KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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: 05/30/2014 TIME: 08:22 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED	6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE
ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE
PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT
MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY PRESENCE ST. MARY'S HOSPITAL (14-0155) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-185,667	517,268	30,989		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		-185,667	517,268	30,989		200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A
VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS

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

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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:

1	STREET: 500 WEST COURT STREET	P.O. BOX:		1
2	CITY: KANKAKEE	STATE: IL	ZIP CODE: 60901	COUNTY: KANKAKEE 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	PRESENCE ST. MARY'S HOSPITAL	14-0155	16974	1	07/01/1969	N	P	O	3
4	SUBPROVIDER - IPF	PSMH PSYCH	14-S155	16974	4	07/01/1969	N	P	O	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	PROVENA ST. MARY S RENAL	14-2318	16974		07/01/1973				18
19	OTHER									19

20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013	20
21	TYPE OF CONTROL (see instructions)	1		21

	INPATIENT PPS INFORMATION	1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	Y	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES Or 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)	N	Y	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	3	N	23

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	2,626	1,639		47			24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25

26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	1	26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.	1	27

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	38

		1	2	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	Y			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE 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 OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
	1	2	3	4	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 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 NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						66
	ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
INPATIENT PSYCHIATRIC FACILITY 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.			Y			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N	N		71
INPATIENT REHABILITATION FACILITY PPS				1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						76

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			86

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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/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97
RURAL PROVIDERS				1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N		108
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	N	N	109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	N				115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			2		118
		PREMIUMS		PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:			47,000		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		121
TRANSPLANT CENTER INFORMATION						
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.			N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					132

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

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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.	Y	148003	140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: PRESENCE HEALTHCARE	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 06101	141
142	STREET: 9223 WEST ST. FRANCIS RD.	P.O. BOX:		142
143	CITY: FRANKFORT	STATE: IL	ZIP CODE: 60423	143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	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, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

		TITLE XVIII				
		PART A	PART B	TITLE V	TITLE XIX	
			1	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N		N	156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.		166

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS	
	0	1	2	3	4	5	

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00		169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	05/02/2013	07/31/2013	170

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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)	Y			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.	Y	A	05/31/2014	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON 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.		Y		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		Y		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.		N		11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	03/05/2014	Y	03/05/2014	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

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

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

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

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

COST REORT PREPARER INFORMATION				
41	FIRST NAME: TOM	LAST NAME: VERTIN	TITLE: DIR. OF REIMBURSEMENT	41
42	EMPLOYER: PRESENCE HEALTH			42
43	PHONE NUMBER: 815-806-3126	E-MAIL ADDRESS: THOMAS.VERTIN@PRESENCEHEALTH.ORG		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	135	49,275			11,756	3,500	19,140	1
2	HMO AND OTHER (see instructions)						400			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)		135	49,275			11,756	3,500	19,140	7
8	INTENSIVE CARE UNIT	31	16	5,840			761	188	1,329	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34	10	3,650			394	101	636	11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						523	1,077	13
14	TOTAL (see instructions)		161	58,765			12,911	4,312	22,182	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	21	7,665				901	3,127	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)		182							27
28	OBSERVATION BED DAYS							272	2,308	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,576	990	5,563	1
2	HMO AND OTHER (see instructions)					86			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)		658.70			2,576	990	5,563	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF						168	636	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)		658.70						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	37,512,988		37,512,988	1,422,796.00	26.37	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		1,847,851		1,847,851	44,929.00	41.13	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		1,538,419		1,538,419	12,881.00	119.43	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		609,054		609,054	3,943.00	154.46	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		10,601,177		10,601,177			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		286,382		286,382			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)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		68,680		68,680	7.00	9,811.43	26
27	ADMINISTRATIVE & GENERAL		3,204,440		3,204,440	129,729.00	24.70	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		883,619		883,619	47,712.00	18.52	30
31	LAUNDRY & LINEN SERVICE		1,729		1,729	171.00	10.11	31
32	HOUSEKEEPING		719,164		719,164	61,264.00	11.74	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		791,801	-395,901	395,900	33,181.00	11.93	34
35	DIETARY UNDER CONTRACT (see instructions)		435,078		435,078	12,896.00	33.74	35
36	CAFETERIA			395,901	395,901	33,182.00	11.93	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		834,256		834,256	21,649.00	38.54	38
39	CENTRAL SERVICES AND SUPPLY		259,193		259,193	16,148.00	16.05	39
40	PHARMACY		1,261,696		1,261,696	34,544.00	36.52	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,236,578		1,236,578	48,449.00	25.52	41
42	SOCIAL SERVICE		701,975		701,975	20,167.00	34.81	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		37,948,066		37,948,066	1,435,692.00	26.43	1
2	EXCLUDED AREA SALARIES (see instructions)		1,847,851		1,847,851	44,929.00	41.13	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		36,100,215		36,100,215	1,390,763.00	25.96	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		2,147,473		2,147,473	16,824.00	127.64	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		10,601,177		10,601,177		29.37%	5

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		48,848,865		48,848,865	1,407,587.00	34.70	6
7	TOTAL OVERHEAD COST (see instructions)		10,398,209		10,398,209	459,099.00	22.65	7

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

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,810,280	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)	4,870,970	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	138,923	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	-10,216	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	268,091	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	535,533	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	2,727,281	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	50,015	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	210,300	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	10,601,177	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

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

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

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

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

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

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

RENAL DIALYSIS STATISTICS

		OUTPATIENT		TRAINING		HOME		
	DESCRIPTION	REGULAR	HIGH FLUX	HEMO-DIALYSIS	CAPD CCPD	HEMO-DIALYSIS	CAPD CCPD	
		1	2	3	4	5	6	
1	NUMBER OF PATIENTS IN PROGRAM AT END OF COST REPORTING PERIOD	3			3	6	7	1
2	NUMBER OF TIMES PER WEEK PATIENT RECEIVES DIALYSIS	5.50			5.50			2
3	AVERAGE PATIENT DIALYSIS TIME INCLUDING SETUP							3
4	CAPD EXCHANGES PER DAY							4
5	NUMBER OF DAYS IN YEAR DIALYSIS FURNISHED	312						5
6	NUMBER OF STATIONS	24						6
7	TREATMENT CAPACITY PER DAY PER STATION	3						7
8	UTILIZATION (see instructions)							8
9	AVERAGE TIMES DIALYZERS RE-USED							9
10	PERCENTAGE OF PATIENTS RE-USING DIALYZERS							10

ESRD PPS

		1	2	
10.01	IS THE DIALYSIS FACILITY APPROVED AS A LOW-VOLUME FACILITY FOR THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)			10.01
10.02	DID YOUR FACILITY ELECT 100% PPS EFFECTIVE JANUARY 1, 2011? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions for 'new' providers)			10.02
10.03	IF YOU RESPONDED 'N' TO LINE 10.02, ENTER IN COLUMN 1 THE YEAR OF TRANSITION FOR PERIODS PRIOR TO JANUARY 1 AND ENTER IN COLUMN 2 THE YEAR OF TRANSITION FOR PERIODS AFTER DECEMBER 31. (see instructions)			10.03

TRANSPLANT INFORMATION

11	NUMBER OF PATIENTS ON TRANSPLANT LIST		11
12	NUMBER OF PATIENTS TRANSPLANTED DURING THE COST REPORTING PERIOD		12

EPOETIN

13	NET COSTS OF EPOETIN FURNISHED TO ALL MAINTENANCE DIALYSIS PATIENTS BY THE PROVIDER		13
14	EPOETIN AMOUNT FROM WORKSHEET A FOR HOME DIALYSIS PROGRAM		14
15	NUMBER OF EPO UNITS FURNISHED RELATING TO THE RENAL DIALYSIS DEPARTMENT		15
16	NUMBER OF EPO UNITS FURNISHED RELATING TO THE HOME DIALYSIS DEPARTMENT		16

ARANESP

17	NET COSTS OF ARANESP FURNISHED TO ALL MAINTENANCE DIALYSIS PATIENTS BY THE PROVIDER		17
18	ARANESP AMOUNT FROM WORKSHEET A FOR HOME DIALYSIS PROGRAM		18
19	NUMBER OF ARANESP UNITS FURNISHED RELATING TO THE RENAL DIALYSIS DEPARTMENT		19
20	NUMBER OF ARANESP UNITS FURNISHED RELATING TO THE HOME DIALYSIS DEPARTMENT		20

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

21	MCP X	INITIAL METHOD	

	ERYTHROPOIESIS-STIMULATING AGENTS (ESA) STATISTICS:	ESA DESCRIPTION	NET COST OF ESAs FOR RENAL PATIENTS	NET COST OF ESAs FOR HOME PATIENTS	NUMBER OF ESA UNITS - RENAL DIALYSIS DEPT.	NUMBER OF ESA UNITS - HOME DIALYSIS DEPT.	
		1	2	3	4	5	
22	ENTER IN COLUMN 1 THE ESA DESCRIPTION. ENTER IN COLUMN 2 THE NET COSTS OF ESAs FURNISHED TO ALL RENAL DIALYSIS PATIENTS. ENTER IN COLUMN 3 THE NET COST OF ESAs FURNISHED TO ALL HOME DIALYSIS PROGRAM PATIENTS. ENTER IN COLUMN 4 THE NUMBER OF ESA UNITS FURNISHED TO PATIENTS IN THE RENAL DIALYSIS DEPARTMENT. ENTER IN COLUMN 5 THE NUMBER OF UNITS FURNISHED TO PATIENTS IN THE HOME DIALYSIS PROGRAM. (see instructions)						22

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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)	0.192644	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	12,678,117	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	93,089,252	6
7	MEDICAID COST (line 1 times line 6)	17,933,086	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.	5,254,969	8

