LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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: 11/20/2018 Time: 11:06 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 CHIEF FINANCIAL 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 07/01/2017 and ending 06/30/2018, 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.

[_] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief Financial 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		809,784	32,278			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		809,784	32,278			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.

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 / 2017	To: 06 / 30 / 2018	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.	2,109	776			9,614	61	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)(i) or (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)(i) or (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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 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 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a 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

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110
		1	2
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.		111

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:	1,891,667			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 care related taxes as defined in §1983(w)(3) of the Act? 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 in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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.	N		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)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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	10/25/2018	Y	10/25/2018	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: JOHN	Last name: MORALES	Title: CONTROLLER	41
42	Employer: LORETTO HOSPITAL			42
43	Phone number: 773-854-5567	E-mail Address: JOHN.MORALES@LORETTOHOSPITAL.ORG		43

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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			4,171	2,732	19,112	1
2	HMO and other (see instructions)						1,734	9,614		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			4,171	2,732	19,112	7
8	Intensive Care Unit	31	12	4,380			782	153	2,052	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			4,953	2,885	21,164	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								620	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
33.01	LTCH site neutral days and discharges									33.01

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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)					723	545	3,812	1
2	HMO and other (see instructions)					281	2,028		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)	1.66	487.19			723	545	3,812	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)	1.66	487.19						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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	30,642,941		30,642,941	1,013,357.98	30.24	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	76,479		76,479	3,200.00	23.90	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)		295,543		295,543	7,152.00	41.32	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)		5,347,908		5,347,908			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		52,213		52,213			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)		13,511		13,511			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		247,252		247,252	7,877.28	31.39	26
27	Administrative & General		6,391,750		6,391,750	174,142.22	36.70	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		1,344,920		1,344,920	40,598.98	33.13	30
31	Laundry & Linen Service		35,824		35,824	2,286.15	15.67	31
32	Housekeeping		711,295		711,295	51,995.61	13.68	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		631,708	-154,583	477,125	36,656.35	13.02	34
35	Dietary under contract (see instructions)							35
36	Cafeteria		148	154,583	154,731	9,664.94	16.01	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,759,924		1,759,924	45,862.97	38.37	38
39	Central Services and Supply		232,148		232,148	12,398.33	18.72	39
40	Pharmacy		725,937		725,937	18,177.76	39.94	40
41	Medical Records & Medical Records Library		607,584		607,584	24,496.53	24.80	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		30,566,462		30,566,462	1,010,157.98	30.26	1
2	Excluded area salaries (see instructions)		295,543		295,543	7,152.00	41.32	2
3	Subtotal salarles (line 1 minus line 2)		30,270,919		30,270,919	1,003,005.98	30.18	3
4	Subtotal other wages & related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)		5,347,908		5,347,908		17.67%	5
6	Total (sum of lines 3 through 5)		35,618,827		35,618,827	1,003,005.98	35.51	6
7	Total overhead cost (see instructions)		12,688,490		12,688,490	424,157.12	29.91	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)	443,895	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)	1,759,058	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)	168,668	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	-24	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	406,439	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	2,327,047	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	173,993	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	134,555	23
24	Total Wage Related cost (Sum of lines 1-23)	5,413,631	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

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)	0.553737	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	7,423,685	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 and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	7,683,703	5
6	Medicaid charges	20,013,551	6
7	Medicaid cost (line 1 times line 6)	11,082,244	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

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)		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)	1,868,523		1,868,523	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,034,670		1,034,670	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)	1,034,670		1,034,670	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)	6,266,133	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	468,265	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	720,408	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,545,725	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,323,016	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	4,357,686	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,357,686	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		2,786,435	2,786,435	-497,605	2,288,830	-45,945	2,242,885	1
2	00200	Cap Rel Costs-Mvble Equip				636,479	636,479		636,479	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	247,252	3,147,733	3,394,985		3,394,985		3,394,985	4
5.01	01160	COMMUNICATIONS	162,630	142,738	305,368		305,368		305,368	5.01
5.04	00570	ADMITTING	102,163	12,612	114,775		114,775		114,775	5.04
5.05	00580	BUSINESS OFFICE	705,426	286,269	991,695		991,695		991,695	5.05
5.06	00590	OTHER ADMINISTRATIVE	5,421,531	13,001,850	18,423,381	-138,874	18,284,507	-8,128,297	10,156,210	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,344,920	1,982,412	3,327,332		3,327,332		3,327,332	7
8	00800	Laundry & Linen Service	35,824	305,250	341,074		341,074		341,074	8
9	00900	Housekeeping	711,295	583,751	1,295,046		1,295,046		1,295,046	9
10	01000	Dietary	631,708	1,491,464	2,123,172	-425,881	1,697,291		1,697,291	10
11	01100	Cafeteria	148	203	351	425,881	426,232	-173,403	252,829	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,759,924	240,056	1,999,980		1,999,980		1,999,980	13
14	01400	Central Services & Supply	232,148	260,398	492,546	-67,357	425,189		425,189	14
15	01500	Pharmacy	725,937	1,142,703	1,868,640	-916,573	952,067		952,067	15
16	01600	Medical Records & Library	607,584	253,433	861,017		861,017		861,017	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	76,479	9,080	85,559		85,559		85,559	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	8,588,314	1,812,387	10,400,701		10,400,701	-703,007	9,697,694	30
31	03100	Intensive Care Unit	1,412,092	612,629	2,024,721		2,024,721	-82,669	1,942,052	31
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	589,648	597,960	1,187,608	-187,738	999,870	-10,968	988,902	50
53	05300	Anesthesiology		438,500	438,500		438,500	-438,333	167	53
54	05400	Radiology-Diagnostic	912,658	1,035,119	1,947,777		1,947,777	-225,475	1,722,302	54
57	05700	CT Scan	165,666	123,058	288,724		288,724		288,724	57
60	06000	Laboratory	980,915	928,659	1,909,574		1,909,574		1,909,574	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	596,601	120,159	716,760	-43,210	673,550		673,550	65
66	06600	Physical Therapy	343,768	68,908	412,676	-2,287	410,389		410,389	66
69	06900	Electrocardiology	159,885	51,795	211,680		211,680		211,680	69
70	07000	Electroencephalography	10,671	1,063	11,734		11,734		11,734	70
71	07100	Medical Supplies Charged to Patients				384,674	384,674		384,674	71
73	07300	Drugs Charged to Patients				916,573	916,573		916,573	73
74	07400	Renal Dialysis		132,996	132,996		132,996		132,996	74
75.01	07501	HYBERBARIC CHAMBER								75.01
76	03550	O/P MENTAL HEALTH	702,666	252,224	954,890		954,890	-193,300	761,590	76
76.10	03950	PARTIAL HOSPITALIZATION	38,419	5,857	44,276		44,276		44,276	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	465,180	368,706	833,886		833,886	-279,832	554,054	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	2,580,361	2,001,150	4,581,511	-84,082	4,497,429	-1,436,100	3,061,329	91
91.01	09101	GOLDEN LIFE	35,585	2,889	38,474		38,474		38,474	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)	30,347,398	34,200,446	64,547,844		64,547,844	-11,717,329	52,830,515	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PUBLIC RELATIONS	295,543	102,010	397,553		397,553		397,553	194
194.10	07951	AUSTIN PRIDE		597	597		597		597	194.10
200		TOTAL (sum of lines 118-199)	30,642,941	34,303,053	64,945,994		64,945,994	-11,717,329	53,228,665	200

