KPMG LLP Compu-Max 2552-10

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/30/2017 Time: 07:48 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 07/01/2016 and ending 06/30/2017, 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		1,135,224	-20,139			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		1,135,224	-20,139			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 / 2016	To: 06 / 30 / 2017	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.	1,918	1,961			9,167	49	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

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	N	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:	1,300,000			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

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WORKSHEET S-2
PART I

All Providers

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

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

141	Name:	Contractor's Name:	Contractor's Number:		141
142	Street:	P.O. Box:			142
143	City:	State:	ZIP Code:		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on 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)	0.25			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 / 2016	06 / 30 / 2017 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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)			N	0 171

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.	N			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	11/16/2017	Y	11/16/2017	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	110	40,150			3,767	1,843	18,884	1
2	HMO and other (see instructions)						425	7,686		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)		110	40,150			3,767	1,843	18,884	7
8	Intensive Care Unit	31	12	4,380			581	75	1,810	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)		122	44,530			4,348	1,918	20,694	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)		122							27
28	Observation Bed Days								436	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)					648	346	3,604	1
2	HMO and other (see instructions)					60	1,482		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)	1.50	480.41			648	346	3,604	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)	1.50	480.41						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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	28,358,887		28,358,887	999,259.12	28.38	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	70,441		70,441	3,200.00	22.01	7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		340,428		340,428	8,291.57	41.06	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
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)		5,639,183		5,639,183			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		68,690		68,690			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)		14,213		14,213			25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		284,419		284,419	8,460.17	33.62	26
27	Administrative & General		4,964,730		4,964,730	166,687.84	29.78	27
28	Administrative & General under contract (see instructions)		73,488		73,488	366.00	200.79	28
29	Maintenance & Repairs							29
30	Operation of Plant		1,333,196		1,333,196	41,456.78	32.16	30
31	Laundry & Linen Service		33,834		33,834	2,126.75	15.91	31
32	Housekeeping		728,394		728,394	55,457.26	13.13	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		740,874	-154,583	586,291	34,619.06	16.94	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			154,583	154,583	9,127.75	16.94	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,640,626		1,640,626	45,342.96	36.18	38
39	Central Services and Supply		213,470		213,470	11,779.65	18.12	39
40	Pharmacy		741,736		741,736	19,200.34	38.63	40
41	Medical Records & Medical Records Library		577,239		577,239	25,359.80	22.76	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		28,361,934		28,361,934	996,425.12	28.46	1
2	Excluded area salaries (see instructions)		340,428		340,428	8,291.57	41.06	2
3	Subtotal salarles (line 1 minus line 2)		28,021,506		28,021,506	988,133.55	28.36	3
4	Subtotal other wages & related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)		5,639,183		5,639,183		20.12%	5
6	Total (sum of lines 3 through 5)		33,660,689		33,660,689	988,133.55	34.06	6
7	Total overhead cost (see instructions)		11,332,006		11,332,006	419,984.36	26.98	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)	370,894	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,800,592	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	88,071	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	-6,729	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	521,783	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	2,842,620	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	16,028	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	88,827	23
24	Total Wage Related cost (Sum of lines 1-23)	5,722,086	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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

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)	0.606785	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	5,754,582	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?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	7,426,529	5
6	Medicaid charges	23,523,451	6
7	Medicaid cost (line 1 times line 6)	14,273,677	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.	1,092,566	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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)	1,092,566	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	888,950		888,950	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	539,402		539,402	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	539,402		539,402	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	4,323,392	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	278,221	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	428,031	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	3,895,361	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,513,457	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,052,859	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,145,425	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		2,694,969	2,694,969	-463,823	2,231,146	-26,956	2,204,190	1
2	00200	Cap Rel Costs-Mvble Equip				583,220	583,220		583,220	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	284,419	2,941,078	3,225,497		3,225,497		3,225,497	4
5.01	01160	COMMUNICATIONS	157,533	212,671	370,204		370,204	-16,385	353,819	5.01
5.04	00570	ADMITTING	119,707	12,401	132,108		132,108		132,108	5.04
5.05	00580	BUSINESS OFFICE	553,330	300,783	854,113		854,113		854,113	5.05
5.06	00590	OTHER ADMINISTRATIVE	4,134,160	13,639,719	17,773,879	-119,397	17,654,482	-7,538,209	10,116,273	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,333,196	2,001,424	3,334,620		3,334,620		3,334,620	7
8	00800	Laundry & Linen Service	33,834	115,989	149,823		149,823		149,823	8
9	00900	Housekeeping	728,394	775,627	1,504,021		1,504,021		1,504,021	9
10	01000	Dietary	740,874	1,300,252	2,041,126	-425,881	1,615,245		1,615,245	10
11	01100	Cafeteria				425,881	425,881	-202,997	222,884	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,640,626	481,302	2,121,928		2,121,928		2,121,928	13
14	01400	Central Services & Supply	213,470	556,944	770,414	-311,741	458,673		458,673	14
15	01500	Pharmacy	741,736	1,196,950	1,938,686	-916,573	1,022,113		1,022,113	15
16	01600	Medical Records & Library	577,239	231,457	808,696		808,696		808,696	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	70,441	10,898	81,339		81,339		81,339	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	8,126,836	2,024,008	10,150,844		10,150,844	-604,680	9,546,164	30
31	03100	Intensive Care Unit	1,432,286	554,727	1,987,013		1,987,013	-159,522	1,827,491	31
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	542,336	625,161	1,167,497	-306,854	860,643	-8,006	852,637	50
53	05300	Anesthesiology		608,580	608,580		608,580	-608,333	247	53
54	05400	Radiology-Diagnostic	919,902	1,063,641	1,983,543		1,983,543	-225,000	1,758,543	54
57	05700	CT Scan	142,405	111,403	253,808		253,808		253,808	57
60	06000	Laboratory	945,367	907,875	1,853,242		1,853,242		1,853,242	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	619,953	153,608	773,561	-41,830	731,731		731,731	65
66	06600	Physical Therapy	339,476	53,650	393,126	-1,268	391,858		391,858	66
69	06900	Electrocardiology	155,372	46,726	202,098		202,098		202,098	69
70	07000	Electroencephalography	7,537	723	8,260		8,260		8,260	70
71	07100	Medical Supplies Charged to Patients				805,509	805,509		805,509	71
73	07300	Drugs Charged to Patients				916,573	916,573		916,573	73
74	07400	Renal Dialysis		117,200	117,200		117,200		117,200	74
75.01	07501	HYBERBARIC CHAMBER								75.01
76	03550	O/P MENTAL HEALTH	667,464	223,632	891,096		891,096	-164,330	726,766	76
76.10	03950	PARTIAL HOSPITALIZATION	62,735	11,920	74,655		74,655	-5,525	69,130	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	321,374	503,219	824,593	-23,812	800,781	-422,090	378,691	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	2,370,788	1,721,240	4,092,028	-120,004	3,972,024	-1,293,890	2,678,134	91
91.01	09101	GOLDEN LIFE	35,669	2,851	38,520		38,520		38,520	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)	28,018,459	35,202,628	63,221,087		63,221,087	-11,275,923	51,945,164	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PUBLIC RELATIONS	340,428	80,773	421,201		421,201		421,201	194
194.10	07951	AUSTIN PRIDE								194.10
200		TOTAL (sum of lines 118-199)	28,358,887	35,283,401	63,642,288		63,642,288	-11,275,923	52,366,365	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		916,573	1
500	Total reclassifications					916,573	500
	Code Letter - A						
1	CAFETERIA RECLASS	B	Cafeteria	11	154,583	271,298	1
500	Total reclassifications				154,583	271,298	500
	Code Letter - B						
1	DEPR EXP	D	Cap Rel Costs-Mvble Equip	2		583,220	1
500	Total reclassifications					583,220	500
	Code Letter - D						
1	SUPPLIES CHARGED	E	Medical Supplies Charged to P	71		805,509	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					805,509	500
	Code Letter - E						
1	CAPITAL INSURANCE EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		119,397	1
500	Total reclassifications					119,397	500
	Code Letter - F						
	GRAND TOTAL (Increases)				154,583	2,695,997	