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

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

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

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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	5,254,969	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	17,130,229	735,038	17,865,267	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	3,300,036	141,601	3,441,637	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	106,848	126,343	233,191	22
23	COST OF CHARITY CARE (line 21 minus line 22)	3,193,188	15,258	3,208,446	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	7,886,994	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	825,350	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	7,061,644	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,360,383	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	4,568,829	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	9,823,798	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		3,924,477	3,924,477	4,213,133	8,137,610	-2,592,132	5,545,478	1
2	00200	CAP REL COSTS-MVBLE EQUIP				3,124,069	3,124,069	404,601	3,528,670	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	68,680	10,597,454	10,666,134	-5,061	10,661,073	-302,802	10,358,271	4
5	00500	ADMINISTRATIVE & GENERAL	3,204,440	25,651,617	28,856,057	-495,803	28,360,254	-2,118,008	26,242,246	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	883,619	3,489,241	4,372,860	-747,996	3,624,864	21,531	3,646,395	7
7.01	00701	BIO MED		1,680,196	1,680,196		1,680,196		1,680,196	7.01
8	00800	LAUNDRY & LINEN SERVICE	1,729	689,562	691,291	172,434	863,725	-500,651	363,074	8
9	00900	HOUSEKEEPING	719,164	477,257	1,196,421	-8,076	1,188,345		1,188,345	9
10	01000	DIETARY	791,801	1,048,121	1,839,922	-942,433	897,489		897,489	10
11	01100	CAFETERIA				919,962	919,962	-415,433	504,529	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	834,256	103,583	937,839	-85,325	852,514		852,514	13
14	01400	CENTRAL SERVICES & SUPPLY		847,052	847,052	-249,248	597,804	-442,113	155,691	14
14.01	01401	STERILE PROCESSING	259,193	316,339	575,532	-242,491	333,041		333,041	14.01
15	01500	PHARMACY	1,261,696	6,798,214	8,059,910	-6,428,285	1,631,625		1,631,625	15
16	01600	MEDICAL RECORDS & LIBRARY	1,236,578	485,108	1,721,686	-6,384	1,715,302	-1,170	1,714,132	16
17	01700	SOCIAL SERVICE	701,975	164,621	866,596		866,596		866,596	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)	163,508	85,496	249,004	-13,793	235,211	-75,649	159,562	23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	6,980,386	615,568	7,595,954	-1,102,915	6,493,039	-2,576	6,490,463	30
31	03100	INTENSIVE CARE UNIT	1,733,463	398,393	2,131,856	-72,018	2,059,838	237,798	2,297,636	31
34	03400	SURGICAL INTENSIVE CARE UNIT	1,216,882	233,827	1,450,709	-48,158	1,402,551	133,171	1,535,722	34
40	04000	SUBPROVIDER - IPF	985,032	35,897	1,020,929		1,020,929	-2,036	1,018,893	40
43	04300	NURSERY								43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	1,535,178	6,248,979	7,784,157	-5,375,237	2,408,920	-4,178	2,404,742	50
50.01	03330	SPECIAL PROCEDURES								50.01
51	05100	RECOVERY ROOM	1,262,555	53,067	1,315,622	-36,414	1,279,208		1,279,208	51
51.01	05101	OP ONCOLOGY	731,195	1,203,813	1,935,008	-13,021	1,921,987	-915,801	1,006,186	51.01
52.02	05201	SUBSTANCE ABUSE	233,408	54,698	288,106		288,106	-285	287,821	52.02
52.04	05202	DIABETES EDUCATION	50,787	3,523	54,310		54,310		54,310	52.04
52.05	05203	PODIATRY								52.05
52.06	05204	INFUSION CLINIC	306,241	17,887	324,128	-10,955	313,173		313,173	52.06
53	05300	ANESTHESIOLOGY	24,542	4,266,237	4,290,779	-158,355	4,132,424		4,132,424	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,547,514	1,765,841	4,313,355	-1,308,050	3,005,305	-67,296	2,938,009	54
56	05600	RADIOISOTOPE	466,307	694,207	1,160,514	-338,358	822,156		822,156	56
59	05900	CARDIAC CATHETERIZATION	513,986	2,074,720	2,588,706	-2,047,828	540,878	-5,642	535,236	59
60	06000	LABORATORY		4,744,207	4,744,207	-533,569	4,210,638	-7,496	4,203,142	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	1,136,468	358,019	1,494,487	26,616	1,521,103	-1,632	1,519,471	65
66	06600	PHYSICAL THERAPY	807,568	115,835	923,403	-31,335	892,068		892,068	66
66.01	06601	WOUND CARE	46,161	1,464,991	1,511,152	-221,568	1,289,584		1,289,584	66.01
67	06700	OCCUPATIONAL THERAPY	154,366	7,816	162,182	13,500	175,682		175,682	67
68	06800	SPEECH PATHOLOGY	169,074	6,192	175,266	2,479	177,745	-170	177,575	68
69	06900	ELECTROCARDIOLOGY	306,825	98,238	405,063	-37,682	367,381	-42,384	324,997	69
70	07000	ELECTROENCEPHALOGRAPHY	25,484	30,858	56,342	-20,443	35,899		35,899	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				5,170,495	5,170,495		5,170,495	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				4,183,942	4,183,942		4,183,942	72
73	07300	DRUGS CHARGED TO PATIENTS				7,776,523	7,776,523		7,776,523	73
74	07400	RENAL DIALYSIS	1,705,269	3,200,002	4,905,271	-1,028,919	3,876,352	-72,753	3,803,599	74
76	03951	OTHER								76
76.97	07697	CARDIAC REHABILITATION	178,690	4,717	183,407	-180,615	2,792		2,792	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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	
90.01	09001	OCCUPATIONAL HEALTH	905,280	359,057	1,264,337	-106,852	1,157,485	-306,099	851,386	90.01
91	09100	EMERGENCY	2,664,377	1,048,367	3,712,744	-373,596	3,339,148	-380,347	2,958,801	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	AMBULANCE SERVICES		3	3	-3				95
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		3,168,089	3,168,089	-3,168,089				113
118		SUBTOTALS (sum of lines 1-117)	36,813,677	88,631,386	125,445,063	164,278	125,609,341	-7,459,552	118,149,789	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	79,880	17,380	97,260		97,260		97,260	190
194	07950	OTHER NRCC	619,431	1,827,133	2,446,564	-163,528	2,283,036		2,283,036	194
194.01	07951	SISTERS RESIDENCE		750	750	-750				194.01
200		TOTAL (sum of lines 118-199)	37,512,988	90,476,649	127,989,637		127,989,637	-7,459,552	120,530,085	200

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	SUPPLIES RECLASS	A	MEDICAL SUPPLIES CHARGED TO P	71		9,354,437	1
2	SUPPLIES RECLASS	A					2
3	SUPPLIES RECLASS	A					3
4	SUPPLIES RECLASS	A					4
5	SUPPLIES RECLASS	A					5
6	SUPPLIES RECLASS	A					6
7							7
8	SUPPLIES RECLASS	A					8
9	SUPPLIES RECLASS	A					9
10	SUPPLIES RECLASS	A					10
11	SUPPLIES RECLASS	A					11
12	SUPPLIES RECLASS	A					12
13	SUPPLIES RECLASS	A					13
14	SUPPLIES RECLASS	A					14
15	SUPPLIES RECLASS	A					15
16	SUPPLIES RECLASS	A					16
17	SUPPLIES RECLASS	A					17
18	SUPPLIES RECLASS	A					18
19	SUPPLIES RECLASS	A					19
20	SUPPLIES RECLASS	A					20
21	SUPPLIES RECLASS	A					21
22	SUPPLIES RECLASS	A					22
23	SUPPLIES RECLASS	A					23
24	SUPPLIES RECLASS	A					24
25	SUPPLIES RECLASS	A					25
26	SUPPLIES RECLASS	A					26
27	SUPPLIES RECLASS	A					27
28	SUPPLIES RECLASS	A					28
29	SUPPLIES RECLASS	A					29
30	SUPPLIES RECLASS	A					30
31	SUPPLIES RECLASS	A					31
32	SUPPLIES RECLASS	A					32
33	SUPPLIES RECLASS	A					33
34	SUPPLIES RECLASS	A					34
35	SUPPLIES RECLASS	A					35
36	SUPPLIES RECLASS	A					36
500	TOTAL RECLASSIFICATIONS					9,354,437	500
	CODE LETTER - A						
1							1
2							2
3							3
4							4
5							5
6							6
7	DRUGS	B	DRUGS CHARGED TO PATIENTS	73		7,073,750	7
8	DRUGS	B					8
9	DRUGS	B					9
10	DRUGS	B					10
11	DRUGS	B					11
12	DRUGS	B					12
13	DRUGS	B					13
14	DRUGS	B					14
15	DRUGS	B					15
16	DRUGS	B					16
17	DRUGS	B					17
18	DRUGS	B					18
19	DRUGS	B					19
20	DRUGS	B					20
21	DRUGS	B					21
22	DRUGS	B					22
23	DRUGS	B					23
24	DRUGS	B					24
25	DRUGS	B					25
26	DRUGS	B					26
27	DRUGS	B					27
28	DRUGS	B					28
29	DRUGS	B					29
30	DRUGS	B					30
31	DRUGS	B					31

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
32	DRUGS	B					32
33	DRUGS	B					33
34	DRUGS	B					34
500	TOTAL RECLASSIFICATIONS					7,073,750	500
	CODE LETTER -						
1	DEPRECIATION	C	CAP REL COSTS-BLDG & FIXT	1		1,045,044	1
2	DEPRECIATION	C	CAP REL COSTS-MVBLE EQUIP	2		3,124,069	2
3	DEPRECIATION	C					3
4	DEPRECIATION	C					4
5	DEPRECIATION	C					5
6	DEPRECIATION	C					6
7	DEPRECIATION	C					7
8	DEPRECIATION	C					8
9	DEPRECIATION	C					9
10	DEPRECIATION	C					10
11	DEPRECIATION	C					11
12	DEPRECIATION	C					12
13	DEPRECIATION	C					13
14	DEPRECIATION	C					14
15	DEPRECIATION	C					15
16	DEPRECIATION	C					16
17	DEPRECIATION	C					17
18	DEPRECIATION	C					18
19	DEPRECIATION	C					19
20	DEPRECIATION	C					20
21	DEPRECIATION	C					21
22	DEPRECIATION	C					22
23	DEPRECIATION	C					23
24	DEPRECIATION	C					24
25	DEPRECIATION	C					25
26	DEPRECIATION	C					26
27	DEPRECIATION	C					27
28	DEPRECIATION	C					28
29	DEPRECIATION	C					29
30	DEPRECIATION	C					30
31	DEPRECIATION	C					31
32	DEPRECIATION	C					32
33	DEPRECIATION	C					33
34	DEPRECIATION	C					34
500	TOTAL RECLASSIFICATIONS					4,169,113	500
	CODE LETTER - C						
1	REHAB RECLASS	D	OCCUPATIONAL THERAPY	67	12,581	1,157	1
2	REHAB RECLASS	D	SPEECH PATHOLOGY	68	3,479	320	2
500	TOTAL RECLASSIFICATIONS				16,060	1,477	500
	CODE LETTER - D						
1	CARDIAC REHAB RECLASS	E	RESPIRATORY THERAPY	65	174,449	4,605	1
500	TOTAL RECLASSIFICATIONS				174,449	4,605	500
	CODE LETTER - E						
1	CAPITAL INTEREST	F	CAP REL COSTS-BLDG & FIXT	1		3,168,089	1
500	TOTAL RECLASSIFICATIONS					3,168,089	500
	CODE LETTER - F						
1	CAFETERIA	G	CAFETERIA	11	395,901	524,061	1
500	TOTAL RECLASSIFICATIONS				395,901	524,061	500
	CODE LETTER - G						
1	IMPLANTS	J	IMPL. DEV. CHARGED TO PATIENT	72		4,183,942	1
500	TOTAL RECLASSIFICATIONS					4,183,942	500
	CODE LETTER - J						
1	EMT TRAINERS	K					1
500	TOTAL RECLASSIFICATIONS						500
	CODE LETTER - K						
1	LINEN SERVICE	M	LAUNDRY & LINEN SERVICE	8		172,471	1
2	LINEN SERVICE	M					2