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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		384,674	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					384,674	500
	Code Letter - E						
1	CAPITAL INSURANCE EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		85,615	1
2			Cap Rel Costs-Mvble Equip	2		53,259	2
500	Total reclassifications					138,874	500
	Code Letter - F						
	GRAND TOTAL (Increases)				154,583	2,294,639	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DRUGS SOLD	A	Pharmacy	15		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		187,738		1
2			Respiratory Therapy	65		43,210		2
3			Emergency	91		84,082		3
4			Physical Therapy	66		2,287		4
5								5
6								6
7								7
8			Central Services & Supply	14		67,357		8
500	Total reclassifications					384,674		500
	Code letter - E							
1	CAPITAL INSURANCE EXPENSE	F	OTHER ADMINISTRATIVE	5.06		138,874	12	1
2							12	2
500	Total reclassifications					138,874		500
	Code letter - F							
	GRAND TOTAL (Decreases)				154,583	2,294,639		

(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	52,143					52,143		2
3	Buildings and Fixtures	40,267,770	1,135,679		1,135,679		41,403,449		3
4	Building Improvements								4
5	Fixed Equipment	11,420,610	21,090		21,090		11,441,700		5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	52,169,551	1,156,769		1,156,769		53,326,320		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	52,169,551	1,156,769		1,156,769		53,326,320		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	2,657,413		129,022				2,786,435	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	2,657,413		129,022				2,786,435	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	41,884,620		41,884,620	0.785440					1
2	Cap Rel Costs-Mvble Equ	11,441,700		11,441,700	0.214560					2
3	Total (sum of lines 1-2)	53,326,320		53,326,320	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	2,028,248		129,022	85,615			2,242,885	1
2	Cap Rel Costs-Mvble Equip	583,220			53,259			636,479	2
3	Total (sum of lines 1-2)	2,611,468		129,022	138,874			2,879,364	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	-3,776,786				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	-171,601	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 and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-1,802	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	-10,968	Operating Room	50		35
36							36
37	LOBBYING EXPENSES	A	-26,049	OTHER ADMINISTRATIVE	5.06		37
38	RENTAL INCOME	B	-43,663	Cap Rel Costs-Bldg & Fixt	1	9	38
39	MEDICAID TAX ASSESSMENT	A	-7,683,703	OTHER ADMINISTRATIVE	5.06		39
40							40
41							41
42	MISC INCOME	B	-475	Radiology-Diagnostic	54		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)		-11,717,329				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.

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	703,007	703,007						1
2	31	Intensive Care Unit AGGREGATE	82,669	82,669						2
3	53	Anesthesiology AGGREGATE	438,333	438,333						3
4	54	Radiology-Diagnostic AGGREGATE	225,000	225,000						4
5										5
6	76	O/P MENTAL HEALTH AGGREGATE	193,300	193,300						6
7	91	Emergency AGGREGATE	1,436,100	1,436,100						7
8	90	Clinic AGGREGATE	279,832	279,832						8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE	418,545	418,545						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	3,776,786	3,776,786						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							703,007	1
2	31	Intensive Care Unit AGGREGATE							82,669	2
3	53	Anesthesiology AGGREGATE							438,333	3
4	54	Radiology-Diagnostic AGGREGATE							225,000	4
5										5
6	76	O/P MENTAL HEALTH AGGREGATE							193,300	6
7	91	Emergency AGGREGATE							1,436,100	7
8	90	Clinic AGGREGATE							279,832	8
9	5.06	OTHER ADMINISTRATIVE AGGREGATE							418,545	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							3,776,786	200

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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	2,242,885	2,242,885					1
2	Cap Rel Costs-Mvble Equip	636,479		636,479				2
4	Employee Benefits Department	3,394,985	13,827	3,924	3,412,736			4
5.01	COMMUNICATIONS	305,368	13,412	3,806	18,260	340,846		5.01
5.04	ADMITTING	114,775	1,733	492	11,471	3,262	131,733	5.04
5.05	BUSINESS OFFICE	991,695	37,009	10,502	79,203	4,893		5.05
5.06	OTHER ADMINISTRATIVE	10,156,210	476,167	135,127	608,713	96,215		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	3,327,332	232,476	65,971	151,004	4,893		7
8	Laundry & Linen Service	341,074	28,545	8,100	4,022	1,631		8
9	Housekeeping	1,295,046	27,666	7,851	79,862	1,631		9
10	Dietary	1,697,291	73,402	20,830	53,570	8,154		10
11	Cafeteria	252,829	31,684	8,991	17,373	4,893		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,999,980	8,351	2,370	197,599	16,308		13
14	Central Services & Supply	425,189	134,146	38,068	26,065	4,893		14
15	Pharmacy	952,067	15,220	4,319	81,506	3,262		15
16	Medical Records & Library	861,017	37,913	10,759	68,218	11,416		16
17	Social Service					11,416		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	85,559	1,130	321	8,587			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,697,694	342,812	97,282	964,269	24,463	58,815	30
31	Intensive Care Unit	1,942,052	80,046	22,715	158,545	8,154	11,140	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	988,902	113,124	32,102	66,204	30,986	3,186	50
53	Anesthesiology	167	4,571	1,297		1,631	265	53
54	Radiology-Diagnostic	1,722,302	110,072	31,236	102,471	13,047	2,293	54
57	CT Scan	288,724			18,600		1,431	57
60	Laboratory	1,909,574	83,185	23,606	110,134	9,785	12,482	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	673,550	25,895	7,348	66,985	3,262	11,444	65
66	Physical Therapy	410,389	39,747	11,279	38,597	11,416	820	66
69	Electrocardiology	211,680	7,233	2,053	17,951	4,893	2,780	69
70	Electroencephalography	11,734	4,910	1,393	1,198	1,631	28	70
71	Medical Supplies Charged to Patients	384,674					1,611	71
73	Drugs Charged to Patients	916,573					16,925	73
74	Renal Dialysis	132,996					236	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	761,590	45,034	12,779	78,893	11,416		76
76.10	PARTIAL HOSPITALIZATION	44,276	75,261	21,357	4,314	3,262		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	554,054	31,722	9,002	52,229	11,416	161	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	3,061,329	111,893	31,753	289,715	27,724	8,116	91
91.01	GOLDEN LIFE	38,474	33,694	9,561	3,995			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)	52,830,515	2,241,880	636,194	3,379,553	335,953	131,733	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	397,553	1,005	285	33,183	1,631		194
194.10	AUSTIN PRIDE	597				3,262		194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	53,228,665	2,242,885	636,479	3,412,736	340,846	131,733	202