(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		916,573		1
500	Total reclassifications					916,573		500
	Code letter - A							
1	CAFETERIA RECLASS	B	Dietary	10	154,583	271,298		1
500	Total reclassifications				154,583	271,298		500
	Code letter - B							
1	DEPR EXP	D	Cap Rel Costs-Bldg & Fixt	1		583,220	9	1
500	Total reclassifications					583,220		500
	Code letter - D							
1	SUPPLIES CHARGED	E	Operating Room	50		306,854		1
2			Respiratory Therapy	65		41,830		2
3			Emergency	91		120,004		3
4			Physical Therapy	66		1,268		4
5			Clinic	90		23,812		5
6								6
7								7
8			Central Services & Supply	14		311,741		8
500	Total reclassifications					805,509		500
	Code letter - E							
1	CAPITAL INSURANCE EXPENSE	F	OTHER ADMINISTRATIVE	5.06		119,397	12	1
500	Total reclassifications					119,397		500
	Code letter - F							
	GRAND TOTAL (Decreases)				154,583	2,695,997		

(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				171,915	52,143		2
3	Buildings and Fixtures	48,792,886				8,525,116	40,267,770		3
4	Building Improvements								4
5	Fixed Equipment	23,216,229				11,795,619	11,420,610		5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	72,662,201				20,492,650	52,169,551		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	72,662,201				20,492,650	52,169,551		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	2,694,969						2,694,969	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	2,694,969						2,694,969	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	40,748,941		40,748,941	0.781087					1
2	Cap Rel Costs-Mvble Equ	11,420,610		11,420,610	0.218913					2
3	Total (sum of lines 1-2)	52,169,551		52,169,551	1.000000					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	2,084,793			119,397			2,204,190	1
2	Cap Rel Costs-Mvble Equip	583,220						583,220	2
3	Total (sum of lines 1-2)	2,668,013			119,397			2,787,410	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	-3,569,001				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	-198,913	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-4,084	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	-8,006	Operating Room	50		35
36							36
37	LOBBYING EXPENSES	A	-26,049	OTHER ADMINISTRATIVE	5.06		37
38	RENTAL INCOME	B	-24,674	Cap Rel Costs-Bldg & Fixt	1	9	38
39	MEDICAID TAX ASSESSMENT	A	-7,426,529	OTHER ADMINISTRATIVE	5.06		39
40							40
41							41
42	MISC INCOME	B	-16,385	COMMUNICATIONS	5.01		42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-11,275,923				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	604,680	604,680						1
2	31	Intensive Care Unit AGGREGATE	159,522	159,522						2
3	53	Anesthesiology AGGREGATE	608,333	608,333						3
4	54	Radiology-Diagnostic AGGREGATE	225,000	225,000						4
5	76.10	PARTIAL HOSPITALIZAT AGGREGATE	5,525	5,525						5
6	76	O/P MENTAL HEALTH AGGREGATE	164,330	164,330						6
7	91	Emergency AGGREGATE	1,293,890	1,293,890						7
8	90	Clinic AGGREGATE	422,090	422,090						8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE	85,631	85,631						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	3,569,001	3,569,001						200

