		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)	12,153,176		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)	12,153,176		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 cap (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 the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		2.00		10
11	Total weighted FTE count	0.00	2.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.00		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	93,855.24	95,562.99		18
19	Approved amount for resident costs		222,662	222,662	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)			222,662	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	5,561			26
27	Total inpatient days (see instructions)	25,314			27
28	Ratio of inpatient days to total inpatient days	0.219681	0.000000		28
29	Program direct GME amount	48,915			29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount			48,915	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)			96,475	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)			8,853,242	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)			8,853,242	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			2,071,194	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			2,071,194	44
45	Total reasonable cost (sum of lines 41 and 44)			10,924,436	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.810407	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.189593	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			48,915	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			39,641	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			9,274	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 cap (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 the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 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)	13,572	2,888		26
27	Total inpatient days (see instructions)	25,314	25,314		27
28	Ratio of inpatient days to total inpatient days	0.536146	0.114087		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	699,508				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	27,999,613				4
5	Other receivables	802,898				5
6	Allowances for uncollectible notes and accounts receivable	-14,911,824				6
7	Inventory	423,952				7
8	Prepaid expenses	446,424				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	15,460,571				11
	FIXED ASSETS					
12	Land	429,028				12
13	Land improvements	36,943				13
14	Accumulated depreciation	-25,463				14
15	Buildings	37,079,883				15
16	Accumulated depreciation	-13,806,040				16
17	Leasehold improvements	83,192				17
18	Accumulated depreciation					18
19	Fixed equipment	11,162,838				19
20	Accumulated depreciation	-5,952,202				20
21	Audomobiles and trucks					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)	29,008,179				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	12,108,270				34
35	Total other assets (sum of lines 31-34)	12,108,270				35
36	Total assets (sum of lines 11, 30 and 35)	56,577,020				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	4,645,292				37
38	Salaries, wages and fees payable	3,053,298				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					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	7,698,590				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	1,028,383				49
50	Total long term liabilities (sum of lines 46 thru 49)	1,028,383				50
51	Total liabilities (sum of lines 45 and 50)	8,726,973				51
	CAPITAL ACCOUNTS					
52	General fund balance	47,850,047				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
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)	47,850,047				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	56,577,020				60

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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		30,128,998			1
2	Net income (loss) (from Worksheet G-3, line 29)		7,825,094			2
3	Total (sum of line 1 and line 2)		37,954,092			3
4	Additions (credit adjustments) (specify)	9,895,955				4
5	NET ASSETS RELEASED					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		9,895,955			10
11	Subtotal (line 3 plus line 10)		47,850,047			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)		47,850,047			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: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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	29,139,182		29,139,182	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)	29,139,182		29,139,182	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	4,590,936		4,590,936	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)	4,590,936		4,590,936	16
17	Total inpatient routine care services (sum of lines 10 and 16)	33,730,118		33,730,118	17
18	Ancillary services	19,387,127	27,216,187	46,603,314	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)	53,117,245	27,216,187	80,333,432	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		56,050,466	29
30	Add (specify)			30
31	BAD DEBTS	5,317,885		31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		5,317,885	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)		61,368,351	43

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	80,333,432	1
2	Less contractual allowances and discounts on patients' accounts	16,504,403	2
3	Net patient revenues (line 1 minus line 2)	63,829,029	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	61,368,351	4
5	Net income from service to patients (line 3 minus line 4)	2,460,678	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	127,577	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	13,052	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	6,844	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER INCOME)		24
24.01	Other (OTHER MISC)	5,216,943	24.01
25	Total other income (sum of lines 6-24)	5,364,416	25
26	Total (line 5 plus line 25)	7,825,094	26
29	Net income (or loss) for the period (line 26 minus line 28)	7,825,094	29

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	417,821	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	13,807	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	69.16	3
4	Number of interns & residents (see instructions)	2.50	4
5	Indirect medical education percentage (see instructions)	1.03	5
6	Indirect medical education adjustment (see instructions)	4,304	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2525	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.6502	8
9	Sum of lines 7 and 8	0.9027	9
10	Allowable disproportionate share percentage (see instructions)	0.2006	10
11	Disproportionate share adjustment (see instructions)	83,815	11
12	Total prospective capital payments (see instructions)	519,747	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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/25/2016 Run Time: 11:59 Version: 2016.05 (11/15/2016)

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