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

	COST CENTER DESCRIPTIONS	BUSINESS OFFICE	SUBTOTAL (cols.0-4)	OTHER ADMINISTRV & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.05	4A	5.06	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	COMMUNICATIONS							5.01
5.04	ADMITTING							5.04
5.05	BUSINESS OFFICE	1,123,302						5.05
5.06	OTHER ADMINISTRATIVE		11,472,432	11,472,432				5.06
6	Maintenance & Repairs							6
7	Operation of Plant		3,781,676	1,039,008	4,820,684			7
8	Laundry & Linen Service		383,372	105,331	93,720	582,423		8
9	Housekeeping		1,412,056	387,960	90,833		1,890,849	9
10	Dietary		1,853,247	509,176	240,999		16,989	10
11	Cafeteria		315,770	86,757	104,028		98,979	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,224,608	611,207	27,419			13
14	Central Services & Supply		628,361	172,641	440,437		50,910	14
15	Pharmacy		1,056,374	290,237	49,973		22,614	15
16	Medical Records & Library		989,323	271,815	124,478		16,989	16
17	Social Service		11,416	3,137			8,466	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		95,597	26,265	3,711			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	384,941	11,570,276	3,178,900	1,125,541	380,193	492,165	30
31	Intensive Care Unit	59,521	2,282,173	627,022	262,811	27,709	90,513	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	36,306	1,270,810	349,153	371,415	174,521	144,263	50
53	Anesthesiology	3,479	11,410	3,135	15,008			53
54	Radiology-Diagnostic	37,124	2,018,545	554,591	361,396		98,979	54
57	CT Scan	29,440	338,195	92,918				57
60	Laboratory	127,463	2,276,229	625,389	273,119		98,979	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	70,676	859,160	236,052	85,020		50,910	65
66	Physical Therapy	10,463	522,711	143,614	130,498		86,279	66
69	Electrocardiology	28,555	275,145	75,596	23,749			69
70	Electroencephalography	207	21,101	5,797	16,122			70
71	Medical Supplies Charged to Patients	23,162	409,447	112,495				71
73	Drugs Charged to Patients	118,836	1,052,334	289,127				73
74	Renal Dialysis	1,260	134,492	36,951				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	7,495	917,207	252,001	147,857		76,365	76
76.10	PARTIAL HOSPITALIZATION	30,600	179,070	49,199	247,101			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	7,498	666,082	183,005	104,151		141,422	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	146,276	3,676,806	1,010,195	367,374		396,027	91
91.01	GOLDEN LIFE		85,724	23,552	110,625			91.01
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,123,302	52,791,149	11,352,226	4,817,385	582,423	1,890,849	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		433,657	119,146	3,299			194
194.10	AUSTIN PRIDE		3,859	1,060				194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,123,302	53,228,665	11,472,432	4,820,684	582,423	1,890,849	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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	2,620,411						10
11	Cafeteria		605,534					11
12	Maintenance of Personnel							12
13	Nursing Administration		41,332	2,904,566				13
14	Central Services & Supply		11,172		1,303,521			14
15	Pharmacy					1,419,198		15
16	Medical Records & Library	4,894	22,081				1,429,580	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,316	3,112					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,902,063	268,165	2,521,154		5,428	489,879	30
31	Intensive Care Unit	9,221	29,204	274,598		4,363	75,751	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		11,566	108,814		8,360	46,206	50
53	Anesthesiology						4,427	53
54	Radiology-Diagnostic	31,770	22,325			432	47,247	54
57	CT Scan		4,105				37,468	57
60	Laboratory	3,802	32,241				162,220	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,707				89,949	65
66	Physical Therapy	66,075	10,141				13,316	66
69	Electrocardiology		5,005			33	36,342	69
70	Electroencephalography		356				263	70
71	Medical Supplies Charged to Patients				1,303,521		29,478	71
73	Drugs Charged to Patients					1,362,798	151,241	73
74	Renal Dialysis						1,604	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	227,942	27,255			74	9,538	76
76.10	PARTIAL HOSPITALIZATION		1,931				38,944	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	50,081	19,645			20,870	9,543	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	274,264	69,731			16,840	186,164	91
91.01	GOLDEN LIFE	28,973	1,012					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)	2,601,401	599,086	2,904,566	1,303,521	1,419,198	1,429,580	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	19,010	6,448					194
194.10	AUSTIN PRIDE							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,620,411	605,534	2,904,566	1,303,521	1,419,198	1,429,580	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	23,019						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		131,001					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	21,794	131,001	22,086,559	-131,001	21,955,558		30
31	Intensive Care Unit			3,683,365		3,683,365		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			2,485,108		2,485,108		50
53	Anesthesiology			33,980		33,980		53
54	Radiology-Diagnostic			3,135,285		3,135,285		54
57	CT Scan			472,686		472,686		57
60	Laboratory			3,471,979		3,471,979		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			1,339,798		1,339,798		65
66	Physical Therapy			972,634		972,634		66
69	Electrocardiology			415,870		415,870		69
70	Electroencephalography			43,639		43,639		70
71	Medical Supplies Charged to Patients			1,854,941		1,854,941		71
73	Drugs Charged to Patients			2,855,500		2,855,500		73
74	Renal Dialysis			173,047		173,047		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			1,658,239		1,658,239		76
76.10	PARTIAL HOSPITALIZATION			516,245		516,245		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	525		1,195,324		1,195,324		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	700		5,998,101		5,998,101		91
91.01	GOLDEN LIFE			249,886		249,886		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)	23,019	131,001	52,642,186	-131,001	52,511,185		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			581,560		581,560		194
194.10	AUSTIN PRIDE			4,919		4,919		194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	23,019	131,001	53,228,665	-131,001	53,097,664		202