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							604,680	1
2	31	Intensive Care Unit AGGREGATE							159,522	2
3	53	Anesthesiology AGGREGATE							608,333	3
4	54	Radiology-Diagnostic AGGREGATE							225,000	4
5	76.10	PARTIAL HOSPITALIZAT AGGREGATE							5,525	5
6	76	O/P MENTAL HEALTH AGGREGATE							164,330	6
7	91	Emergency AGGREGATE							1,293,890	7
8	90	Clinic AGGREGATE							422,090	8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE							85,631	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							3,569,001	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	2,204,190	2,204,190					1
2	Cap Rel Costs-Mvble Equip	583,220		583,220				2
4	Employee Benefits Department	3,225,497	13,588	3,595	3,242,680			4
5.01	COMMUNICATIONS	353,819	13,181	3,488	18,196	388,684		5.01
5.04	ADMITTING	132,108	1,703	451	13,827	3,719	151,808	5.04
5.05	BUSINESS OFFICE	854,113	36,370	9,623	63,911	5,579		5.05
5.06	OTHER ADMINISTRATIVE	10,116,273	467,950	123,817	477,508	109,727		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	3,334,620	228,466	60,451	153,988	5,579		7
8	Laundry & Linen Service	149,823	28,052	7,423	3,908	1,860		8
9	Housekeeping	1,504,021	27,188	7,194	84,132	1,860		9
10	Dietary	1,615,245	72,136	19,087	67,718	9,299		10
11	Cafeteria	222,884	31,138	8,239	17,855	5,579		11
12	Maintenance of Personnel							12
13	Nursing Administration	2,121,928	8,207	2,172	189,497	18,597		13
14	Central Services & Supply	458,673	131,832	34,882	24,656	5,579		14
15	Pharmacy	1,022,113	14,958	3,958	85,673	3,719		15
16	Medical Records & Library	808,696	37,259	9,859	66,673	13,018		16
17	Social Service					13,018		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	81,339	1,111	294	8,136			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,546,164	336,898	89,142	938,670	27,896	72,641	30
31	Intensive Care Unit	1,827,491	78,665	20,814	165,433	9,299	11,669	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	852,637	111,172	29,416	62,641	35,335	3,950	50
53	Anesthesiology	247	4,492	1,189		1,860	439	53
54	Radiology-Diagnostic	1,758,543	108,173	28,622	106,251	14,878	2,826	54
57	CT Scan	253,808			16,448		1,697	57
60	Laboratory	1,853,242	81,750	21,631	109,193	11,158	12,488	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	731,731	25,448	6,733	71,606	3,719	10,883	65
66	Physical Therapy	391,858	39,061	10,335	39,210	13,018	826	66
69	Electrocardiology	202,098	7,109	1,881	17,946	5,579	3,202	69
70	Electroencephalography	8,260	4,826	1,277	871	1,860	84	70
71	Medical Supplies Charged to Patients	805,509					2,393	71
73	Drugs Charged to Patients	916,573					19,745	73
74	Renal Dialysis	117,200					266	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	726,766	44,257	11,710	77,094	13,018		76
76.10	PARTIAL HOSPITALIZATION	69,130	73,963	19,570	7,246	3,719		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	378,691	31,175	8,249	37,120	13,018	157	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	2,678,134	109,963	29,096	273,833	31,615	8,542	91
91.01	GOLDEN LIFE	38,520	33,112	8,761	4,120			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)	51,945,164	2,203,203	582,959	3,203,360	383,105	151,808	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	421,201	987	261	39,320	1,860		194
194.10	AUSTIN PRIDE					3,719		194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	52,366,365	2,204,190	583,220	3,242,680	388,684	151,808	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	969,596						5.05
5.06	OTHER ADMINISTRATIVE		11,295,275	11,295,275				5.06
6	Maintenance & Repairs							6
7	Operation of Plant		3,783,104	1,040,422	4,823,526			7
8	Laundry & Linen Service		191,066	52,547	93,775	337,388		8
9	Housekeeping		1,624,395	446,738	90,887		2,162,020	9
10	Dietary		1,783,485	490,490	241,141		19,425	10
11	Cafeteria		285,695	78,571	104,089		113,174	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,340,401	643,652	27,435			13
14	Central Services & Supply		655,622	180,308	440,696		58,211	14
15	Pharmacy		1,130,421	310,886	50,002		25,857	15
16	Medical Records & Library		935,505	257,281	124,552		19,425	16
17	Social Service		13,018	3,580			9,681	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		90,880	24,994	3,713			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	320,120	11,331,531	3,116,360	1,126,206	220,238	562,748	30
31	Intensive Care Unit	50,659	2,164,030	595,147	262,966	16,052	103,493	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	40,443	1,135,594	312,309	371,634	101,098	164,952	50
53	Anesthesiology	5,626	13,853	3,810	15,017			53
54	Radiology-Diagnostic	35,663	2,054,956	565,150	361,609		113,174	54
57	CT Scan	26,501	298,454	82,080				57
60	Laboratory	99,413	2,188,875	601,980	273,280		113,174	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	56,080	906,200	249,221	85,070		58,211	65
66	Physical Therapy	10,597	504,905	138,858	130,575		98,653	66
69	Electrocardiology	23,854	261,669	71,964	23,763			69
70	Electroencephalography	430	17,608	4,843	16,131			70
71	Medical Supplies Charged to Patients	25,545	833,447	229,213				71
73	Drugs Charged to Patients	109,117	1,045,435	287,513				73
74	Renal Dialysis	1,155	118,621	32,623				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	5,785	878,630	241,639	147,944		87,316	76
76.10	PARTIAL HOSPITALIZATION	28,290	201,918	55,531	247,247			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	7,667	476,077	130,930	104,213		161,704	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	30	30	8				90.05
91	Emergency	122,606	3,253,789	894,851	367,591		452,822	91
91.01	GOLDEN LIFE	15	84,528	23,247	110,690			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)	969,596	51,899,017	11,166,746	4,820,226	337,388	2,162,020	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		463,629	127,506	3,300			194
194.10	AUSTIN PRIDE		3,719	1,023				194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	969,596	52,366,365	11,295,275	4,823,526	337,388	2,162,020	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	2,534,541						10
11	Cafeteria		581,529					11
12	Maintenance of Personnel							12
13	Nursing Administration		39,827	3,051,315				13
14	Central Services & Supply		10,340		1,345,177			14
15	Pharmacy					1,517,166		15
16	Medical Records & Library		22,270				1,359,033	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		2,813					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,878,801	259,187	1,904,990		6,911	474,038	30
31	Intensive Care Unit	113,397	30,437	223,706		4,418	64,980	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	542,343	11,656	85,669		7,496	15,428	50
53	Anesthesiology						1,953	53
54	Radiology-Diagnostic		22,453			253	41,002	54
57	CT Scan		3,526				53,729	57
60	Laboratory		30,638			2,152	194,242	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		19,402				73,817	65
66	Physical Therapy		9,993				18,095	66
69	Electrocardiology		4,841			43	34,432	69
70	Electroencephalography		274				1,614	70
71	Medical Supplies Charged to Patients				1,345,177		56,137	71
73	Drugs Charged to Patients					1,475,276	148,633	73
74	Renal Dialysis						2,687	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		25,888	190,271			18,536	76
76.10	PARTIAL HOSPITALIZATION		3,215	23,633			36,699	76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		13,044	95,874		11,869	23,807	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						1,320	90.05
91	Emergency		63,431	466,210		8,748	97,884	91
91.01	GOLDEN LIFE		1,005	7,385				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)	2,534,541	574,240	2,997,738	1,345,177	1,517,166	1,359,033	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		7,289	53,577				194
194.10	AUSTIN PRIDE							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,534,541	581,529	3,051,315	1,345,177	1,517,166	1,359,033	202

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I/R-SALARY AND FRINGES	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	21	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	26,279						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		122,400					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,881	122,400	21,028,291	-122,400	20,905,891		30
31	Intensive Care Unit			3,578,626		3,578,626		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			2,748,179		2,748,179		50
53	Anesthesiology			34,633		34,633		53
54	Radiology-Diagnostic			3,158,597		3,158,597		54
57	CT Scan			437,789		437,789		57
60	Laboratory			3,404,341		3,404,341		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			1,391,921		1,391,921		65
66	Physical Therapy			901,079		901,079		66
69	Electrocardiology			396,712		396,712		69
70	Electroencephalography			40,470		40,470		70
71	Medical Supplies Charged to Patients			2,463,974		2,463,974		71
73	Drugs Charged to Patients			2,956,857		2,956,857		73
74	Renal Dialysis			153,931		153,931		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			1,590,224		1,590,224		76
76.10	PARTIAL HOSPITALIZATION			568,243		568,243		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	599		1,018,117		1,018,117		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			1,358		1,358		90.05
91	Emergency	799		5,606,125		5,606,125		91
91.01	GOLDEN LIFE			226,855		226,855		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)	26,279	122,400	51,706,322	-122,400	51,583,922		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			655,301		655,301		194
194.10	AUSTIN PRIDE			4,742		4,742		194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	26,279	122,400	52,366,365	-122,400	52,243,965		202