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
3	LINEN SERVICE	M					3
4	LINEN SERVICE	M					4
5	LINEN SERVICE	M					5
6	LINEN SERVICE	M					6
7	LINEN SERVICE	M					7
8	LINEN SERVICE	M					8
9	LINEN SERVICE	M					9
10	LINEN SERVICE	M					10
11	LINEN SERVICE	M					11
12	LINEN SERVICE	M					12
13	LINEN SERVICE	M					13
14	LINEN SERVICE	M					14
15	LINEN SERVICE	M					15
16	LINEN SERVICE	M					16
17	LINEN SERVICE	M					17
18	LINEN SERVICE	M					18
500	TOTAL RECLASSIFICATIONS					172,471	500
	CODE LETTER - M						
1	IV THERAPY	N	DRUGS CHARGED TO PATIENTS	73	649,641	53,132	1
500	TOTAL RECLASSIFICATIONS				649,641	53,132	500
	CODE LETTER - N						
	GRAND TOTAL (INCREASES)				1,236,051	28,705,077	

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

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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	SUPPLIES RECLASS	A	EMPLOYEE BENEFITS DEPARTMENT	4		1,420		1
2	SUPPLIES RECLASS	A	ADMINISTRATIVE & GENERAL	5		4,247		2
3	SUPPLIES RECLASS	A	OPERATION OF PLANT	7		315		3
4	SUPPLIES RECLASS	A	LAUNDRY & LINEN SERVICE	8		37		4
5	SUPPLIES RECLASS	A	HOUSEKEEPING	9		2,764		5
6	SUPPLIES RECLASS	A	DIETARY	10		4,925		6
7			NURSING ADMINISTRATION	13		557		7
8	SUPPLIES RECLASS	A	CENTRAL SERVICES & SUPPLY	14		96,539		8
9	SUPPLIES RECLASS	A	STERILE PROCESSING	14.01		97,944		9
10	SUPPLIES RECLASS	A	PHARMACY	15		1,333		10
11	SUPPLIES RECLASS	A	MEDICAL RECORDS & LIBRARY	16		2		11
12	SUPPLIES RECLASS	A	PARAMED ED PRGM-(SPECIFY)	23		4,089		12
13	SUPPLIES RECLASS	A	ADULTS & PEDIATRICS	30		142,238		13
14	SUPPLIES RECLASS	A	INTENSIVE CARE UNIT	31		32,983		14
15	SUPPLIES RECLASS	A	SURGICAL INTENSIVE CARE UNIT	34		20,739		15
16	SUPPLIES RECLASS	A	OPERATING ROOM	50		4,840,618		16
17	SUPPLIES RECLASS	A	RECOVERY ROOM	51		18,856		17
18	SUPPLIES RECLASS	A	OP ONCOLOGY	51.01		5,995		18
19	SUPPLIES RECLASS	A	INFUSION CLINIC	52.06		2,912		19
20	SUPPLIES RECLASS	A	ANESTHESIOLOGY	53		95,259		20
21	SUPPLIES RECLASS	A	RADIOLOGY-DIAGNOSTIC	54		214,839		21
22	SUPPLIES RECLASS	A	RADIOISOTOPE	56		7,953		22
23	SUPPLIES RECLASS	A	CARDIAC CATHETERIZATION	59		1,912,905		23
24	SUPPLIES RECLASS	A	LABORATORY	60		412,952		24
25	SUPPLIES RECLASS	A	RESPIRATORY THERAPY	65		97,931		25
26	SUPPLIES RECLASS	A	PHYSICAL THERAPY	66		4,483		26
27	SUPPLIES RECLASS	A	WOUND CARE	66.01		164,607		27
28	SUPPLIES RECLASS	A	OCCUPATIONAL THERAPY	67		238		28
29	SUPPLIES RECLASS	A	SPEECH PATHOLOGY	68		1,320		29
30	SUPPLIES RECLASS	A	ELECTROCARDIOLOGY	69		396		30
31	SUPPLIES RECLASS	A	ELECTROENCEPHALOGRAPHY	70		16,455		31
32	SUPPLIES RECLASS	A	RENAL DIALYSIS	74		945,146		32
33	SUPPLIES RECLASS	A	CARDIAC REHABILITATION	76.97		621		33
34	SUPPLIES RECLASS	A	OCCUPATIONAL HEALTH	90.01		11,849		34
35	SUPPLIES RECLASS	A	EMERGENCY	91		183,774		35
36	SUPPLIES RECLASS	A	OTHER NRCC	194		5,196		36
500	TOTAL RECLASSIFICATIONS					9,354,437		500
	CODE LETTER - A							
1								1
2								2
3								3
4								4
5								5
6								6
7	DRUGS	B	EMPLOYEE BENEFITS DEPARTMENT	4		2,919		7
8	DRUGS	B	OPERATION OF PLANT	7		28		8
9	DRUGS	B	DIETARY	10		160		9
10	DRUGS	B	NURSING ADMINISTRATION	13		84		10
11	DRUGS	B	CENTRAL SERVICES & SUPPLY	14		152,439		11
12	DRUGS	B	STERILE PROCESSING	14.01		165		12
13	DRUGS	B	PHARMACY	15		6,420,490		13
14	DRUGS	B	PARAMED ED PRGM-(SPECIFY)	23		6,098		14
15	DRUGS	B	ADULTS & PEDIATRICS	30		19,421		15
16	DRUGS	B	INTENSIVE CARE UNIT	31		6,673		16
17	DRUGS	B	SURGICAL INTENSIVE CARE UNIT	34		4,000		17
18	DRUGS	B	OPERATING ROOM	50		41,067		18
19	DRUGS	B	RECOVERY ROOM	51		2,102		19
20	DRUGS	B	OP ONCOLOGY	51.01		3,833		20
21	DRUGS	B	INFUSION CLINIC	52.06		4,604		21
22	DRUGS	B	ANESTHESIOLOGY	53		22,338		22
23	DRUGS	B	RADIOLOGY-DIAGNOSTIC	54		16,269		23
24	DRUGS	B	RADIOISOTOPE	56		127,132		24
25	DRUGS	B	CARDIAC CATHETERIZATION	59		6,758		25
26	DRUGS	B	RESPIRATORY THERAPY	65		1,872		26
27	DRUGS	B	PHYSICAL THERAPY	66		84		27
28	DRUGS	B	WOUND CARE	66.01		52,424		28
29	DRUGS	B	ELECTROCARDIOLOGY	69		2,591		29
30	DRUGS	B	OCCUPATIONAL HEALTH	90.01		53,442		30