	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	1,909	13,827	3,924	19,660	19,660		4
5.01	COMMUNICATIONS	408	13,412	3,806	17,626	105	17,731	5.01
5.04	ADMITTING	157	1,733	492	2,382	66	170	5.04
5.05	BUSINESS OFFICE	5,985	37,009	10,502	53,496	456	255	5.05
5.06	OTHER ADMINISTRATIVE	80,259	476,167	135,127	691,553	3,508	5,000	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	353	232,476	65,971	298,800	870	255	7
8	Laundry & Linen Service		28,545	8,100	36,645	23	85	8
9	Housekeeping		27,666	7,851	35,517	460	85	9
10	Dietary		73,402	20,830	94,232	309	424	10
11	Cafeteria		31,684	8,991	40,675	100	255	11
12	Maintenance of Personnel							12
13	Nursing Administration		8,351	2,370	10,721	1,139	848	13
14	Central Services & Supply	1,567	134,146	38,068	173,781	150	255	14
15	Pharmacy	141,813	15,220	4,319	161,352	470	170	15
16	Medical Records & Library	955	37,913	10,759	49,627	393	594	16
17	Social Service						594	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		1,130	321	1,451	49		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,001	342,812	97,282	441,095	5,552	1,273	30
31	Intensive Care Unit		80,046	22,715	102,761	914	424	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	80,799	113,124	32,102	226,025	382	1,612	50
53	Anesthesiology		4,571	1,297	5,868		85	53
54	Radiology-Diagnostic	24,669	110,072	31,236	165,977	590	679	54
57	CT Scan					107		57
60	Laboratory	1,165	83,185	23,606	107,956	635	509	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,952	25,895	7,348	42,195	386	170	65
66	Physical Therapy	619	39,747	11,279	51,645	222	594	66
69	Electrocardiology		7,233	2,053	9,286	103	255	69
70	Electroencephalography		4,910	1,393	6,303	7	85	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	422	45,034	12,779	58,235	455	594	76
76.10	PARTIAL HOSPITALIZATION		75,261	21,357	96,618	25	170	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		31,722	9,002	40,724	301	594	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	683	111,893	31,753	144,329	1,669	1,442	91
91.01	GOLDEN LIFE		33,694	9,561	43,255	23		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)	351,716	2,241,880	636,194	3,229,790	19,469	17,476	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	749	1,005	285	2,039	191	85	194
194.10	AUSTIN PRIDE						170	194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	352,465	2,242,885	636,479	3,231,829	19,660	17,731	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	2,618						5.04
5.05	BUSINESS OFFICE		54,207					5.05
5.06	OTHER ADMINISTRATIVE			700,061				5.06
6	Maintenance & Repairs							6
7	Operation of Plant			63,400	363,325			7
8	Laundry & Linen Service			6,427	7,063	50,243		8
9	Housekeeping			23,673	6,846		66,581	9
10	Dietary			31,070	18,164		598	10
11	Cafeteria			5,294	7,840		3,485	11
12	Maintenance of Personnel							12
13	Nursing Administration			37,296	2,067			13
14	Central Services & Supply			10,534	33,195		1,793	14
15	Pharmacy			17,710	3,766		796	15
16	Medical Records & Library			16,586	9,382		598	16
17	Social Service			191			298	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			1,603	280			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,171	18,550	193,993	84,828	32,798	17,331	30
31	Intensive Care Unit	221	2,874	38,261	19,807	2,390	3,187	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	63	1,753	21,305	27,993	15,055	5,080	50
53	Anesthesiology	5	168	191	1,131			53
54	Radiology-Diagnostic	46	1,793	33,841	27,238		3,485	54
57	CT Scan	28	1,422	5,670				57
60	Laboratory	248	6,155	38,161	20,584		3,485	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	227	3,413	14,404	6,408		1,793	65
66	Physical Therapy	16	505	8,763	9,835		3,038	66
69	Electrocardiology	55	1,379	4,613	1,790			69
70	Electroencephalography	1	10	354	1,215			70
71	Medical Supplies Charged to Patients	32	1,119	6,864				71
73	Drugs Charged to Patients	336	5,739	17,642				73
74	Renal Dialysis	5	61	2,255				74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		362	15,377	11,144		2,689	76
76.10	PARTIAL HOSPITALIZATION		1,478	3,002	18,624			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	3	362	11,167	7,850		4,980	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	161	7,064	61,642	27,688		13,945	91
91.01	GOLDEN LIFE			1,437	8,338			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)	2,618	54,207	692,726	363,076	50,243	66,581	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			7,270	249			194
194.10	AUSTIN PRIDE			65				194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,618	54,207	700,061	363,325	50,243	66,581	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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	144,797						10
11	Cafeteria		57,649					11
12	Maintenance of Personnel							12
13	Nursing Administration		3,935	56,006				13
14	Central Services & Supply		1,064		220,772			14
15	Pharmacy					184,264		15
16	Medical Records & Library	270	2,102				79,552	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	128	296					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	105,104	25,532	48,613		705	27,253	30
31	Intensive Care Unit	510	2,780	5,295		567	4,216	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,101	2,098		1,085	2,572	50
53	Anesthesiology						246	53
54	Radiology-Diagnostic	1,756	2,125			56	2,630	54
57	CT Scan		391				2,085	57
60	Laboratory	210	3,069				9,028	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,781				5,006	65
66	Physical Therapy	3,651	965				741	66
69	Electrocardiology		476			4	2,023	69
70	Electroencephalography		34				15	70
71	Medical Supplies Charged to Patients				220,772		1,641	71
73	Drugs Charged to Patients					176,941	8,417	73
74	Renal Dialysis						89	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	12,595	2,595			10	531	76
76.10	PARTIAL HOSPITALIZATION		184				2,167	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	2,767	1,870			2,710	531	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	15,155	6,639			2,186	10,361	91
91.01	GOLDEN LIFE	1,601	96					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)	143,747	57,035	56,006	220,772	184,264	79,552	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	1,050	614					194
194.10	AUSTIN PRIDE							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	144,797	57,649	56,006	220,772	184,264	79,552	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	1,083						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		3,807					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,025		1,004,823		1,004,823		30
31	Intensive Care Unit			184,207		184,207		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			306,124		306,124		50
53	Anesthesiology			7,694		7,694		53
54	Radiology-Diagnostic			240,216		240,216		54
57	CT Scan			9,703		9,703		57
60	Laboratory			190,040		190,040		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			75,783		75,783		65
66	Physical Therapy			79,975		79,975		66
69	Electrocardiology			19,984		19,984		69
70	Electroencephalography			8,024		8,024		70
71	Medical Supplies Charged to Patients			230,428		230,428		71
73	Drugs Charged to Patients			209,075		209,075		73
74	Renal Dialysis			2,410		2,410		74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH			104,587		104,587		76
76.10	PARTIAL HOSPITALIZATION			122,268		122,268		76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	25		73,884		73,884		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	33		292,314		292,314		91
91.01	GOLDEN LIFE			54,750		54,750		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)	1,083		3,216,289		3,216,289		118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS			11,498		11,498		194
194.10	AUSTIN PRIDE			235		235		194.10
200	Cross Foot Adjustments		3,807	3,807		3,807		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,083	3,807	3,231,829		3,231,829		202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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	30,395,689				4
5.01	COMMUNICATIONS	1,068	1,068	162,630	209			5.01
5.04	ADMITTING	138	138	102,163	2	59,425,415		5.04
5.05	BUSINESS OFFICE	2,947	2,947	705,426	3		94,830,552	5.05
5.06	OTHER ADMINISTRATIVE	37,917	37,917	5,421,531	59			5.06
6	Maintenance & Repairs							6
7	Operation of Plant	18,512	18,512	1,344,920	3			7
8	Laundry & Linen Service	2,273	2,273	35,824	1			8
9	Housekeeping	2,203	2,203	711,295	1			9
10	Dietary	5,845	5,845	477,125	5			10
11	Cafeteria	2,523	2,523	154,731	3			11
12	Maintenance of Personnel							12
13	Nursing Administration	665	665	1,759,924	10			13
14	Central Services & Supply	10,682	10,682	232,148	3			14
15	Pharmacy	1,212	1,212	725,937	2			15
16	Medical Records & Library	3,019	3,019	607,584	7			16
17	Social Service				7			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	90	90	76,479				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	8,588,314	15	26,534,661	32,495,433	30
31	Intensive Care Unit	6,374	6,374	1,412,092	5	5,024,950	5,024,950	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,008	9,008	589,648	19	1,437,289	3,065,073	50
53	Anesthesiology	364	364		1	119,368	293,698	53
54	Radiology-Diagnostic	8,765	8,765	912,658	8	1,034,202	3,134,134	54
57	CT Scan			165,666		645,660	2,485,430	57
60	Laboratory	6,624	6,624	980,915	6	5,630,295	10,760,878	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,062	2,062	596,601	2	5,161,812	5,966,752	65
66	Physical Therapy	3,165	3,165	343,768	7	369,800	883,310	66
69	Electrocardiology	576	576	159,885	3	1,253,800	2,410,764	69
70	Electroencephalography	391	391	10,671	1	12,781	17,471	70
71	Medical Supplies Charged to Patients					726,779	1,955,455	71
73	Drugs Charged to Patients					7,633,968	10,032,546	73
74	Renal Dialysis					106,372	106,372	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	3,586	3,586	702,666	7		632,722	76
76.10	PARTIAL HOSPITALIZATION	5,993	5,993	38,419	2		2,583,350	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	465,180	7	72,666	633,031	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	8,910	8,910	2,580,361	17	3,661,012	12,349,183	91
91.01	GOLDEN LIFE	2,683	2,683	35,585				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	30,100,146	206	59,425,415	94,830,552	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	80	80	295,543	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)	2,242,885	636,479	3,412,736	340,846	131,733	1,123,302	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.558147	3.563712	0.112277	1,630.842105	0.002217	0.011845	203
204	Cost to be allocated (Per Wkst. B, Part II)			19,660	17,731	2,618	54,207	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000647	84.837321	0.000044	0.000572	205