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	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		13,588	3,595	17,183	17,183		4
5.01	COMMUNICATIONS		13,181	3,488	16,669	96	16,765	5.01
5.04	ADMITTING		1,703	451	2,154	73	160	5.04
5.05	BUSINESS OFFICE	423	36,370	9,623	46,416	339	241	5.05
5.06	OTHER ADMINISTRATIVE		467,950	123,817	591,767	2,530	4,732	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	13	228,466	60,451	288,930	816	241	7
8	Laundry & Linen Service		28,052	7,423	35,475	21	80	8
9	Housekeeping		27,188	7,194	34,382	446	80	9
10	Dietary	1,829	72,136	19,087	93,052	359	401	10
11	Cafeteria		31,138	8,239	39,377	95	241	11
12	Maintenance of Personnel							12
13	Nursing Administration		8,207	2,172	10,379	1,004	802	13
14	Central Services & Supply	60	131,832	34,882	166,774	131	241	14
15	Pharmacy	142,014	14,958	3,958	160,930	454	160	15
16	Medical Records & Library		37,259	9,859	47,118	353	562	16
17	Social Service						562	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		1,111	294	1,405	43		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,710	336,898	89,142	427,750	4,974	1,203	30
31	Intensive Care Unit	891	78,665	20,814	100,370	877	401	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	795	111,172	29,416	141,383	332	1,524	50
53	Anesthesiology		4,492	1,189	5,681		80	53
54	Radiology-Diagnostic	25,369	108,173	28,622	162,164	563	642	54
57	CT Scan					87		57
60	Laboratory		81,750	21,631	103,381	579	481	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,182	25,448	6,733	37,363	379	160	65
66	Physical Therapy		39,061	10,335	49,396	208	562	66
69	Electrocardiology		7,109	1,881	8,990	95	241	69
70	Electroencephalography		4,826	1,277	6,103	5	80	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		44,257	11,710	55,967	408	562	76
76.10	PARTIAL HOSPITALIZATION		73,963	19,570	93,533	38	160	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		31,175	8,249	39,424	197	562	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		109,963	29,096	139,059	1,451	1,364	91
91.01	GOLDEN LIFE		33,112	8,761	41,873	22		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)	178,286	2,203,203	582,959	2,964,448	16,975	16,525	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		987	261	1,248	208	80	194
194.10	AUSTIN PRIDE						160	194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	178,286	2,204,190	583,220	2,965,696	17,183	16,765	202

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

	COST CENTER DESCRIPTIONS	ADMITTING	BUSINESS OFFICE	OTHER ADMINISTRV & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.04	5.05	5.06	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING	2,387						5.04
5.05	BUSINESS OFFICE		46,996					5.05
5.06	OTHER ADMINISTRATIVE			599,029				5.06
6	Maintenance & Repairs							6
7	Operation of Plant			55,177	345,164			7
8	Laundry & Linen Service			2,787	6,710	45,073		8
9	Housekeeping			23,692	6,504		65,104	9
10	Dietary			26,012	17,256		585	10
11	Cafeteria			4,167	7,448		3,408	11
12	Maintenance of Personnel							12
13	Nursing Administration			34,135	1,963			13
14	Central Services & Supply			9,562	31,536		1,753	14
15	Pharmacy			16,487	3,578		779	15
16	Medical Records & Library			13,644	8,913		585	16
17	Social Service			190			292	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			1,325	266			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,153	15,503	165,276	80,590	29,423	16,945	30
31	Intensive Care Unit	182	2,456	31,562	18,817	2,144	3,116	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	62	1,961	16,563	26,594	13,506	4,967	50
53	Anesthesiology	7	273	202	1,075			53
54	Radiology-Diagnostic	44	1,729	29,972	25,876		3,408	54
57	CT Scan	26	1,285	4,353				57
60	Laboratory	195	4,820	31,925	19,555		3,408	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	170	2,719	13,217	6,087		1,753	65
66	Physical Therapy	13	514	7,364	9,344		2,971	66
69	Electrocardiology	50	1,157	3,816	1,700			69
70	Electroencephalography	1	21	257	1,154			70
71	Medical Supplies Charged to Patients	37	1,239	12,156				71
73	Drugs Charged to Patients	308	5,291	15,248				73
74	Renal Dialysis	4	56	1,730				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		281	12,815	10,587		2,629	76
76.10	PARTIAL HOSPITALIZATION		1,372	2,945	17,693			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	372	6,944	7,457		4,869	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					90.05
91	Emergency	133	5,945	47,457	26,304		13,636	91
91.01	GOLDEN LIFE		1	1,233	7,921			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)	2,387	46,996	592,213	344,928	45,073	65,104	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			6,762	236			194
194.10	AUSTIN PRIDE			54				194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,387	46,996	599,029	345,164	45,073	65,104	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	137,665						10
11	Cafeteria		54,736					11
12	Maintenance of Personnel							12
13	Nursing Administration		3,749	52,032				13
14	Central Services & Supply		973		210,970			14
15	Pharmacy					182,388		15
16	Medical Records & Library		2,096				73,271	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		265					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	102,048	24,394	32,483		831	25,539	30
31	Intensive Care Unit	6,159	2,865	3,815		531	3,505	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	29,458	1,097	1,461		901	832	50
53	Anesthesiology						105	53
54	Radiology-Diagnostic		2,113			30	2,211	54
57	CT Scan		332				2,898	57
60	Laboratory		2,884			259	10,477	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,826				3,981	65
66	Physical Therapy		941				976	66
69	Electrocardiology		456			5	1,857	69
70	Electroencephalography		26				87	70
71	Medical Supplies Charged to Patients				210,970		3,028	71
73	Drugs Charged to Patients					177,352	8,017	73
74	Renal Dialysis						145	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		2,437	3,245			1,000	76
76.10	PARTIAL HOSPITALIZATION		303	403			1,979	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		1,228	1,635		1,427	1,284	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						71	90.05
91	Emergency		5,970	7,950		1,052	5,279	91
91.01	GOLDEN LIFE		95	126				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)	137,665	54,050	51,118	210,970	182,388	73,271	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		686	914				194
194.10	AUSTIN PRIDE							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	137,665	54,736	52,032	210,970	182,388	73,271	202

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I/R-SALARY AND FRINGES	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	21	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	1,044						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		3,304					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	988		929,100		929,100		30
31	Intensive Care Unit			176,800		176,800		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			240,641		240,641		50
53	Anesthesiology			7,423		7,423		53
54	Radiology-Diagnostic			228,752		228,752		54
57	CT Scan			8,981		8,981		57
60	Laboratory			177,964		177,964		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			67,655		67,655		65
66	Physical Therapy			72,289		72,289		66
69	Electrocardiology			18,367		18,367		69
70	Electroencephalography			7,734		7,734		70
71	Medical Supplies Charged to Patients			227,430		227,430		71
73	Drugs Charged to Patients			206,216		206,216		73
74	Renal Dialysis			1,935		1,935		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			89,931		89,931		76
76.10	PARTIAL HOSPITALIZATION			118,426		118,426		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	24		65,425		65,425		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			72		72		90.05
91	Emergency	32		255,632		255,632		91
91.01	GOLDEN LIFE			51,271		51,271		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)	1,044		2,952,044		2,952,044		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			10,134		10,134		194
194.10	AUSTIN PRIDE			214		214		194.10
200	Cross Foot Adjustments		3,304	3,304		3,304		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,044	3,304	2,965,696		2,965,696		202