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
31	DRUGS	B	EMERGENCY	91		87,369		31
32	DRUGS	B	AMBULANCE SERVICES	95		3		32
33	DRUGS	B	OTHER NRCC	194		39,385		33
34	DRUGS	B						34
500	TOTAL RECLASSIFICATIONS					7,073,750		500
	CODE LETTER -							
1	DEPRECIATION	C	EMPLOYEE BENEFITS DEPARTMENT	4		722	9	1
2	DEPRECIATION	C	ADMINISTRATIVE & GENERAL	5		491,556	9	2
3	DEPRECIATION	C	OPERATION OF PLANT	7		747,653	9	3
4	DEPRECIATION	C	HOUSEKEEPING	9		5,312	9	4
5	DEPRECIATION	C	DIETARY	10		17,386	9	5
6	DEPRECIATION	C	NURSING ADMINISTRATION	13		84,684	9	6
7	DEPRECIATION	C	CENTRAL SERVICES & SUPPLY	14		270	9	7
8	DEPRECIATION	C	STERILE PROCESSING	14.01		141,409	9	8
9	DEPRECIATION	C	PHARMACY	15		6,462	9	9
10	DEPRECIATION	C	MEDICAL RECORDS & LIBRARY	16		6,382	9	10
11	DEPRECIATION	C	PARAMED ED PRGM-(SPECIFY)	23		3,606	9	11
12	DEPRECIATION	C	ADULTS & PEDIATRICS	30		172,058	9	12
13	DEPRECIATION	C	INTENSIVE CARE UNIT	31		22,186	9	13
14	DEPRECIATION	C	SURGICAL INTENSIVE CARE UNIT	34		16,344	9	14
15	DEPRECIATION	C	OPERATING ROOM	50		474,271	9	15
16	DEPRECIATION	C	RECOVERY ROOM	51		3,623	9	16
17	DEPRECIATION	C	OP ONCOLOGY	51.01		2,531	9	17
18	DEPRECIATION	C	INFUSION CLINIC	52.06		3,018	9	18
19	DEPRECIATION	C	ANESTHESIOLOGY	53		40,758	9	19
20	DEPRECIATION	C	RADIOLOGY-DIAGNOSTIC	54		1,064,095	9	20
21	DEPRECIATION	C	RADIOISOTOPE	56		201,894	9	21
22	DEPRECIATION	C	CARDIAC CATHETERIZATION	59		125,720	9	22
23	DEPRECIATION	C	LABORATORY	60		120,617	9	23
24	DEPRECIATION	C	RESPIRATORY THERAPY	65		51,514	9	24
25	DEPRECIATION	C	PHYSICAL THERAPY	66		9,186	9	25
26	DEPRECIATION	C	WOUND CARE	66.01		598	9	26
27	DEPRECIATION	C	ELECTROCARDIOLOGY	69		34,695	9	27
28	DEPRECIATION	C	ELECTROENCEPHALOGRAPHY	70		2,828	9	28
29	DEPRECIATION	C	RENAL DIALYSIS	74		83,773	9	29
30	DEPRECIATION	C	CARDIAC REHABILITATION	76.97		930	9	30
31	DEPRECIATION	C	OCCUPATIONAL HEALTH	90.01		40,733	9	31
32	DEPRECIATION	C	EMERGENCY	91		72,602	9	32
33	DEPRECIATION	C	OTHER NRCC	194		118,947	9	33
34	DEPRECIATION	C	SISTERS RESIDENCE	194.01		750	9	34
500	TOTAL RECLASSIFICATIONS					4,169,113		500
	CODE LETTER - C							
1	REHAB RECLASS	D	PHYSICAL THERAPY	66	16,060	1,477		1
2	REHAB RECLASS	D						2
500	TOTAL RECLASSIFICATIONS				16,060	1,477		500
	CODE LETTER - D							
1	CARDIAC REHAB RECLASS	E	CARDIAC REHABILITATION	76.97	174,449	4,605		1
500	TOTAL RECLASSIFICATIONS				174,449	4,605		500
	CODE LETTER - E							
1	CAPITAL INTEREST	F	INTEREST EXPENSE	113		3,168,089	11	1
500	TOTAL RECLASSIFICATIONS					3,168,089		500
	CODE LETTER - F							
1	CAFETERIA	G	DIETARY	10	395,901	524,061		1
500	TOTAL RECLASSIFICATIONS				395,901	524,061		500
	CODE LETTER - G							
1	IMPLANTS	J	MEDICAL SUPPLIES CHARGED TO P	71		4,183,942		1
500	TOTAL RECLASSIFICATIONS					4,183,942		500
	CODE LETTER - J							
1	EMT TRAINERS	K						1
500	TOTAL RECLASSIFICATIONS							500
	CODE LETTER - K							

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	LINEN SERVICE	M	STERILE PROCESSING	14.01		2,973		1
2	LINEN SERVICE	M	ADULTS & PEDIATRICS	30		66,425		2
3	LINEN SERVICE	M	INTENSIVE CARE UNIT	31		10,176		3
4	LINEN SERVICE	M	SURGICAL INTENSIVE CARE UNIT	34		7,075		4
5	LINEN SERVICE	M	OPERATING ROOM	50		19,281		5
6	LINEN SERVICE	M	RECOVERY ROOM	51		11,833		6
7	LINEN SERVICE	M	OP ONCOLOGY	51.01		662		7
8	LINEN SERVICE	M	INFUSION CLINIC	52.06		421		8
9	LINEN SERVICE	M	RADIOLOGY-DIAGNOSTIC	54		12,847		9
10	LINEN SERVICE	M	RADIOISOTOPE	56		1,379		10
11	LINEN SERVICE	M	CARDIAC CATHETERIZATION	59		2,445		11
12	LINEN SERVICE	M	RESPIRATORY THERAPY	65		1,121		12
13	LINEN SERVICE	M	PHYSICAL THERAPY	66		45		13
14	LINEN SERVICE	M	WOUND CARE	66.01		3,939		14
15	LINEN SERVICE	M	ELECTROENCEPHALOGRAPHY	70		1,160		15
16	LINEN SERVICE	M	CARDIAC REHABILITATION	76.97		10		16
17	LINEN SERVICE	M	OCCUPATIONAL HEALTH	90.01		828		17
18	LINEN SERVICE	M	EMERGENCY	91		29,851		18
500	TOTAL RECLASSIFICATIONS					172,471		500
	CODE LETTER - M							
1	IV THERAPY	N	ADULTS & PEDIATRICS	30	649,641	53,132		1
500	TOTAL RECLASSIFICATIONS				649,641	53,132		500
	CODE LETTER - N							
	GRAND TOTAL (DECREASES)				1,236,051	28,705,077		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	5,113,245					5,113,245		1
2	LAND IMPROVEMENTS	1,933,152					1,933,152		2
3	BUILDINGS AND FIXTURES	86,901,875	73,714		73,714		86,975,589		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	42,116,663	1,818,437		1,818,437	17,614	43,917,486		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	136,064,935	1,892,151		1,892,151	17,614	137,939,472		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	136,064,935	1,892,151		1,892,151	17,614	137,939,472		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	3,924,477						3,924,477	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)	3,924,477						3,924,477	3

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	94,031,268		94,031,268	0.681685					1
2	CAP REL COSTS-MVBLE EQU	43,908,204		43,908,204	0.318315					2
3	TOTAL (sum of lines 1-2)	137,939,472		137,939,472	1.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	4,969,521		1,364,854			-788,897	5,545,478	1
2	CAP REL COSTS-MVBLE EQUIP	3,528,670						3,528,670	2
3	TOTAL (sum of lines 1-2)	8,498,191		1,364,854			-788,897	9,074,148	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-783,069	CAP REL COSTS-BLDG & FIXT	1	11	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)	B	-2,261	ADMINISTRATIVE & GENERAL	5		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)	B	-75,716	ADMINISTRATIVE & GENERAL	5		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	-1,822,850				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-2,584,167				12
13	LAUNDRY AND LINEN SERVICE	B	-83	LAUNDRY & LINEN SERVICE	8		13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-408,027	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	B	-1,170	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-7,406	CAFETERIA	11		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	RADIOLOGY OTHER OPER INCOME	B	-28,821	RADIOLOGY-DIAGNOSTIC	54		33
34							34
35	OTHER OPER INC 211077000 651900	B	10,917	ADMINISTRATIVE & GENERAL	5		35
36	OB NURSERY PHOTOS & OTHER OPER	B	-510	ADULTS & PEDIATRICS	30		36
37							37
38	VOLUNTEER HOURS CONTRIBUTION	B	-309,458	ADMINISTRATIVE & GENERAL	5		38
39	REAL ESTATE TAXES 211085000 772	A	-36,300	ADMINISTRATIVE & GENERAL	5		39
40	MEDICAL AFFAIRS ADJUSTMENT	A	-200,546	ADMINISTRATIVE & GENERAL	5		40
41	MARKETING EXPENSES	A	-287,907	ADMINISTRATIVE & GENERAL	5		41
42	MARKETING DEPRECIATION	A	-10,407	ADMINISTRATIVE & GENERAL	5	9	42
42.10	AHA DUES	A	-5,209	ADMINISTRATIVE & GENERAL	5		42.10
42.20	IHA DUES	A	-28,544	ADMINISTRATIVE & GENERAL	5		42.20
42.30	ADMIN NON-ALLOWABLE EXP	A	-679	ADMINISTRATIVE & GENERAL	5		42.30
43							43
43.10	MISC INCOME 211061300 651900	B	-8,445	CENTRAL SERVICES & SUPPLY	14		43.10
43.20	MISC INCOME 211063700 651900	B	-4,178	OPERATING ROOM	50		43.20
43.30	MISC INCOME 211065100 651900	B	-170	SPEECH PATHOLOGY	68		43.30
43.40	MISC INCOME EMS EDUCATION	B	-75,649	PARAMED ED PRGM-(SPECIFY)	23		43.40
44							44
45	OFFSET RENTAL INCOME	B	-788,897	CAP REL COSTS-BLDG & FIXT	1	14	45
46							46
47							47
48							48
49							49

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-7,459,552				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	1	CAP REL COSTS-BLDG & FIXT		2,142,232	3,162,398	-1,020,166	11	1
2	2	CAP REL COSTS-MVBLE EQUIP		2,220,766	1,816,165	404,601	9	2
3	31	INTENSIVE CARE UNIT		544,765	306,967	237,798		3
3.01	34	SURGICAL INTENSIVE CARE UNIT		305,078	171,907	133,171		3.01
3.02	69	ELECTROCARDIOLOGY			42,384	-42,384		3.02
3.03	54	RADIOLOGY-DIAGNOSTIC		122,637	161,112	-38,475		3.03
3.04	14	CENTRAL SERVICES & SUPPLY			433,668	-433,668		3.04
3.05	8	LAUNDRY & LINEN SERVICE			500,568	-500,568		3.05
3.06	5	ADMINISTRATIVE & GENERAL		10,507,391	11,550,596	-1,043,205		3.06
3.07	4	EMPLOYEE BENEFITS DEPARTMENT		523,092	825,894	-302,802		3.07
3.08	7	OPERATION OF PLANT		97,491	75,960	21,531		3.08
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			16,463,452	19,047,619	-2,584,167		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	B	PROVENA HEALTH		PROVENA HEALTH		MANAGEMENT	6
7							7
8							8
9							9
10							10