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	
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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	-11,472,432	41,756,233					5.06
6	Maintenance & Repairs			135,429				6
7	Operation of Plant		3,781,676	18,512	116,917			7
8	Laundry & Linen Service		383,372	2,273	2,273	257,967		8
9	Housekeeping		1,412,056	2,203	2,203		33,947	9
10	Dietary		1,853,247	5,845	5,845		305	10
11	Cafeteria		315,770	2,523	2,523		1,777	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,224,608	665	665			13
14	Central Services & Supply		628,361	10,682	10,682		914	14
15	Pharmacy		1,056,374	1,212	1,212		406	15
16	Medical Records & Library		989,323	3,019	3,019		305	16
17	Social Service		11,416				152	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		95,597	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		11,570,276	27,298	27,298	168,395	8,836	30
31	Intensive Care Unit		2,282,173	6,374	6,374	12,273	1,625	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,270,810	9,008	9,008	77,299	2,590	50
53	Anesthesiology		11,410	364	364			53
54	Radiology-Diagnostic		2,018,545	8,765	8,765		1,777	54
57	CT Scan		338,195					57
60	Laboratory		2,276,229	6,624	6,624		1,777	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		859,160	2,062	2,062		914	65
66	Physical Therapy		522,711	3,165	3,165		1,549	66
69	Electrocardiology		275,145	576	576			69
70	Electroencephalography		21,101	391	391			70
71	Medical Supplies Charged to Patients		409,447					71
73	Drugs Charged to Patients		1,052,334					73
74	Renal Dialysis		134,492					74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		917,207	3,586	3,586		1,371	76
76.10	PARTIAL HOSPITALIZATION		179,070	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		666,082	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							90.05
91	Emergency		3,676,806	8,910	8,910		7,110	91
91.01	GOLDEN LIFE		85,724	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)	-11,472,432	41,318,717	135,349	116,837	257,967	33,947	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS		433,657	80	80			194
194.10	AUSTIN PRIDE		3,859					194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		11,472,432		4,820,684	582,423	1,890,849	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.274748		41.231677	2.257742	55.700032	203
204	Cost to be allocated (Per Wkst. B, Part II)		700,061		363,325	50,243	66,581	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.016765		3.107546	0.194765	1.961322	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	
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	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	59,963						10
11	Cafeteria		32,304					11
12	Maintenance of Personnel							12
13	Nursing Administration		2,205	342,817				13
14	Central Services & Supply		596		100			14
15	Pharmacy					847,634		15
16	Medical Records & Library	112	1,178				94,830,552	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	53	166					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	43,525	14,306	297,564		3,242	32,495,433	30
31	Intensive Care Unit	211	1,558	32,410		2,606	5,024,950	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		617	12,843		4,993	3,065,073	50
53	Anesthesiology						293,698	53
54	Radiology-Diagnostic	727	1,191			258	3,134,134	54
57	CT Scan		219				2,485,430	57
60	Laboratory	87	1,720				10,760,878	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		998				5,966,752	65
66	Physical Therapy	1,512	541				883,310	66
69	Electrocardiology		267			20	2,410,764	69
70	Electroencephalography		19				17,471	70
71	Medical Supplies Charged to Patients				100		1,955,455	71
73	Drugs Charged to Patients					813,948	10,032,546	73
74	Renal Dialysis						106,372	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH	5,216	1,454			44	632,722	76
76.10	PARTIAL HOSPITALIZATION		103				2,583,350	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	1,146	1,048			12,465	633,031	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	6,276	3,720			10,058	12,349,183	91
91.01	GOLDEN LIFE	663	54					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)	59,528	31,960	342,817	100	847,634	94,830,552	118
	NONREIMBURSABLE COST CENTERS							
194	PUBLIC RELATIONS	435	344					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)	2,620,411	605,534	2,904,566	1,303,521	1,419,198	1,429,580	202
203	Unit Cost Multiplier (Wkst. B, Part I)	43.700465	18.744861	8.472643	13,035.210000	1.674305	0.015075	203
204	Cost to be allocated (Per Wkst. B, Part II)	144,797	57,649	56,006	220,772	184,264	79,552	204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.414772	1.784578	0.163370	2,207.720000	0.217386	0.000839	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	
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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)	23,019	131,001					202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.682675	13.100100					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)	1,083	3,807					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.079167	0.380700					205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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	21,955,558		21,955,558		21,955,558	30
31	Intensive Care Unit	3,683,365		3,683,365		3,683,365	31
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,485,108		2,485,108		2,485,108	50
53	Anesthesiology	33,980		33,980		33,980	53
54	Radiology-Diagnostic	3,135,285		3,135,285		3,135,285	54
57	CT Scan	472,686		472,686		472,686	57
60	Laboratory	3,471,979		3,471,979		3,471,979	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,339,798		1,339,798		1,339,798	65
66	Physical Therapy	972,634		972,634		972,634	66
69	Electrocardiology	415,870		415,870		415,870	69
70	Electroencephalography	43,639		43,639		43,639	70
71	Medical Supplies Charged to Patients	1,854,941		1,854,941		1,854,941	71
73	Drugs Charged to Patients	2,855,500		2,855,500		2,855,500	73
74	Renal Dialysis	173,047		173,047		173,047	74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	1,658,239		1,658,239		1,658,239	76
76.10	PARTIAL HOSPITALIZATION	516,245		516,245		516,245	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	1,195,324		1,195,324		1,195,324	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	5,998,101		5,998,101		5,998,101	91
91.01	GOLDEN LIFE	249,886		249,886		249,886	91.01
92	Observation Beds (Non-Distinct Part)	689,868		689,868		689,868	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)	53,201,053		53,201,053		53,201,053	200
201	Less Observation Beds	689,868		689,868		689,868	201
202	Total (line 200 minus line 201)	52,511,185		52,511,185		52,511,185	202