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

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	COMMUNICATIONS (PHONES	ADMITTING INPATIENT REVENUE	BUSINESS OFFICE GROSS REVENUE	
		1	2	4	5.01	5.04	5.05	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	178,600						1
2	Cap Rel Costs-Mvble Equip		178,600					2
4	Employee Benefits Department	1,101	1,101	28,074,468				4
5.01	COMMUNICATIONS	1,068	1,068	157,533	209			5.01
5.04	ADMITTING	138	138	119,707	2	57,796,997		5.04
5.05	BUSINESS OFFICE	2,947	2,947	553,330	3		85,011,877	5.05
5.06	OTHER ADMINISTRATIVE	37,917	37,917	4,134,160	59			5.06
6	Maintenance & Repairs							6
7	Operation of Plant	18,512	18,512	1,333,196	3			7
8	Laundry & Linen Service	2,273	2,273	33,834	1			8
9	Housekeeping	2,203	2,203	728,394	1			9
10	Dietary	5,845	5,845	586,291	5			10
11	Cafeteria	2,523	2,523	154,583	3			11
12	Maintenance of Personnel							12
13	Nursing Administration	665	665	1,640,626	10			13
14	Central Services & Supply	10,682	10,682	213,470	3			14
15	Pharmacy	1,212	1,212	741,736	2			15
16	Medical Records & Library	3,019	3,019	577,239	7			16
17	Social Service				7			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	90	90	70,441				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	8,126,836	15	27,661,183	28,065,209	30
31	Intensive Care Unit	6,374	6,374	1,432,286	5	4,441,850	4,441,850	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,008	9,008	542,336	19	1,503,788	3,546,080	50
53	Anesthesiology	364	364		1	167,180	493,298	53
54	Radiology-Diagnostic	8,765	8,765	919,902	8	1,075,840	3,126,968	54
57	CT Scan			142,405		645,976	2,323,664	57
60	Laboratory	6,624	6,624	945,367	6	4,753,676	8,716,611	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,062	2,062	619,953	2	4,142,581	4,917,166	65
66	Physical Therapy	3,165	3,165	339,476	7	314,287	929,180	66
69	Electrocardiology	576	576	155,372	3	1,218,866	2,091,567	69
70	Electroencephalography	391	391	7,537	1	31,926	37,672	70
71	Medical Supplies Charged to Patients					910,973	2,239,790	71
73	Drugs Charged to Patients					7,516,341	9,567,481	73
74	Renal Dialysis					101,303	101,303	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	3,586	3,586	667,464	7		507,242	76
76.10	PARTIAL HOSPITALIZATION	5,993	5,993	62,735	2		2,480,500	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	2,526	2,526	321,374	7	59,644	672,224	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						2,606	90.05
91	Emergency	8,910	8,910	2,370,788	17	3,251,583	10,750,183	91
91.01	GOLDEN LIFE	2,683	2,683	35,669			1,283	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	27,734,040	206	57,796,997	85,011,877	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	80	80	340,428	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)	2,204,190	583,220	3,242,680	388,684	151,808	969,596	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.341489	3.265510	0.115503	1,859.732057	0.002627	0.011405	203
204	Cost to be allocated (Per Wkst. B, Part II)			17,183	16,765	2,387	46,996	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000612	80.215311	0.000041	0.000553	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	-11,295,275	41,071,090					5.06
6	Maintenance & Repairs			135,429				6
7	Operation of Plant		3,783,104	18,512	116,917			7
8	Laundry & Linen Service		191,066	2,273	2,273	251,345		8
9	Housekeeping		1,624,395	2,203	2,203		33,947	9
10	Dietary		1,783,485	5,845	5,845		305	10
11	Cafeteria		285,695	2,523	2,523		1,777	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,340,401	665	665			13
14	Central Services & Supply		655,622	10,682	10,682		914	14
15	Pharmacy		1,130,421	1,212	1,212		406	15
16	Medical Records & Library		935,505	3,019	3,019		305	16
17	Social Service		13,018				152	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		90,880	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		11,331,531	27,298	27,298	164,072	8,836	30
31	Intensive Care Unit		2,164,030	6,374	6,374	11,958	1,625	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,135,594	9,008	9,008	75,315	2,590	50
53	Anesthesiology		13,853	364	364			53
54	Radiology-Diagnostic		2,054,956	8,765	8,765		1,777	54
57	CT Scan		298,454					57
60	Laboratory		2,188,875	6,624	6,624		1,777	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		906,200	2,062	2,062		914	65
66	Physical Therapy		504,905	3,165	3,165		1,549	66
69	Electrocardiology		261,669	576	576			69
70	Electroencephalography		17,608	391	391			70
71	Medical Supplies Charged to Patients		833,447					71
73	Drugs Charged to Patients		1,045,435					73
74	Renal Dialysis		118,621					74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		878,630	3,586	3,586		1,371	76
76.10	PARTIAL HOSPITALIZATION		201,918	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		476,077	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		30					90.05
91	Emergency		3,253,789	8,910	8,910		7,110	91
91.01	GOLDEN LIFE		84,528	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)	-11,295,275	40,603,742	135,349	116,837	251,345	33,947	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		463,629	80	80			194
194.10	AUSTIN PRIDE		3,719					194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		11,295,275		4,823,526	337,388	2,162,020	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.275018		41.255985	1.342330	63.688102	203
204	Cost to be allocated (Per Wkst. B, Part II)		599,029		345,164	45,073	65,104	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.014585		2.952214	0.179327	1.917813	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	68,193						10
11	Cafeteria		31,831					11
12	Maintenance of Personnel							12
13	Nursing Administration		2,180	22,724				13
14	Central Services & Supply		566		100			14
15	Pharmacy					942,599		15
16	Medical Records & Library		1,219				86,134,390	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		154					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	50,550	14,187	14,187		4,294	30,043,968	30
31	Intensive Care Unit	3,051	1,666	1,666		2,745	4,118,400	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,592	638	638		4,657	977,848	50
53	Anesthesiology						123,755	53
54	Radiology-Diagnostic		1,229			157	2,598,664	54
57	CT Scan		193				3,405,317	57
60	Laboratory		1,677			1,337	12,310,946	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,062				4,678,490	65
66	Physical Therapy		547				1,146,832	66
69	Electrocardiology		265			27	2,182,276	69
70	Electroencephalography		15				102,317	70
71	Medical Supplies Charged to Patients				100		3,557,907	71
73	Drugs Charged to Patients					916,573	9,420,249	73
74	Renal Dialysis						170,271	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		1,417	1,417			1,174,784	76
76.10	PARTIAL HOSPITALIZATION		176	176			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		714	714		7,374	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		3,472	3,472		5,435	6,203,848	91
91.01	GOLDEN LIFE		55	55				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)	68,193	31,432	22,325	100	942,599	86,134,390	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		399	399				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)	2,534,541	581,529	3,051,315	1,345,177	1,517,166	1,359,033	202
203	Unit Cost Multiplier (Wkst. B, Part I)	37.167173	18.269266	134.277196	13,451.770000	1.609556	0.015778	203
204	Cost to be allocated (Per Wkst. B, Part II)	137,665	54,736	52,032	210,970	182,388	73,271	204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.018756	1.719582	2.289738	2,109.700000	0.193495	0.000851	205