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

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

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GEN ADMINISTRATIVE	342,611		342,611	177,200	2,511	213,918	10,696	1
2	30	ADULTS & PEDIATRICS ADULTS & PEDIAT	5,400		5,400	138,700	50	3,334	167	2
3	52.02	SUBSTANCE ABUSE SUBSTANCE ABUSE	3,685		3,685	208,000	34	3,400	170	3
4	51.01	OP ONCOLOGY OP ONCOLOGY	922,361	910,811	11,550	177,200	77	6,560	328	4
5	59	CARDIAC CATHETERIZAT CARDIAC CATHETE	11,094		11,094	177,200	64	5,452	273	5
6	60	LABORATORY LABORATORY	44,206		44,206	215,700	354	36,710	1,836	6
7	65	RESPIRATORY THERAPY RESPIRATORY THE	5,125		5,125	177,200	41	3,493	175	7
8	90.01	OCCUPATIONAL HEALTH OCCUPATIONAL HE	306,099	306,099						8
9	74	RENAL DIALYSIS RENAL DIALYSIS	106,053		106,053	208,000	333	33,300	1,665	9
10	91	EMERGENCY EMERGENCY	417,150	342,990	74,160	177,200	432	36,803	1,840	10
11	40	SUBPROVIDER - IPF PSYCH	5,170		5,170	138,700	47	3,134	157	11
200		TOTAL	2,168,954	1,559,900	609,054		3,943	346,104	17,307	200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATIO N	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT - ICE INSURANC E	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GEN ADMINISTRATIVE					213,918	128,693	128,693	1
2	30	ADULTS & PEDIATRICS ADULTS & PEDIAT					3,334	2,066	2,066	2
3	52.02	SUBSTANCE ABUSE SUBSTANCE ABUSE					3,400	285	285	3
4	51.01	OP ONCOLOGY OP ONCOLOGY					6,560	4,990	915,801	4
5	59	CARDIAC CATHETERIZAT CARDIAC CATHETE					5,452	5,642	5,642	5
6	60	LABORATORY LABORATORY					36,710	7,496	7,496	6
7	65	RESPIRATORY THERAPY RESPIRATORY THE					3,493	1,632	1,632	7
8	90.01	OCCUPATIONAL HEALTH OCCUPATIONAL HE							306,099	8
9	74	RENAL DIALYSIS RENAL DIALYSIS					33,300	72,753	72,753	9
10	91	EMERGENCY EMERGENCY					36,803	37,357	380,347	10
11	40	SUBPROVIDER - IPF PSYCH					3,134	2,036	2,036	11
200		TOTAL					346,104	262,950	1,822,850	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	5,545,478	5,545,478					1
2	CAP REL COSTS-MVBLE EQUIP	3,528,670		3,528,670				2
4	EMPLOYEE BENEFITS DEPARTMENT	10,358,271	65,690	936	10,424,897			4
5	ADMINISTRATIVE & GENERAL	26,242,246	244,833	162,584	922,934	27,572,597	27,572,597	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	3,646,395	1,490,594	401,872	217,492	5,756,353	1,707,421	7
7.01	BIO MED	1,680,196	6,528	516		1,687,240	500,461	7.01
8	LAUNDRY & LINEN SERVICE	363,074	15,939		10,458	389,471	115,523	8
9	HOUSEKEEPING	1,188,345	16,491	7,974	180,059	1,392,869	413,146	9
10	DIETARY	897,489	110,362	24,307	106,361	1,138,519	337,702	10
11	CAFETERIA	504,529	60,308		106,360	671,197	199,087	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	852,514	8,418	111,268	200,251	1,172,451	347,767	13
14	CENTRAL SERVICES & SUPPLY	155,691	109,354	3,494	57,456	325,995	96,695	14
14.01	STERILE PROCESSING	333,041	99,335	153,544	74,802	660,722	195,980	14.01
15	PHARMACY	1,631,625	28,056	7,857	364,876	2,032,414	602,844	15
16	MEDICAL RECORDS & LIBRARY	1,714,132	94,615	7,677	339,084	2,155,508	639,356	16
17	SOCIAL SERVICE	866,596	4,140		168,984	1,039,720	308,397	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)	159,562	2,760	915	47,956	211,193	62,643	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,490,463	599,378	175,289	1,954,427	9,219,557	2,734,671	30
31	INTENSIVE CARE UNIT	2,297,636	100,481	31,660	502,766	2,932,543	869,836	31
34	SURGICAL INTENSIVE CARE UNIT	1,535,722	80,042	9,222	335,658	1,960,644	581,556	34
40	SUBPROVIDER - IPF	1,018,893	80,553	23,559	262,686	1,385,691	411,017	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,404,742	161,189	514,263	418,227	3,498,421	1,037,684	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	1,279,208	59,714	3,719	343,730	1,686,371	500,203	51
51.01	OP ONCOLOGY	1,006,186	402,102	1,526	238,654	1,648,468	488,960	51.01
52.02	SUBSTANCE ABUSE	287,821	67,815		58,368	414,004	122,800	52.02
52.04	DIABETES EDUCATION	54,310	14,035		17,895	86,240	25,580	52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	313,173	32,652	3,862	75,718	425,405	126,182	52.06
53	ANESTHESIOLOGY	4,132,424	4,278	37,813	8,130	4,182,645	1,240,635	53
54	RADIOLOGY-DIAGNOSTIC	2,938,009	199,291	699,194	699,930	4,536,424	1,345,571	54
56	RADIOISOTOPE	822,156	24,841	252,086	126,295	1,225,378	363,465	56
59	CARDIAC CATHETERIZATION	535,236	55,685	268,759	137,425	997,105	295,756	59
60	LABORATORY	4,203,142	163,328	225,740		4,592,210	1,362,118	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,519,471	38,172	48,624	352,714	1,958,981	581,063	65
66	PHYSICAL THERAPY	892,068	102,702	12,547	198,149	1,205,466	357,559	66
66.01	WOUND CARE	1,289,584	45,417	730	26,512	1,362,243	404,062	66.01
67	OCCUPATIONAL THERAPY	175,682	5,603		38,233	219,518	65,112	67
68	SPEECH PATHOLOGY	177,575	3,312	87	33,145	214,119	63,511	68
69	ELECTROCARDIOLOGY	324,997	41,870	40,030	94,420	501,317	148,698	69
70	ELECTROENCEPHALOGRAPHY	35,899	11,027	3,065	2,525	52,516	15,577	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,170,495				5,170,495	1,533,646	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,183,942				4,183,942	1,241,020	72
73	DRUGS CHARGED TO PATIENTS	7,776,523			128,003	7,904,526	2,344,601	73
74	RENAL DIALYSIS	3,803,599	183,890	74,686	430,604	4,492,779	1,332,626	74
76	OTHER							76
76.97	CARDIAC REHABILITATION	2,792	95,181	6,186	750	104,909	31,118	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH	851,386	110,403	2,436	242,078	1,206,303	357,808	90.01
91	EMERGENCY	2,958,801	141,012	135,844	690,627	3,926,284	1,164,595	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	118,149,789	5,181,396	3,453,871	10,214,742	117,500,753	26,674,052	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	97,260			19,811	117,071	34,725	190
194	OTHER NRCC	2,283,036	364,082	74,799	190,344	2,912,261	863,820	194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	120,530,085	5,545,478	3,528,670	10,424,897	120,530,085	27,572,597	202

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	BIO MED	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	7.01	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	7,463,774						7
7.01	BIO MED	13,012	2,200,713					7.01
8	LAUNDRY & LINEN SERVICE	31,773		536,767				8
9	HOUSEKEEPING	32,873			1,838,888			9
10	DIETARY	219,988			99,189	1,795,398		10
11	CAFETERIA	120,214					990,498	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	16,780	24,801		30,593		17,418	13
14	CENTRAL SERVICES & SUPPLY	217,980			23,686		13,486	14
14.01	STERILE PROCESSING	198,008	222,703		28,523		16,239	14.01
15	PHARMACY	55,925			55,737		31,734	15
16	MEDICAL RECORDS & LIBRARY	188,600			71,870		40,919	16
17	SOCIAL SERVICE	8,253			25,041		14,257	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)	5,502			5,282		3,008	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,194,760	357,844	177,548	418,666	1,488,675	238,367	30
31	INTENSIVE CARE UNIT	200,292		30,772	95,167	76,291	54,183	31
34	SURGICAL INTENSIVE CARE UNIT	159,551		20,759	57,249	30,339	32,595	34
40	SUBPROVIDER - IPF	160,569	48,084	23,863	56,271	200,093	32,038	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	321,303	1,518	68,979	83,983		47,816	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	119,031		34,106	60,277		34,319	51
51.01	OP ONCOLOGY	801,524	23,283	1,666	29,919		17,034	51.01
52.02	SUBSTANCE ABUSE	135,178			13,752		7,830	52.02
52.04	DIABETES EDUCATION	27,976			3,086		1,757	52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	65,086	9,617	1,074	11,298		6,432	52.06
53	ANESTHESIOLOGY	8,528	135,140		3,010		1,714	53
54	RADIOLOGY-DIAGNOSTIC	397,255	66,811	34,899	153,525		87,409	54
56	RADIOISOTOPE	49,516		3,115	7,058		4,019	56
59	CARDIAC CATHETERIZATION	110,998	75,922	7,103	21,680		12,344	59
60	LABORATORY	325,567	96,167					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	76,089	14,678	2,059	56,647		32,252	65
66	PHYSICAL THERAPY	204,721		6,225	36,560		20,816	66
66.01	WOUND CARE	90,532		5,955	16,619		9,462	66.01
67	OCCUPATIONAL THERAPY	11,169			6,404		3,646	67
68	SPEECH PATHOLOGY	6,602			3,695		2,104	68
69	ELECTROCARDIOLOGY	83,462	7,592	3,290	18,063		10,284	69
70	ELECTROENCEPHALOGRAPHY	21,980		590	472		269	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	366,555	214,605		90,795		51,694	74
76	OTHER							76
76.97	CARDIAC REHABILITATION	189,728	200,433		6,452		3,673	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH	220,071		2,451	39,055		22,236	90.01
91	EMERGENCY	281,085	594,213	97,423	138,221		78,696	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	6,738,036	2,093,411	521,877	1,767,845	1,795,398	950,050	118

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	BIO MED	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	7.01	8	9	10	11	
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				9,869		5,619	190
194	OTHER NRCC	725,738	107,302	14,890	61,174		34,829	194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	7,463,774	2,200,713	536,767	1,838,888	1,795,398	990,498	202