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C**
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	26,534,661		26,534,661				30
31	Intensive Care Unit	5,024,950		5,024,950				31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,437,289	1,627,784	3,065,073	0.810783	0.810783	0.810783	50
53	Anesthesiology	119,368	174,330	293,698	0.115697	0.115697	0.115697	53
54	Radiology-Diagnostic	1,034,202	2,099,932	3,134,134	1.000367	1.000367	1.000367	54
57	CT Scan	645,660	1,839,770	2,485,430	0.190183	0.190183	0.190183	57
60	Laboratory	5,630,295	5,130,583	10,760,878	0.322648	0.322648	0.322648	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,161,812	804,940	5,966,752	0.224544	0.224544	0.224544	65
66	Physical Therapy	369,800	513,510	883,310	1.101124	1.101124	1.101124	66
69	Electrocardiology	1,253,800	1,156,964	2,410,764	0.172505	0.172505	0.172505	69
70	Electroencephalography	12,781	4,690	17,471	2.497796	2.497796	2.497796	70
71	Medical Supplies Charged to Patients	726,779	1,228,676	1,955,455	0.948598	0.948598	0.948598	71
73	Drugs Charged to Patients	7,633,968	2,398,578	10,032,546	0.284624	0.284624	0.284624	73
74	Renal Dialysis	106,372		106,372	1.626810	1.626810	1.626810	74
75.01	HYBERBARIC CHAMBER							75.01
76	O/P MENTAL HEALTH		632,722	632,722	2.620802	2.620802	2.620802	76
76.10	PARTIAL HOSPITALIZATION		2,583,350	2,583,350	0.199835	0.199835	0.199835	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	72,666	560,365	633,031	1.888255	1.888255	1.888255	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	3,661,012	8,688,171	12,349,183	0.485708	0.485708	0.485708	91
91.01	GOLDEN LIFE							91.01
92	Observation Beds (Non-Distinct Part)		5,960,772	5,960,772	0.115735	0.115735	0.115735	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)	59,425,415	35,405,137	94,830,552				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	59,425,415	35,405,137	94,830,552				202

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	22,086,559		22,086,559		22,086,559	30
31	Intensive Care Unit	3,683,365		3,683,365		3,683,365	31
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,485,108		2,485,108		2,485,108	50
53	Anesthesiology	33,980		33,980		33,980	53
54	Radiology-Diagnostic	3,135,285		3,135,285		3,135,285	54
57	CT Scan	472,686		472,686		472,686	57
60	Laboratory	3,471,979		3,471,979		3,471,979	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,339,798		1,339,798		1,339,798	65
66	Physical Therapy	972,634		972,634		972,634	66
69	Electrocardiology	415,870		415,870		415,870	69
70	Electroencephalography	43,639		43,639		43,639	70
71	Medical Supplies Charged to Patients	1,854,941		1,854,941		1,854,941	71
73	Drugs Charged to Patients	2,855,500		2,855,500		2,855,500	73
74	Renal Dialysis	173,047		173,047		173,047	74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	1,658,239		1,658,239		1,658,239	76
76.10	PARTIAL HOSPITALIZATION	516,245		516,245		516,245	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	1,195,324		1,195,324		1,195,324	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	5,998,101		5,998,101		5,998,101	91
91.01	GOLDEN LIFE	249,886		249,886		249,886	91.01
92	Observation Beds (Non-Distinct Part)	693,985		693,985		693,985	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)	53,336,171		53,336,171		53,336,171	200
201	Less Observation Beds	693,985		693,985		693,985	201
202	Total (line 200 minus line 201)	52,642,186		52,642,186		52,642,186	202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
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
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	2,485,108	306,124	2,178,984		50
53	Anesthesiology	33,980	7,694	26,286		53
54	Radiology-Diagnostic	3,135,285	240,216	2,895,069		54
57	CT Scan	472,686	9,703	462,983		57
60	Laboratory	3,471,979	190,040	3,281,939		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,339,798	75,783	1,264,015		65
66	Physical Therapy	972,634	79,975	892,659		66
69	Electrocardiology	415,870	19,984	395,886		69
70	Electroencephalography	43,639	8,024	35,615		70
71	Medical Supplies Charged to Patients	1,854,941	230,428	1,624,513		71
73	Drugs Charged to Patients	2,855,500	209,075	2,646,425		73
74	Renal Dialysis	173,047	2,410	170,637		74
75.01	HYBERBARIC CHAMBER					75.01
76	O/P MENTAL HEALTH	1,658,239	104,587	1,553,652		76
76.10	PARTIAL HOSPITALIZATION	516,245	122,268	393,977		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	1,195,324	73,884	1,121,440		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	5,998,101	292,314	5,705,787		91
91.01	GOLDEN LIFE	249,886	54,750	195,136		91.01
92	Observation Beds (Non-Distinct Part)	693,985	31,573	662,412		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	27,566,247	2,058,832	25,507,415		200
201	Less Observation Beds	693,985	31,573	662,412		201
202	Total	26,872,262	2,027,259	24,845,003		202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		2,485,108			50
53	Anesthesiology		33,980			53
54	Radiology-Diagnostic		3,135,285			54
57	CT Scan		472,686			57
60	Laboratory		3,471,979			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		1,339,798			65
66	Physical Therapy		972,634			66
69	Electrocardiology		415,870			69
70	Electroencephalography		43,639			70
71	Medical Supplies Charged to Patients		1,854,941			71
73	Drugs Charged to Patients		2,855,500			73
74	Renal Dialysis		173,047			74
75.01	HYBERBARIC CHAMBER					75.01
76	O/P MENTAL HEALTH		1,658,239			76
76.10	PARTIAL HOSPITALIZATION		516,245			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		1,195,324			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		5,998,101			91
91.01	GOLDEN LIFE		249,886			91.01
92	Observation Beds (Non-Distinct Part)		693,985	5,960,772	0.116425	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		27,566,247	5,960,772		200
201	Less Observation Beds		693,985	5,960,772		201
202	Total		26,872,262			202