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)	26,279	122,400					202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.920980	12.240000					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)	1,044	3,304					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.076316	0.330400					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	20,905,891		20,905,891		20,905,891	30
31	Intensive Care Unit	3,578,626		3,578,626		3,578,626	31
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,748,179		2,748,179		2,748,179	50
53	Anesthesiology	34,633		34,633		34,633	53
54	Radiology-Diagnostic	3,158,597		3,158,597		3,158,597	54
57	CT Scan	437,789		437,789		437,789	57
60	Laboratory	3,404,341		3,404,341		3,404,341	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,391,921		1,391,921		1,391,921	65
66	Physical Therapy	901,079		901,079		901,079	66
69	Electrocardiology	396,712		396,712		396,712	69
70	Electroencephalography	40,470		40,470		40,470	70
71	Medical Supplies Charged to Patients	2,463,974		2,463,974		2,463,974	71
73	Drugs Charged to Patients	2,956,857		2,956,857		2,956,857	73
74	Renal Dialysis	153,931		153,931		153,931	74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	1,590,224		1,590,224		1,590,224	76
76.10	PARTIAL HOSPITALIZATION	568,243		568,243		568,243	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	1,018,117		1,018,117		1,018,117	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	1,358		1,358		1,358	90.05
91	Emergency	5,606,125		5,606,125		5,606,125	91
91.01	GOLDEN LIFE	226,855		226,855		226,855	91.01
92	Observation Beds (Non-Distinct Part)	471,791		471,791		471,791	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)	52,055,713		52,055,713		52,055,713	200
201	Less Observation Beds	471,791		471,791		471,791	201
202	Total (line 200 minus line 201)	51,583,922		51,583,922		51,583,922	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	27,661,183		27,661,183				30
31	Intensive Care Unit	4,441,850		4,441,850				31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,503,788	2,042,292	3,546,080	0.774991	0.774991	0.774991	50
53	Anesthesiology	167,180	326,118	493,298	0.070207	0.070207	0.070207	53
54	Radiology-Diagnostic	1,075,840	2,051,128	3,126,968	1.010115	1.010115	1.010115	54
57	CT Scan	645,976	1,677,688	2,323,664	0.188405	0.188405	0.188405	57
60	Laboratory	4,753,676	3,962,935	8,716,611	0.390558	0.390558	0.390558	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,142,581	774,585	4,917,166	0.283074	0.283074	0.283074	65
66	Physical Therapy	314,287	614,893	929,180	0.969757	0.969757	0.969757	66
69	Electrocardiology	1,218,866	872,701	2,091,567	0.189672	0.189672	0.189672	69
70	Electroencephalography	31,926	5,746	37,672	1.074273	1.074273	1.074273	70
71	Medical Supplies Charged to Patients	910,973	1,328,817	2,239,790	1.100092	1.100092	1.100092	71
73	Drugs Charged to Patients	7,516,341	2,051,140	9,567,481	0.309053	0.309053	0.309053	73
74	Renal Dialysis	101,303		101,303	1.519511	1.519511	1.519511	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		507,242	507,242	3.135040	3.135040	3.135040	76
76.10	PARTIAL HOSPITALIZATION		2,480,500	2,480,500	0.229084	0.229084	0.229084	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	59,644	612,580	672,224	1.514550	1.514550	1.514550	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		2,606	2,606	0.521105	0.521105	0.521105	90.05
91	Emergency	3,251,583	7,498,600	10,750,183	0.521491	0.521491	0.521491	91
91.01	GOLDEN LIFE		1,283	1,283	176.816056	176.816056	176.816056	91.01
92	Observation Beds (Non-Distinct Part)	1,275	402,751	404,026	1.167724	1.167724	1.167724	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)	57,798,272	27,213,605	85,011,877				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	57,798,272	27,213,605	85,011,877				202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)	929,100		929,100	19,320	48.09	3,767	181,155	30
31	Intensive Care Unit	176,800		176,800	1,810	97.68	581	56,752	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)	1,105,900		1,105,900	21,130		4,348	237,907	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	240,641	3,546,080	0.067861	553,243	37,544	50
53	Anesthesiology	7,423	493,298	0.015048			53
54	Radiology-Diagnostic	228,752	3,126,968	0.073155	292,470	21,396	54
57	CT Scan	8,981	2,323,664	0.003865	183,703	710	57
60	Laboratory	177,964	8,716,611	0.020417	1,200,569	24,512	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	67,655	4,917,166	0.013759	1,398,429	19,241	65
66	Physical Therapy	72,289	929,180	0.077799	109,746	8,538	66
69	Electrocardiology	18,367	2,091,567	0.008781	407,705	3,580	69
70	Electroencephalography	7,734	37,672	0.205298	7,072	1,452	70
71	Medical Supplies Charged to Pat	227,430	2,239,790	0.101541	282,926	28,729	71
73	Drugs Charged to Patients	206,216	9,567,481	0.021554	2,119,376	45,681	73
74	Renal Dialysis	1,935	101,303	0.019101			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	89,931	507,242	0.177294			76
76.10	PARTIAL HOSPITALIZATION	118,426	2,480,500	0.047743			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	65,425	672,224	0.097326			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	72	2,606	0.027629			90.05
91	Emergency	255,632	10,750,183	0.023779	673,907	16,025	91
91.01	GOLDEN LIFE	51,271	1,283	39.961808			91.01
92	Observation Beds (Non-Distinct	20,967	404,026	0.051895			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,867,111	52,908,844		7,229,146	207,408	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)	19,320		3,767		30
31	Intensive Care Unit	1,810		581		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)	21,130		4,348		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	3,546,080			553,243		579,892		50
53	Anesthesiology	493,298							53
54	Radiology-Diagnostic	3,126,968			292,470		373,550		54
57	CT Scan	2,323,664			183,703		226,461		57
60	Laboratory	8,716,611			1,200,569		315,201		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,917,166			1,398,429		63,081		65
66	Physical Therapy	929,180			109,746				66
69	Electrocardiology	2,091,567			407,705		192,434		69
70	Electroencephalography	37,672			7,072		3,536		70
71	Medical Supplies Charged to Pat	2,239,790			282,926		204,023		71
73	Drugs Charged to Patients	9,567,481			2,119,376		221,212		73
74	Renal Dialysis	101,303							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	507,242					8,899		76
76.10	PARTIAL HOSPITALIZATION	2,480,500							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	672,224					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	2,606							90.05
91	Emergency	10,750,183			673,907		541,162		91
91.01	GOLDEN LIFE	1,283							91.01
92	Observation Beds (Non-Distinct	404,026					100,350		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	52,908,844			7,229,146		2,988,462		200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	0.774991	579,892			449,411			50
53	Anesthesiology	0.070207							53
54	Radiology-Diagnostic	1.010115	373,550			377,328			54
57	CT Scan	0.188405	226,461			42,666			57
60	Laboratory	0.390558	315,201			123,104			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.283074	63,081			17,857			65
66	Physical Therapy	0.969757							66
69	Electrocardiology	0.189672	192,434			36,499			69
70	Electroencephalography	1.074273	3,536			3,799			70
71	Medical Supplies Charged to Pat	1.100092	204,023			224,444			71
73	Drugs Charged to Patients	0.309053	221,212		4,889	68,366		1,511	73
74	Renal Dialysis	1.519511							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	3.135040	8,899			27,899			76
76.10	PARTIAL HOSPITALIZATION	0.229084							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	1.514550	158,661	6		240,300	9		90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	0.521105							90.05
91	Emergency	0.521491	541,162			282,211			91
91.01	GOLDEN LIFE	176.816056							91.01
92	Observation Beds (Non-Distinct	1.167724	100,350			117,181			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		2,988,462	6	4,889	2,011,065	9	1,511	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,988,462	6	4,889	2,011,065	9	1,511	202