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	STERILE PR OCESSING	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13	14	14.01	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	BIO MED							7.01
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,609,810						13
14	CENTRAL SERVICES & SUPPLY		677,842					14
14.01	STERILE PROCESSING		43,408	1,365,583				14.01
15	PHARMACY		16,597		2,795,251			15
16	MEDICAL RECORDS & LIBRARY	101,933	29,528			3,227,714		16
17	SOCIAL SERVICE		548				1,396,216	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)	7,492	11,252					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	593,804	70,190	29,376		2,191,294	931,355	30
31	INTENSIVE CARE UNIT	134,976	7,537			350,530	148,963	31
34	SURGICAL INTENSIVE CARE UNIT	81,196	6,073			230,136	97,873	34
40	SUBPROVIDER - IPF	79,809	9,433	3,943		294,368	125,201	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	118,265	123,303	1,223,505				50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	85,492	4,900					51
51.01	OP ONCOLOGY	42,434	7,299					51.01
52.02	SUBSTANCE ABUSE		3,158					52.02
52.04	DIABETES EDUCATION		803					52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	16,024	648					52.06
53	ANESTHESIOLOGY		2,461					53
54	RADIOLOGY-DIAGNOSTIC		100,378	4,337				54
56	RADIOISOTOPE		48					56
59	CARDIAC CATHETERIZATION		49,738	7,393				59
60	LABORATORY		22,508					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		18,646	1,521				65
66	PHYSICAL THERAPY		2,666					66
66.01	WOUND CARE	23,570	3,385	66,357				66.01
67	OCCUPATIONAL THERAPY		736					67
68	SPEECH PATHOLOGY		8					68
69	ELECTROCARDIOLOGY		3,953					69
70	ELECTROENCEPHALOGRAPHY		71					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		9,174					71
72	IMPL. DEV. CHARGED TO PATIENTS		8,854					72
73	DRUGS CHARGED TO PATIENTS				2,795,251			73
74	RENAL DIALYSIS	128,775	57,177			161,386	92,824	74
76	OTHER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH		16,023	2,380				90.01
91	EMERGENCY	196,040	25,678	26,771				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,609,810	656,181	1,365,583	2,795,251	3,227,714	1,396,216	118

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	STERILE PR OCESSING	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13	14	14.01	15	16	17	
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
194	OTHER NRCC		21,661					194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,609,810	677,842	1,365,583	2,795,251	3,227,714	1,396,216	202

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		23	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	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	BIO MED							7.01
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
14.01	STERILE PROCESSING							14.01
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)	306,372						23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	25,464	19,671,571		19,671,571			30
31	INTENSIVE CARE UNIT	28,949	4,930,039		4,930,039			31
34	SURGICAL INTENSIVE CARE UNIT		3,257,971		3,257,971			34
40	SUBPROVIDER - IPF	3,485	2,833,865		2,833,865			40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	28,949	6,553,726		6,553,726			50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	19,299	2,543,998		2,543,998			51
51.01	OP ONCOLOGY		3,060,587		3,060,587			51.01
52.02	SUBSTANCE ABUSE		696,722		696,722			52.02
52.04	DIABETES EDUCATION		145,442		145,442			52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC		661,766		661,766			52.06
53	ANESTHESIOLOGY		5,574,133		5,574,133			53
54	RADIOLOGY-DIAGNOSTIC	9,650	6,736,259		6,736,259			54
56	RADIOISOTOPE		1,652,599		1,652,599			56
59	CARDIAC CATHETERIZATION	9,650	1,587,689		1,587,689			59
60	LABORATORY		6,398,570		6,398,570			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	19,299	2,761,235		2,761,235			65
66	PHYSICAL THERAPY		1,834,013		1,834,013			66
66.01	WOUND CARE		1,982,185		1,982,185			66.01
67	OCCUPATIONAL THERAPY		306,585		306,585			67
68	SPEECH PATHOLOGY		290,039		290,039			68
69	ELECTROCARDIOLOGY	9,650	786,309		786,309			69
70	ELECTROENCEPHALOGRAPHY		91,475		91,475			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		6,713,315		6,713,315			71
72	IMPL. DEV. CHARGED TO PATIENTS		5,433,816		5,433,816			72
73	DRUGS CHARGED TO PATIENTS		13,044,378		13,044,378			73
74	RENAL DIALYSIS	9,650	6,998,866		6,998,866			74
76	OTHER							76
76.97	CARDIAC REHABILITATION		536,313		536,313			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH		1,866,327		1,866,327			90.01
91	EMERGENCY	142,327	6,671,333		6,671,333			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	306,372	115,621,126		115,621,126			118

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		23	24	25	26			
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		167,284		167,284			190
194	OTHER NRCC		4,741,675		4,741,675			194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	306,372	120,530,085		120,530,085			202

KPMG LLP

COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		65,690	936	66,626	66,626		4
5	ADMINISTRATIVE & GENERAL		244,833	162,584	407,417	5,897	413,314	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		1,490,594	401,872	1,892,466	1,390	25,593	7
7.01	BIO MED		6,528	516	7,044		7,501	7.01
8	LAUNDRY & LINEN SERVICE		15,939		15,939	67	1,732	8
9	HOUSEKEEPING		16,491	7,974	24,465	1,150	6,193	9
10	DIETARY		110,362	24,307	134,669	680	5,062	10
11	CAFETERIA		60,308		60,308	680	2,984	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		8,418	111,268	119,686	1,279	5,213	13
14	CENTRAL SERVICES & SUPPLY		109,354	3,494	112,848	367	1,449	14
14.01	STERILE PROCESSING		99,335	153,544	252,879	478	2,938	14.01
15	PHARMACY		28,056	7,857	35,913	2,331	9,036	15
16	MEDICAL RECORDS & LIBRARY		94,615	7,677	102,292	2,166	9,583	16
17	SOCIAL SERVICE		4,140		4,140	1,080	4,623	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)		2,760	915	3,675	306	939	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		599,378	175,289	774,667	12,506	41,014	30
31	INTENSIVE CARE UNIT		100,481	31,660	132,141	3,212	13,038	31
34	SURGICAL INTENSIVE CARE UNIT		80,042	9,222	89,264	2,145	8,717	34
40	SUBPROVIDER - IPF		80,553	23,559	104,112	1,678	6,161	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		161,189	514,263	675,452	2,672	15,554	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM		59,714	3,719	63,433	2,196	7,498	51
51.01	OP ONCOLOGY		402,102	1,526	403,628	1,525	7,329	51.01
52.02	SUBSTANCE ABUSE		67,815		67,815	373	1,841	52.02
52.04	DIABETES EDUCATION		14,035		14,035	114	383	52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC		32,652	3,862	36,514	484	1,891	52.06
53	ANESTHESIOLOGY		4,278	37,813	42,091	52	18,596	53
54	RADIOLOGY-DIAGNOSTIC		199,291	699,194	898,485	4,472	20,169	54
56	RADIOISOTOPE		24,841	252,086	276,927	807	5,448	56
59	CARDIAC CATHETERIZATION		55,685	268,759	324,444	878	4,433	59
60	LABORATORY		163,328	225,740	389,068		20,417	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		38,172	48,624	86,796	2,254	8,710	65
66	PHYSICAL THERAPY		102,702	12,547	115,249	1,266	5,360	66
66.01	WOUND CARE		45,417	730	46,147	169	6,057	66.01
67	OCCUPATIONAL THERAPY		5,603		5,603	244	976	67
68	SPEECH PATHOLOGY		3,312	87	3,399	212	952	68
69	ELECTROCARDIOLOGY		41,870	40,030	81,900	603	2,229	69
70	ELECTROENCEPHALOGRAPHY		11,027	3,065	14,092	16	233	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						22,988	71
72	IMPL. DEV. CHARGED TO PATIENTS						18,602	72
73	DRUGS CHARGED TO PATIENTS					818	35,144	73
74	RENAL DIALYSIS		183,890	74,686	258,576	2,751	19,975	74
76	OTHER							76
76.97	CARDIAC REHABILITATION		95,181	6,186	101,367	5	466	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH		110,403	2,436	112,839	1,547	5,363	90.01
91	EMERGENCY		141,012	135,844	276,856	4,413	17,456	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
118	SUBTOTALS (sum of lines 1-117)		5,181,396	3,453,871	8,635,267	65,283	399,846	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					127	520	190
194	OTHER NRCC		364,082	74,799	438,881	1,216	12,948	194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		5,545,478	3,528,670	9,074,148	66,626	413,314	202

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	BIO MED	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	7.01	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,919,449						7
7.01	BIO MED	3,346	17,891					7.01
8	LAUNDRY & LINEN SERVICE	8,171		25,909				8
9	HOUSEKEEPING	8,454			40,262			9
10	DIETARY	56,574			2,172	199,157		10
11	CAFETERIA	30,915					94,887	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	4,315	202		670		1,669	13
14	CENTRAL SERVICES & SUPPLY	56,058			519		1,292	14
14.01	STERILE PROCESSING	50,922	1,810		624		1,556	14.01
15	PHARMACY	14,382			1,220		3,040	15
16	MEDICAL RECORDS & LIBRARY	48,502			1,574		3,920	16
17	SOCIAL SERVICE	2,122			548		1,366	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)	1,415			116		288	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	307,256	2,909	8,574	9,168	165,133	22,833	30
31	INTENSIVE CARE UNIT	51,509		1,485	2,084	8,463	5,191	31
34	SURGICAL INTENSIVE CARE UNIT	41,032		1,002	1,253	3,365	3,122	34
40	SUBPROVIDER - IPF	41,293	391	1,152	1,232	22,196	3,069	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	82,629	12	3,329	1,839		4,581	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	30,611		1,646	1,320		3,288	51
51.01	OP ONCOLOGY	206,127	189	80	655		1,632	51.01
52.02	SUBSTANCE ABUSE	34,764			301		750	52.02
52.04	DIABETES EDUCATION	7,195			68		168	52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	16,738	78	52	247		616	52.06
53	ANESTHESIOLOGY	2,193	1,099		66		164	53
54	RADIOLOGY-DIAGNOSTIC	102,161	543	1,684	3,361		8,374	54
56	RADIOISOTOPE	12,734		150	155		385	56
59	CARDIAC CATHETERIZATION	28,545	617	343	475		1,183	59
60	LABORATORY	83,726	782					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	19,568	119	99	1,240		3,090	65
66	PHYSICAL THERAPY	52,648		300	800		1,994	66
66.01	WOUND CARE	23,282		287	364		906	66.01
67	OCCUPATIONAL THERAPY	2,872			140		349	67
68	SPEECH PATHOLOGY	1,698			81		202	68
69	ELECTROCARDIOLOGY	21,464	62	159	395		985	69
70	ELECTROENCEPHALOGRAPHY	5,652		28	10		26	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	94,266	1,745		1,988		4,952	74
76	OTHER							76
76.97	CARDIAC REHABILITATION	48,792	1,629		141		352	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH	56,595		118	855		2,130	90.01
91	EMERGENCY	72,286	4,832	4,702	3,026		7,539	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,732,812	17,019	25,190	38,707	199,157	91,012	118