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,004,823		1,004,823	19,732	50.92	4,171	212,387	30
31	Intensive Care Unit	184,207		184,207	2,052	89.77	782	70,200	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)	1,189,030		1,189,030	21,784		4,953	282,587	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	306,124	3,065,073	0.099875	731,530	73,062	50
53	Anesthesiology	7,694	293,698	0.026197			53
54	Radiology-Diagnostic	240,216	3,134,134	0.076645	334,640	25,648	54
57	CT Scan	9,703	2,485,430	0.003904	204,065	797	57
60	Laboratory	190,040	10,760,878	0.017660	1,589,722	28,074	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	75,783	5,966,752	0.012701	1,831,336	23,260	65
66	Physical Therapy	79,975	883,310	0.090540	164,409	14,886	66
69	Electrocardiology	19,984	2,410,764	0.008289	439,182	3,640	69
70	Electroencephalography	8,024	17,471	0.459275	3,094	1,421	70
71	Medical Supplies Charged to Pat	230,428	1,955,455	0.117839	201,335	23,725	71
73	Drugs Charged to Patients	209,075	10,032,546	0.020840	2,474,235	51,563	73
74	Renal Dialysis	2,410	106,372	0.022656			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	104,587	632,722	0.165297			76
76.10	PARTIAL HOSPITALIZATION	122,268	2,583,350	0.047329			76.10
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	73,884	633,031	0.116715			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	292,314	12,349,183	0.023671	769,820	18,222	91
91.01	GOLDEN LIFE	54,750					91.01
92	Observation Beds (Non-Distinct	31,572	5,960,772	0.005297			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,058,831	63,270,941		8,743,368	264,298	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	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: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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)	19,732		4,171		30
31	Intensive Care Unit	2,052		782		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)	21,784		4,953		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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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	3,065,073			731,530		472,404		50
53	Anesthesiology	293,698							53
54	Radiology-Diagnostic	3,134,134			334,640		361,229		54
57	CT Scan	2,485,430			204,065		234,955		57
60	Laboratory	10,760,878			1,589,722		380,605		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,966,752			1,831,336		78,470		65
66	Physical Therapy	883,310			164,409				66
69	Electrocardiology	2,410,764			439,182		266,450		69
70	Electroencephalography	17,471			3,094		442		70
71	Medical Supplies Charged to Pat	1,955,455			201,335		151,134		71
73	Drugs Charged to Patients	10,032,546			2,474,235		344,809		73
74	Renal Dialysis	106,372							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	632,722							76
76.10	PARTIAL HOSPITALIZATION	2,583,350							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	633,031					143,537		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	12,349,183			769,820		765,422		91
91.01	GOLDEN LIFE								91.01
92	Observation Beds (Non-Distinct	5,960,772					555,819		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	63,270,941			8,743,368		3,755,276		200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.810783	472,404			383,017			50
53	Anesthesiology	0.115697							53
54	Radiology-Diagnostic	1.000367	361,229			361,362			54
57	CT Scan	0.190183	234,955			44,684			57
60	Laboratory	0.322648	380,605			122,801			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.224544	78,470			17,620			65
66	Physical Therapy	1.101124							66
69	Electrocardiology	0.172505	266,450			45,964			69
70	Electroencephalography	2.497796	442			1,104			70
71	Medical Supplies Charged to Pat	0.948598	151,134			143,365			71
73	Drugs Charged to Patients	0.284624	344,809		6,168	98,141		1,756	73
74	Renal Dialysis	1.626810							74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH	2.620802							76
76.10	PARTIAL HOSPITALIZATION	0.199835							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	1.888255	143,537	6		271,034	11		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	0.485708	765,422			371,772			91
91.01	GOLDEN LIFE								91.01
92	Observation Beds (Non-Distinct	0.115735	555,819			64,328			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		3,755,276	6	6,168	1,925,192	11	1,756	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		3,755,276	6	6,168	1,925,192	11	1,756	202

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,004,823		1,004,823	19,732	50.92	2,732	139,113	30
31	Intensive Care Unit	184,207		184,207	2,052	89.77	153	13,735	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)	1,189,030		1,189,030	21,784		2,885	152,848	200

(A) Worksheet A line numbers

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

Check Applicable Boxes: **[ ] Title V** **[XX] Hospital** **[ ] SUB (Other)** **[ ] Title XVIII, Part A** **[ ] IPF** **[XX] Title XIX** **[ ] IRF**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	306,124	3,065,073	0.099875			50
53	Anesthesiology	7,694	293,698	0.026197			53
54	Radiology-Diagnostic	240,216	3,134,134	0.076645			54
57	CT Scan	9,703	2,485,430	0.003904			57
60	Laboratory	190,040	10,760,878	0.017660			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	75,783	5,966,752	0.012701			65
66	Physical Therapy	79,975	883,310	0.090540			66
69	Electrocardiology	19,984	2,410,764	0.008289			69
70	Electroencephalography	8,024	17,471	0.459275			70
71	Medical Supplies Charged to Pat	230,428	1,955,455	0.117839			71
73	Drugs Charged to Patients	209,075	10,032,546	0.020840			73
74	Renal Dialysis	2,410	106,372	0.022656			74
75.01	HYBERBARIC CHAMBER						75.01
76	O/P MENTAL HEALTH	104,587	632,722	0.165297			76
76.10	PARTIAL HOSPITALIZATION	122,268	2,583,350	0.047329			76.10
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	73,884	633,031	0.116715			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	292,314	12,349,183	0.023671			91
91.01	GOLDEN LIFE	54,750					91.01
92	Observation Beds (Non-Distinct	31,573	5,960,772	0.005297			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,058,832	63,270,941				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	19,732		2,732		30
31	Intensive Care Unit	2,052		153		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)	21,784		2,885		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 [XX] Title XIX [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [XX] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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								50
53	Anesthesiology								53
54	Radiology-Diagnostic								54
57	CT Scan								57
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75.01	HYBERBARIC CHAMBER								75.01
76	O/P MENTAL HEALTH								76
76.10	PARTIAL HOSPITALIZATION								76.10
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
90.01	CICERO CLINIC								90.01
90.02	YMCA CLINIC								90.02
90.03	NORTH AVENUE CLINIC								90.03
90.04	CLINIC #4								90.04
90.05	WOUND CARE								90.05
91	Emergency								91
91.01	GOLDEN LIFE								91.01
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[XX] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/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								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	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: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,732	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,732	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)	19,112	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,171	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)	21,955,558	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)	21,955,558	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)	21,955,558	37

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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)					1,112.69	38
39	Program general inpatient routine service cost (line 9 x line 38)					4,641,030	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)					4,641,030	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	3,683,365	2,052	1,795.01	782	1,403,698	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)					3,424,467	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					9,469,195	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					282,587	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					264,298	51
52	Total Program excludable cost (sum of lines 50 and 51)					546,885	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					8,922,310	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					620	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,112.69	88
89	Observation bed cost (line 87 x line 88) (see instructions)					689,868	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,004,823	21,955,558	0.045766	689,868	31,572	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: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,732	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,732	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)	19,112	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)	2,732	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)	22,086,559	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)	22,086,559	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)	22,086,559	37