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)	929,100		929,100	19,320	48.09	1,843	88,630	30
31	Intensive Care Unit	176,800		176,800	1,810	97.68	75	7,326	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)	1,105,900		1,105,900	21,130		1,918	95,956	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	240,641	3,546,080	0.067861			50
53	Anesthesiology	7,423	493,298	0.015048			53
54	Radiology-Diagnostic	228,752	3,126,968	0.073155			54
57	CT Scan	8,981	2,323,664	0.003865			57
60	Laboratory	177,964	8,716,611	0.020417			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	67,655	4,917,166	0.013759			65
66	Physical Therapy	72,289	929,180	0.077799			66
69	Electrocardiology	18,367	2,091,567	0.008781			69
70	Electroencephalography	7,734	37,672	0.205298			70
71	Medical Supplies Charged to Pat	227,430	2,239,790	0.101541			71
73	Drugs Charged to Patients	206,216	9,567,481	0.021554			73
74	Renal Dialysis	1,935	101,303	0.019101			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	89,931	507,242	0.177294			76
76.10	PARTIAL HOSPITALIZATION	118,426	2,480,500	0.047743			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	65,425	672,224	0.097326			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	72	2,606	0.027629			90.05
91	Emergency	255,632	10,750,183	0.023779			91
91.01	GOLDEN LIFE	51,271	1,283	39.961808			91.01
92	Observation Beds (Non-Distinct	20,967	404,026	0.051895			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,867,111	52,908,844				200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)	19,320		1,843		30
31	Intensive Care Unit	1,810		75		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)	21,130		1,918		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	3,546,080							50
53	Anesthesiology	493,298							53
54	Radiology-Diagnostic	3,126,968							54
57	CT Scan	2,323,664							57
60	Laboratory	8,716,611							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,917,166							65
66	Physical Therapy	929,180							66
69	Electrocardiology	2,091,567							69
70	Electroencephalography	37,672							70
71	Medical Supplies Charged to Pat	2,239,790							71
73	Drugs Charged to Patients	9,567,481							73
74	Renal Dialysis	101,303							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	507,242							76
76.10	PARTIAL HOSPITALIZATION	2,480,500							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	672,224							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	2,606							90.05
91	Emergency	10,750,183							91
91.01	GOLDEN LIFE	1,283							91.01
92	Observation Beds (Non-Distinct	404,026							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	52,908,844							200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.774991							50
53	Anesthesiology	0.070207							53
54	Radiology-Diagnostic	1.010115							54
57	CT Scan	0.188405							57
60	Laboratory	0.390558							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.283074							65
66	Physical Therapy	0.969757							66
69	Electrocardiology	0.189672							69
70	Electroencephalography	1.074273							70
71	Medical Supplies Charged to Pat	1.100092							71
73	Drugs Charged to Patients	0.309053							73
74	Renal Dialysis	1.519511							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	3.135040							76
76.10	PARTIAL HOSPITALIZATION	0.229084							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	1.514550							90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE	0.521105							90.05
91	Emergency	0.521491							91
91.01	GOLDEN LIFE	176.816056							91.01
92	Observation Beds (Non-Distinct	1.167724							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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)	19,320	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,320	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)	18,884	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)	3,767	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)	20,905,891	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)	20,905,891	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)	20,905,891	37

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)					1,082.09	38
39	Program general inpatient routine service cost (line 9 x line 38)					4,076,233	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)					4,076,233	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	3,578,626	1,810	1,977.14	581	1,148,718	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)					3,132,583	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					8,357,534	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					237,907	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					207,408	51
52	Total Program excludable cost (sum of lines 50 and 51)					445,315	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					7,912,219	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)					436	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,082.09	88
89	Observation bed cost (line 87 x line 88) (see instructions)					471,791	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	929,100	20,905,891	0.044442	471,791	20,967	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,320	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,320	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)	18,884	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)	1,843	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)	20,905,891	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)	20,905,891	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)	20,905,891	37

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

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[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)					1,082.09	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,994,292	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)					1,994,292	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	3,578,626	1,810	1,977.14	75	148,286	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)					2,142,578	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					95,956	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)					95,956	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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					436	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		5,023,286		30
31	Intensive Care Unit		1,423,450		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.774991	553,243	428,758	50
53	Anesthesiology	0.070207			53
54	Radiology-Diagnostic	1.010115	292,470	295,428	54
57	CT Scan	0.188405	183,703	34,611	57
60	Laboratory	0.390558	1,200,569	468,892	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.283074	1,398,429	395,859	65
66	Physical Therapy	0.969757	109,746	106,427	66
69	Electrocardiology	0.189672	407,705	77,330	69
70	Electroencephalography	1.074273	7,072	7,597	70
71	Medical Supplies Charged to Patients	1.100092	282,926	311,245	71
73	Drugs Charged to Patients	0.309053	2,119,376	655,000	73
74	Renal Dialysis	1.519511			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	3.135040			76
76.10	PARTIAL HOSPITALIZATION	0.229084			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	1.514550			90
90.01	CICERO CLINIC				90.01
90.02	YMCA CLINIC				90.02
90.03	NORTH AVENUE CLINIC				90.03
90.04	CLINIC #4				90.04
90.05	WOUND CARE	0.521105			90.05
91	Emergency	0.521491	673,907	351,436	91
91.01	GOLDEN LIFE	176.816056			91.01
92	Observation Beds (Non-Distinct Part)	1.167724			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		7,229,146	3,132,583	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		7,229,146		202

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	0.774991			50
53	Anesthesiology	0.070207			53
54	Radiology-Diagnostic	1.010115			54
57	CT Scan	0.188405			57
60	Laboratory	0.390558			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.283074			65
66	Physical Therapy	0.969757			66
69	Electrocardiology	0.189672			69
70	Electroencephalography	1.074273			70
71	Medical Supplies Charged to Patients	1.100092			71
73	Drugs Charged to Patients	0.309053			73
74	Renal Dialysis	1.519511			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	3.135040			76
76.10	PARTIAL HOSPITALIZATION	0.229084			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	1.514550			90
90.01	CICERO CLINIC				90.01
90.02	YMCA CLINIC				90.02
90.03	NORTH AVENUE CLINIC				90.03
90.04	CLINIC #4				90.04
90.05	WOUND CARE	0.521105			90.05
91	Emergency	0.521491			91
91.01	GOLDEN LIFE	176.816056			91.01
92	Observation Beds (Non-Distinct Part)	1.167724			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)	1,113,066			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,339,198			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)	536,942			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)	120.81			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	1.50			11
12	Current year allowable FTE (see instructions)	1.50			12
13	Total allowable FTE count for the prior year	2.00			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	3.00			14
15	Sum of lines 12 through 14 divided by 3	2.17			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	2.17			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.017962			19
20	Prior year resident to bed ratio (see instructions)	0.012926			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.012926			21
22	IME payment adjustment (see instructions)	31,344			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)	31,344			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)	0.2517			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.6328			31
32	Sum of lines 30 and 31	0.8845			32
33	Allowable disproportionate share percentage (see instructions)	0.6219			33
34	Disproportionate share adjustment (see instructions)	692,216			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)	6,406,145,534			35
35.01	Factor 3 (see instructions)	0.000383450		0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,456,437		2,756,356	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	617,465		2,061,603	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,679,068			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)	8,391,834			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)	8,391,834			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	443,760			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)	37,319			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)	8,872,913			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	8,872,913			61
62	Deductibles billed to program beneficiaries	451,388			62
63	Coinsurance billed to program beneficiaries	119,630			63
64	Allowable bad debts (see instructions)	357,530			64
65	Adjusted reimbursable bad debts (see instructions)	232,395			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	227,495			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,534,290			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)	-2,985			70.93
70.94	HRR adjustment amount (see instructions)	-10,987			70.94
71	Amount due provider (see instructions)	8,520,318			71
71.01	Sequestration adjustment (see instructions)	170,406			71.01
72	Interim payments	7,214,688			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	1,135,224			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	230,627			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