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	BIO MED	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	7.01	8	9	10	11	
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				216		538	190
194	OTHER NRCC	186,637	872	719	1,339		3,337	194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,919,449	17,891	25,909	40,262	199,157	94,887	202

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	STERILE PR OCESSING	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13	14	14.01	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	BIO MED							7.01
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	133,034						13
14	CENTRAL SERVICES & SUPPLY		172,533					14
14.01	STERILE PROCESSING		11,049	322,256				14.01
15	PHARMACY		4,225		70,147			15
16	MEDICAL RECORDS & LIBRARY	8,424	7,516			183,977		16
17	SOCIAL SERVICE		139				14,018	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)	619	2,864					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	49,072	17,866	6,932		124,901	9,350	30
31	INTENSIVE CARE UNIT	11,154	1,918			19,980	1,496	31
34	SURGICAL INTENSIVE CARE UNIT	6,710	1,546			13,118	983	34
40	SUBPROVIDER - IPF	6,595	2,401	931		16,779	1,257	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	9,773	31,383	288,726				50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	7,065	1,247					51
51.01	OP ONCOLOGY	3,507	1,858					51.01
52.02	SUBSTANCE ABUSE		804					52.02
52.04	DIABETES EDUCATION		204					52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	1,324	165					52.06
53	ANESTHESIOLOGY		627					53
54	RADIOLOGY-DIAGNOSTIC		25,550	1,024				54
56	RADIOISOTOPE		12					56
59	CARDIAC CATHETERIZATION		12,660	1,745				59
60	LABORATORY		5,729					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		4,746	359				65
66	PHYSICAL THERAPY		679					66
66.01	WOUND CARE	1,948	862	15,659				66.01
67	OCCUPATIONAL THERAPY		187					67
68	SPEECH PATHOLOGY		2					68
69	ELECTROCARDIOLOGY		1,006					69
70	ELECTROENCEPHALOGRAPHY		18					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,335					71
72	IMPL. DEV. CHARGED TO PATIENTS		2,254					72
73	DRUGS CHARGED TO PATIENTS				70,147			73
74	RENAL DIALYSIS	10,642	14,554			9,199	932	74
76	OTHER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH		4,078	562				90.01
91	EMERGENCY	16,201	6,536	6,318				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	133,034	167,020	322,256	70,147	183,977	14,018	118

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	STERILE PR OCESSING	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13	14	14.01	15	16	17	
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
194	OTHER NRCC		5,513					194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	133,034	172,533	322,256	70,147	183,977	14,018	202

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		23	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	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	BIO MED							7.01
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
14.01	STERILE PROCESSING							14.01
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)	10,222						23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		1,552,181		1,552,181			30
31	INTENSIVE CARE UNIT		251,671		251,671			31
34	SURGICAL INTENSIVE CARE UNIT		172,257		172,257			34
40	SUBPROVIDER - IPF		209,247		209,247			40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		1,115,950		1,115,950			50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM		118,304		118,304			51
51.01	OP ONCOLOGY		626,530		626,530			51.01
52.02	SUBSTANCE ABUSE		106,648		106,648			52.02
52.04	DIABETES EDUCATION		22,167		22,167			52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC		58,109		58,109			52.06
53	ANESTHESIOLOGY		64,888		64,888			53
54	RADIOLOGY-DIAGNOSTIC		1,065,823		1,065,823			54
56	RADIOISOTOPE		296,618		296,618			56
59	CARDIAC CATHETERIZATION		375,323		375,323			59
60	LABORATORY		499,722		499,722			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		126,981		126,981			65
66	PHYSICAL THERAPY		178,296		178,296			66
66.01	WOUND CARE		95,681		95,681			66.01
67	OCCUPATIONAL THERAPY		10,371		10,371			67
68	SPEECH PATHOLOGY		6,546		6,546			68
69	ELECTROCARDIOLOGY		108,803		108,803			69
70	ELECTROENCEPHALOGRAPHY		20,075		20,075			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		25,323		25,323			71
72	IMPL. DEV. CHARGED TO PATIENTS		20,856		20,856			72
73	DRUGS CHARGED TO PATIENTS		106,109		106,109			73
74	RENAL DIALYSIS		419,580		419,580			74
76	OTHER							76
76.97	CARDIAC REHABILITATION		152,752		152,752			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH		184,087		184,087			90.01
91	EMERGENCY		420,165		420,165			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		8,411,063		8,411,063			118

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		23	24	25	26			
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,401		1,401			190
194	OTHER NRCC		651,462		651,462			194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS	10,222	10,222		10,222			200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	10,222	9,074,148		9,074,148			202

KPMG LLP

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT SQUARE FEET	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	401,835						1
2	CAP REL COSTS-MVBLE EQUIP		1,628,123					2
4	EMPLOYEE BENEFITS DEPARTMENT	4,760	432	39,553,028				4
5	ADMINISTRATIVE & GENERAL	17,741	75,016	3,501,694	-27,572,597	92,957,488		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	108,011	185,423	825,184		5,756,353	271,323	7
7.01	BIO MED	473	238			1,687,240	473	7.01
8	LAUNDRY & LINEN SERVICE	1,155		39,677		389,471	1,155	8
9	HOUSEKEEPING	1,195	3,679	683,159		1,392,869	1,195	9
10	DIETARY	7,997	11,215	403,542		1,138,519	7,997	10
11	CAFETERIA	4,370		403,541		671,197	4,370	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	610	51,339	759,770		1,172,451	610	13
14	CENTRAL SERVICES & SUPPLY	7,924	1,612	217,994		325,995	7,924	14
14.01	STERILE PROCESSING	7,198	70,845	283,806		660,722	7,198	14.01
15	PHARMACY	2,033	3,625	1,384,372		2,032,414	2,033	15
16	MEDICAL RECORDS & LIBRARY	6,856	3,542	1,286,516		2,155,508	6,856	16
17	SOCIAL SERVICE	300		641,141		1,039,720	300	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)	200	422	181,951		211,193	200	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	43,432	80,878	7,415,326		9,219,557	43,432	30
31	INTENSIVE CARE UNIT	7,281	14,608	1,907,539		2,932,543	7,281	31
34	SURGICAL INTENSIVE CARE UNIT	5,800	4,255	1,273,515		1,960,644	5,800	34
40	SUBPROVIDER - IPF	5,837	10,870	996,652		1,385,691	5,837	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,680	237,280	1,586,788		3,498,421	11,680	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	4,327	1,716	1,304,142		1,686,371	4,327	51
51.01	OP ONCOLOGY	29,137	704	905,475		1,648,468	29,137	51.01
52.02	SUBSTANCE ABUSE	4,914		221,452		414,004	4,914	52.02
52.04	DIABETES EDUCATION	1,017		67,896		86,240	1,017	52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	2,366	1,782	287,279		425,405	2,366	52.06
53	ANESTHESIOLOGY	310	17,447	30,846		4,182,645	310	53
54	RADIOLOGY-DIAGNOSTIC	14,441	322,609	2,655,594		4,536,424	14,441	54
56	RADIOISOTOPE	1,800	116,312	479,174		1,225,378	1,800	56
59	CARDIAC CATHETERIZATION	4,035	124,005	521,401		997,105	4,035	59
60	LABORATORY	11,835	104,156			4,592,210	11,835	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,766	22,435	1,338,229		1,958,981	2,766	65
66	PHYSICAL THERAPY	7,442	5,789	751,796		1,205,466	7,442	66
66.01	WOUND CARE	3,291	337	100,589		1,362,243	3,291	66.01
67	OCCUPATIONAL THERAPY	406		145,061		219,518	406	67
68	SPEECH PATHOLOGY	240	40	125,754		214,119	240	68
69	ELECTROCARDIOLOGY	3,034	18,470	358,238		501,317	3,034	69
70	ELECTROENCEPHALOGRAPHY	799	1,414	9,579		52,516	799	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					5,170,495		71
72	IMPL. DEV. CHARGED TO PATIENTS					4,183,942		72
73	DRUGS CHARGED TO PATIENTS			485,653		7,904,526		73
74	RENAL DIALYSIS	13,325	34,460	1,633,748		4,492,779	13,325	74
76	OTHER							76
76.97	CARDIAC REHABILITATION	6,897	2,854	2,845		104,909	6,897	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH	8,000	1,124	918,464		1,206,303	8,000	90.01
91	EMERGENCY	10,218	62,678	2,620,300		3,926,284	10,218	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT SQUARE FEET	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
118	SUBTOTALS (sum of lines 1-117)	375,453	1,593,611	38,755,682	-27,572,597	89,928,156	244,941	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			75,164		117,071		190
194	OTHER NRCC	26,382	34,512	722,182		2,912,261	26,382	194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	5,545,478	3,528,670	10,424,897		27,572,597	7,463,774	202
203	UNIT COST MULT-WS B PT I	13.800386	2.167324	0.263568		0.296615	27.508814	203
204	COST TO BE ALLOC PER B PT II			66,626		413,314	1,919,449	204
205	UNIT COST MULT-WS B PT II			0.001684		0.004446	7.074406	205