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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)					1,119.33	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,058,010	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)					3,058,010	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	3,683,365	2,052	1,795.01	153	274,637	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)					3,332,647	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					152,848	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)					152,848	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					620	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,119.33	88
89	Observation bed cost (line 87 x line 88) (see instructions)					693,985	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,004,823	22,086,559	0.045495	693,985	31,573	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: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		5,519,784		30
31	Intensive Care Unit		1,915,900		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.810783	731,530	593,112	50
53	Anesthesiology	0.115697			53
54	Radiology-Diagnostic	1.000367	334,640	334,763	54
57	CT Scan	0.190183	204,065	38,810	57
60	Laboratory	0.322648	1,589,722	512,921	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.224544	1,831,336	411,216	65
66	Physical Therapy	1.101124	164,409	181,035	66
69	Electrocardiology	0.172505	439,182	75,761	69
70	Electroencephalography	2.497796	3,094	7,728	70
71	Medical Supplies Charged to Patients	0.948598	201,335	190,986	71
73	Drugs Charged to Patients	0.284624	2,474,235	704,227	73
74	Renal Dialysis	1.626810			74
75.01	HYBERBARIC CHAMBER				75.01
76	O/P MENTAL HEALTH	2.620802			76
76.10	PARTIAL HOSPITALIZATION	0.199835			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	1.888255			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	0.485708	769,820	373,908	91
91.01	GOLDEN LIFE				91.01
92	Observation Beds (Non-Distinct Part)	0.115735			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		8,743,368	3,424,467	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		8,743,368		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)	1,326,892			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,980,675			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)	434,673			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	2,642,015			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	120.30			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	1.66			11
12	Current year allowable FTE (see instructions)	1.66			12
13	Total allowable FTE count for the prior year	1.50			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	2.00			14
15	Sum of lines 12 through 14 divided by 3	1.72			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	1.72			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.014298			19
20	Prior year resident to bed ratio (see instructions)	0.012416			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.012416			21
22	IME payment adjustment (see instructions)	35,900			22
22.01	IME payment adjustment - Managed Care (see instructions)	17,871			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)	35,900			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	17,871			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.2116			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.5935			31
32	Sum of lines 30 and 31	0.8051			32
33	Allowable disproportionate share percentage (see instructions)	0.5563			33
34	Disproportionate share adjustment (see instructions)	738,151			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)	5,977,483,147		6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000461123		0.000301652	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,756,355		2,041,187	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	694,753		1,526,696	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,221,449			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)	8,737,740			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)	8,755,611			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	536,280			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)	41,393			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	9,333,284			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	9,333,284			61
62	Deductibles billed to program beneficiaries	435,656			62
63	Coinsurance billed to program beneficiaries	234,263			63
64	Allowable bad debts (see instructions)	603,495			64
65	Adjusted reimbursable bad debts (see instructions)	392,272			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	430,665			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,055,637			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJUSTMENTS)				70
70.93	HVBP payment adjustment amount (see instructions)	-3,606			70.93
70.94	HRR adjustment amount (see instructions)	-4,128			70.94
71	Amount due provider (see instructions)	9,047,903			71
71.01	Sequestration adjustment (see instructions)	180,958			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	8,057,161			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	809,784			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	736,680			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

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

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	1,767			1
2	Medical and other services reimbursed under OPPS (see instructions)	1,925,192			2
3	OPPS payments	856,494			3
4	Outlier payment (see instructions)	216,660			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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)	1,767			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	6,174			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)	6,174			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)	6,174			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	4,407			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 (see instructions)	1,767			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, 4.01, 8 and 9)	1,073,154			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	187,839			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)	887,082			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	8,423			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	895,505			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	895,505			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)	116,913			34
35	Adjusted reimbursable bad debts (see instructions)	75,993			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	83,363			36
37	Subtotal (see instructions)	971,498			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)	971,498			40
40.01	Sequestration adjustment (see instructions)	19,430			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	919,790			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	32,278			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: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				8,172,942		930,700	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	02/01/2018	77,695	02/01/2018	10,910	3.50
			.51	06/18/2018	38,086			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		-115,781		-10,910	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				8,057,161		919,790	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		809,784		32,278	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				8,866,945		952,068	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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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	3,332,647		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	3,332,647		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	3,332,647		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)	3,332,647		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)	3,332,647		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		1.66		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.00	1.66		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	1.25		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	1.64		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	1.64		17
18	Per resident amount	98,011.01	99,794.38		18
19	Approved amount for resident costs		163,663	163,663	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)			163,663	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	4,953	1,734		26
27	Total inpatient days (see instructions)	21,164	21,164		27
28	Ratio of inpatient days to total inpatient days	0.234029	0.081932		28
29	Program direct GME amount	38,302	13,409		29
30	Reduction for direct GME payments for Medicare Advantage		1,895		30
31	Net Program direct GME amount			49,816	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)			106,372	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)			9,469,195	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)			9,469,195	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			1,926,959	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			1,926,959	44
45	Total reasonable cost (sum of lines 41 and 44)			11,396,154	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.830911	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.169089	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			49,816	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			41,393	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			8,423	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)	2,885	9,614		26
27	Total inpatient days (see instructions)	21,164	21,164		27
28	Ratio of inpatient days to total inpatient days	0.136316	0.454262		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	1,580,872				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	101,030,089				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-95,598,654				6
7	Inventory	366,865				7
8	Prepaid expenses	220,192				8
9	Other current assets	460,960				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,060,324				11
	FIXED ASSETS					
12	Land	429,028				12
13	Land improvements	52,143				13
14	Accumulated depreciation	-25,900				14
15	Buildings	41,320,257				15
16	Accumulated depreciation	-20,739,652				16
17	Leasehold improvements	83,192				17
18	Accumulated depreciation	-83,192				18
19	Fixed equipment	11,441,700				19
20	Accumulated depreciation	-8,533,376				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)	23,944,200				30
	OTHER ASSETS					
31	Investments	9,064,830				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,275,974				34
35	Total other assets (sum of lines 31-34)	12,340,804				35
36	Total assets (sum of lines 11, 30 and 35)	44,345,328				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	3,899,251				37
38	Salaries, wages and fees payable	3,298,211				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)	7,197,462				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	6,807,801				49
50	Total long term liabilities (sum of lines 46 thru 49)	6,807,801				50
51	Total liabilities (sum of lines 45 and 50)	14,005,263				51
	CAPITAL ACCOUNTS					
52	General fund balance	30,340,065				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)	30,340,065				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	44,345,328				60

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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		48,331,707			1
2	Net income (loss) (from Worksheet G-3, line 29)		-2,986,161			2
3	Total (sum of line 1 and line 2)		45,345,546			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)		45,345,546			11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS					13
14	OTHER	15,005,481				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		15,005,481			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,340,065			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

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	27,070,372		27,070,372	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)	27,070,372		27,070,372	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	5,122,950		5,122,950	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)	5,122,950		5,122,950	16
17	Total inpatient routine care services (sum of lines 10 and 16)	32,193,322		32,193,322	17
18	Ancillary services	27,556,876	35,094,316	62,651,192	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)	59,750,198	35,094,316	94,844,514	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		64,945,994	29
30	Add (specify)			30
31	BAD DEBTS	5,945,756		31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		5,945,756	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)		70,891,750	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	94,844,514	1
2	Less contractual allowances and discounts on patients' accounts	37,797,483	2
3	Net patient revenues (line 1 minus line 2)	57,047,031	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	70,891,750	4
5	Net income from service to patients (line 3 minus line 4)	-13,844,719	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	173,403	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	10,968	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	43,663	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER INCOME)		24
24.01	Other (OTHER MISC)	19,874,275	24.01
25	Total other income (sum of lines 6-24)	20,102,309	25
26	Total (line 5 plus line 25)	6,257,590	26
27	Other expenses (specify):	9,243,751	27
28	Total other expenses (sum of line 27 and subscripts)	9,243,751	28
29	Net income (or loss) for the period (line 26 minus line 28)	-2,986,161	29

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[XX] PPS** **[ ] Cost Method**

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	434,062	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	21,743	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)	57.98	3
4	Number of interns & residents (see instructions)	1.72	4
5	Indirect medical education percentage (see instructions)	0.84	5
6	Indirect medical education adjustment (see instructions)	3,646	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2116	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.5935	8
9	Sum of lines 7 and 8	0.8051	9
10	Allowable disproportionate share percentage (see instructions)	0.1770	10
11	Disproportionate share adjustment (see instructions)	76,829	11
12	Total prospective capital payments (see instructions)	536,280	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

LORETTO HOSPITAL Provider CCN: 14-0083	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 11:06 Version: 2018.04 (09/26/2018)

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