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)	1,520			1
2	Medical and other services reimbursed under OPPS (see instructions)	2,011,065			2
3	PPS payments	748,165			3
4	Outlier payment (see instructions)	320,413			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)	1,520			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	4,895			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)	4,895			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	4,895			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	3,375			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)	1,520			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)	1,068,578			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	172,332			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)	897,766			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	8,987			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	906,753			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	906,753			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)	70,501			34
35	Adjusted reimbursable bad debts (see instructions)	45,826			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,055			36
37	Subtotal (see instructions)	952,579			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)	952,579			40
40.01	Sequestration adjustment (see instructions)	19,052			40.01
41	Interim payments	953,666			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-20,139			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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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				7,163,667		928,562	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	01/26/2017	51,021	01/26/2017	25,104	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					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		51,021		25,104	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)				7,214,688		953,666	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		1,135,224			6.01
	based on the cost report (1)		.02				-20,139	6.02
7	Total Medicare program liability (see instructions)				8,349,912		933,527	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.

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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)	3,604	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	4,348	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	425	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	20,694	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	85,011,877	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	888,950	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)	145,163	8
9	Sequestration adjustment amount (see instructions)	2,903	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	142,260	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	142,260	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

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

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[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	2,142,578		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,142,578		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,142,578		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)	2,142,578		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)	2,142,578		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		1.25		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.00	1.25		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	2.08		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.00	2.08		17
18	Per resident amount	96,004.52	97,751.38		18
19	Approved amount for resident costs		203,323	203,323	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)			203,323	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	4,348	425		26
27	Total inpatient days (see instructions)	20,694	20,694		27
28	Ratio of inpatient days to total inpatient days	0.210109	0.020537		28
29	Program direct GME amount	42,720	4,176		29
30	Reduction for direct GME payments for Medicare Advantage		590		30
31	Net Program direct GME amount			46,306	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)			101,303	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)			8,357,534	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)			8,357,534	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			2,012,585	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			2,012,585	44
45	Total reasonable cost (sum of lines 41 and 44)			10,370,119	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.805925	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.194075	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			46,306	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			37,319	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			8,987	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
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
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
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
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)	1,918	7,686		26
27	Total inpatient days (see instructions)	20,694	20,694		27
28	Ratio of inpatient days to total inpatient days	0.092684	0.371412		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	4,067,455				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	31,340,955				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-16,251,440				6
7	Inventory	499,142				7
8	Prepaid expenses	387,233				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	20,043,345				11
	FIXED ASSETS					
12	Land	429,028				12
13	Land improvements	52,143				13
14	Accumulated depreciation	-26,084				14
15	Buildings	40,267,770				15
16	Accumulated depreciation	-15,866,283				16
17	Leasehold improvements	83,192				17
18	Accumulated depreciation	-82,952				18
19	Fixed equipment	11,420,610				19
20	Accumulated depreciation	-6,503,355				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)	29,774,069				30
	OTHER ASSETS					
31	Investments	7,155,253				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,065,829				34
35	Total other assets (sum of lines 31-34)	8,221,082				35
36	Total assets (sum of lines 11, 30 and 35)	58,038,496				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	4,027,801				37
38	Salaries, wages and fees payable	3,610,985				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)	7,638,786				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	2,068,003				49
50	Total long term liabilities (sum of lines 46 thru 49)	2,068,003				50
51	Total liabilities (sum of lines 45 and 50)	9,706,789				51
	CAPITAL ACCOUNTS					
52	General fund balance	48,331,707				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)	48,331,707				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	58,038,496				60

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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		47,850,047			1
2	Net income (loss) (from Worksheet G-3, line 29)		360,199			2
3	Total (sum of line 1 and line 2)		48,210,246			3
4	Additions (credit adjustments) (specify)	121,461				4
5	NET ASSETS RELEASED					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		121,461			10
11	Subtotal (line 3 plus line 10)		48,331,707			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)		48,331,707			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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	26,554,913		26,554,913	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)	26,554,913		26,554,913	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	4,490,850		4,490,850	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)	4,490,850		4,490,850	16
17	Total inpatient routine care services (sum of lines 10 and 16)	31,045,763		31,045,763	17
18	Ancillary services	25,593,643	28,271,499	53,865,142	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)	56,639,406	28,271,499	84,910,905	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		63,642,288	29
30	Add (specify)			30
31	BAD DEBTS	4,323,392		31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		4,323,392	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)		67,965,680	43

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	84,910,905	1
2	Less contractual allowances and discounts on patients' accounts	24,629,085	2
3	Net patient revenues (line 1 minus line 2)	60,281,820	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	67,965,680	4
5	Net income from service to patients (line 3 minus line 4)	-7,683,860	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	198,913	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	8,006	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	4,084	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER INCOME)	905	24
24.01	Other (OTHER MISC)	7,832,151	24.01
25	Total other income (sum of lines 6-24)	8,044,059	25
26	Total (line 5 plus line 25)	360,199	26
29	Net income (or loss) for the period (line 26 minus line 28)	360,199	29

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 07:48 Version: 2017.10 (11/19/2017)

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	359,528	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	9,810	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)	56.70	3
4	Number of interns & residents (see instructions)	2.17	4
5	Indirect medical education percentage (see instructions)	1.09	5
6	Indirect medical education adjustment (see instructions)	3,919	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2517	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.6328	8
9	Sum of lines 7 and 8	0.8845	9
10	Allowable disproportionate share percentage (see instructions)	0.1961	10
11	Disproportionate share adjustment (see instructions)	70,503	11
12	Total prospective capital payments (see instructions)	443,760	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH							76
76.10	PARTIAL HOSPITALIZATION							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	CICERO CLINIC							90.01
90.02	YMCA CLINIC							90.02
90.03	NORTH AVENUE CLINIC							90.03
90.04	CLINIC #4							90.04
90.05	WOUND CARE							90.05
91	Emergency							91
91.01	GOLDEN LIFE							91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS							194
194.10	AUSTIN PRIDE							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202