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	BIO MED WORKORDERS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA HOURS OF SERVICE	NURSING ADMINIS-TRATION HOURS OF SERVICE	
		7.01	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	BIO MED	4,348						7.01
8	LAUNDRY & LINEN SERVICE		788,553					8
9	HOUSEKEEPING			1,191,946				9
10	DIETARY			64,293	85,215			10
11	CAFETERIA					1,127,653		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	49		19,830		19,830	735,707	13
14	CENTRAL SERVICES & SUPPLY			15,353		15,353		14
14.01	STERILE PROCESSING	440		18,488		18,488		14.01
15	PHARMACY			36,128		36,128		15
16	MEDICAL RECORDS & LIBRARY			46,585		46,585	46,585	16
17	SOCIAL SERVICE			16,231		16,231		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)			3,424		3,424	3,424	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	707	260,830	271,377	70,657	271,377	271,377	30
31	INTENSIVE CARE UNIT		45,207	61,686	3,621	61,686	61,686	31
34	SURGICAL INTENSIVE CARE UNIT		30,496	37,108	1,440	37,108	37,108	34
40	SUBPROVIDER - IPF	95	35,057	36,474	9,497	36,474	36,474	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3	101,336	54,437		54,437	54,049	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM		50,104	39,071		39,071	39,071	51
51.01	OP ONCOLOGY	46	2,448	19,393		19,393	19,393	51.01
52.02	SUBSTANCE ABUSE			8,914		8,914		52.02
52.04	DIABETES EDUCATION			2,000		2,000		52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	19	1,578	7,323		7,323	7,323	52.06
53	ANESTHESIOLOGY	267		1,951		1,951		53
54	RADIOLOGY-DIAGNOSTIC	132	51,269	99,513		99,513		54
56	RADIOISOTOPE		4,576	4,575		4,575		56
59	CARDIAC CATHETERIZATION	150	10,435	14,053		14,053		59
60	LABORATORY	190						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	29	3,025	36,718		36,718		65
66	PHYSICAL THERAPY		9,145	23,698		23,698		66
66.01	WOUND CARE		8,749	10,772		10,772	10,772	66.01
67	OCCUPATIONAL THERAPY			4,151		4,151		67
68	SPEECH PATHOLOGY			2,395		2,395		68
69	ELECTROCARDIOLOGY	15	4,833	11,708		11,708		69
70	ELECTROENCEPHALOGRAPHY		867	306		306		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	424		58,852		58,852	58,852	74
76	OTHER							76
76.97	CARDIAC REHABILITATION	396		4,182		4,182		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH		3,601	25,315		25,315		90.01
91	EMERGENCY	1,174	143,122	89,593		89,593	89,593	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	BIO MED WORKORDERS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA HOURS OF SERVICE	NURSING ADMINIS-TRATION HOURS OF SERVICE	
		7.01	8	9	10	11	13	
118	SUBTOTALS (sum of lines 1-117)	4,136	766,678	1,145,897	85,215	1,081,604	735,707	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			6,397		6,397		190
194	OTHER NRCC	212	21,875	39,652		39,652		194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,200,713	536,767	1,838,888	1,795,398	990,498	1,609,810	202
203	UNIT COST MULT-WS B PT I	506.143744	0.680699	1.542761	21.069037	0.878371	2.188113	203
204	COST TO BE ALLOC PER B PT II	17,891	25,909	40,262	199,157	94,887	133,034	204
205	UNIT COST MULT-WS B PT II	4.114765	0.032856	0.033778	2.337112	0.084146	0.180825	205

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	STERILE PR OCESSING TIME SERV	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	PARAMED EDUCATION ASSIGNED TIME	
		14	14.01	15	16	17	23	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	BIO MED							7.01
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	535,908						14
14.01	STERILE PROCESSING	34,319	96,970					14.01
15	PHARMACY	13,122		100				15
16	MEDICAL RECORDS & LIBRARY	23,345			10,000			16
17	SOCIAL SERVICE	433				9,401		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)	8,896					2,286	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	55,493	2,086		6,789	6,271	190	30
31	INTENSIVE CARE UNIT	5,959			1,086	1,003	216	31
34	SURGICAL INTENSIVE CARE UNIT	4,801			713	659		34
40	SUBPROVIDER - IPF	7,458	280		912	843	26	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	97,484	86,881				216	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	3,874					144	51
51.01	OP ONCOLOGY	5,771						51.01
52.02	SUBSTANCE ABUSE	2,497						52.02
52.04	DIABETES EDUCATION	635						52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	512						52.06
53	ANESTHESIOLOGY	1,946						53
54	RADIOLOGY-DIAGNOSTIC	79,360	308				72	54
56	RADIOISOTOPE	38						56
59	CARDIAC CATHETERIZATION	39,323	525				72	59
60	LABORATORY	17,795						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	14,742	108				144	65
66	PHYSICAL THERAPY	2,108						66
66.01	WOUND CARE	2,676	4,712					66.01
67	OCCUPATIONAL THERAPY	582						67
68	SPEECH PATHOLOGY	6						68
69	ELECTROCARDIOLOGY	3,125					72	69
70	ELECTROENCEPHALOGRAPHY	56						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,253						71
72	IMPL. DEV. CHARGED TO PATIENTS	7,000						72
73	DRUGS CHARGED TO PATIENTS			100				73
74	RENAL DIALYSIS	45,205			500	625	72	74
76	OTHER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH	12,668	169					90.01
91	EMERGENCY	20,301	1,901				1,062	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	STERILE PR OCESSING TIME SERV	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	PARAMED EDUCATION ASSIGNED TIME	
		14	14.01	15	16	17	23	
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	518,783	96,970	100	10,000	9,401	2,286	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
194	OTHER NRCC	17,125						194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	677,842	1,365,583	2,795,251	3,227,714	1,396,216	306,372	202
203	UNIT COST MULT-WS B PT I	1.264848	14.082531	27,952.510000	322.771400	148.517817	134.020997	203
204	COST TO BE ALLOC PER B PT II	172,533	322,256	70,147	183,977	14,018	10,222	204
205	UNIT COST MULT-WS B PT II	0.321945	3.323255	701.470000	18.397700	1.491118	4.471566	205

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	19,671,571		19,671,571	2,066	19,673,637	30
31	INTENSIVE CARE UNIT	4,930,039		4,930,039		4,930,039	31
34	SURGICAL INTENSIVE CARE UNIT	3,257,971		3,257,971		3,257,971	34
40	SUBPROVIDER - IPF	2,833,865		2,833,865	2,036	2,835,901	40
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,553,726		6,553,726		6,553,726	50
50.01	SPECIAL PROCEDURES						50.01
51	RECOVERY ROOM	2,543,998		2,543,998		2,543,998	51
51.01	OP ONCOLOGY	3,060,587		3,060,587	4,990	3,065,577	51.01
52.02	SUBSTANCE ABUSE	696,722		696,722	285	697,007	52.02
52.04	DIABETES EDUCATION	145,442		145,442		145,442	52.04
52.05	PODIATRY						52.05
52.06	INFUSION CLINIC	661,766		661,766		661,766	52.06
53	ANESTHESIOLOGY	5,574,133		5,574,133		5,574,133	53
54	RADIOLOGY-DIAGNOSTIC	6,736,259		6,736,259		6,736,259	54
56	RADIOISOTOPE	1,652,599		1,652,599		1,652,599	56
59	CARDIAC CATHETERIZATION	1,587,689		1,587,689	5,642	1,593,331	59
60	LABORATORY	6,398,570		6,398,570	7,496	6,406,066	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,761,235		2,761,235	1,632	2,762,867	65
66	PHYSICAL THERAPY	1,834,013		1,834,013		1,834,013	66
66.01	WOUND CARE	1,982,185		1,982,185		1,982,185	66.01
67	OCCUPATIONAL THERAPY	306,585		306,585		306,585	67
68	SPEECH PATHOLOGY	290,039		290,039		290,039	68
69	ELECTROCARDIOLOGY	786,309		786,309		786,309	69
70	ELECTROENCEPHALOGRAPHY	91,475		91,475		91,475	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,713,315		6,713,315		6,713,315	71
72	IMPL. DEV. CHARGED TO PATIENTS	5,433,816		5,433,816		5,433,816	72
73	DRUGS CHARGED TO PATIENTS	13,044,378		13,044,378		13,044,378	73
74	RENAL DIALYSIS	6,998,866		6,998,866	72,753	7,071,619	74
76	OTHER						76
76.97	CARDIAC REHABILITATION	536,313		536,313		536,313	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OCCUPATIONAL HEALTH	1,866,327		1,866,327		1,866,327	90.01
91	EMERGENCY	6,671,333		6,671,333	37,357	6,708,690	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,117,059		2,117,059		2,117,059	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	117,738,185		117,738,185	134,257	117,872,442	200
201	LESS OBSERVATION BEDS	2,117,059		2,117,059		2,117,059	201
202	TOTAL (SEE INSTRUCTIONS)	115,621,126		115,621,126		115,755,383	202

KPMG LLP

COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	33,582,385		33,582,385				30
31	INTENSIVE CARE UNIT	21,409,211		21,409,211				31
34	SURGICAL INTENSIVE CARE UNIT	15,101,612		15,101,612				34
40	SUBPROVIDER - IPF	3,539,380		3,539,380				40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,649,626	29,791,326	40,440,952	0.162057	0.162057	0.162057	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	2,145,020	6,842,356	8,987,376	0.283063	0.283063	0.283063	51
51.01	OP ONCOLOGY		3,090,162	3,090,162	0.990429	0.990429	0.992044	51.01
52.02	SUBSTANCE ABUSE	60,713	792,642	853,355	0.816450	0.816450	0.816784	52.02
52.04	DIABETES EDUCATION	1,522,299	290,228	1,812,527	0.080243	0.080243	0.080243	52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	357,200	3,268,804	3,626,004	0.182506	0.182506	0.182506	52.06
53	ANESTHESIOLOGY	2,333,151	7,015,591	9,348,742	0.596244	0.596244	0.596244	53
54	RADIOLOGY-DIAGNOSTIC	26,257,140	72,080,099	98,337,239	0.068502	0.068502	0.068502	54
56	RADIOISOTOPE	1,366,372	9,581,431	10,947,803	0.150953	0.150953	0.150953	56
59	CARDIAC CATHETERIZATION	6,192,897	8,790,114	14,983,011	0.105966	0.105966	0.106343	59
60	LABORATORY	25,146,505	34,092,433	59,238,938	0.108013	0.108013	0.108139	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	7,977,154	3,478,844	11,455,998	0.241030	0.241030	0.241172	65
66	PHYSICAL THERAPY	2,013,205	4,590,554	6,603,759	0.277723	0.277723	0.277723	66
66.01	WOUND CARE	153,419	7,146,326	7,299,745	0.271542	0.271542	0.271542	66.01
67	OCCUPATIONAL THERAPY	778,372	917,675	1,696,047	0.180764	0.180764	0.180764	67
68	SPEECH PATHOLOGY	132,130	336,897	469,027	0.618384	0.618384	0.618384	68
69	ELECTROCARDIOLOGY	5,355,749	6,594,400	11,950,149	0.065799	0.065799	0.065799	69
70	ELECTROENCEPHALOGRAPHY	216,881	310,113	526,994	0.173579	0.173579	0.173579	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,615,558	20,634,730	49,250,288	0.136310	0.136310	0.136310	71
72	IMPL. DEV. CHARGED TO PATIENTS	8,905,171	6,096,075	15,001,246	0.362224	0.362224	0.362224	72
73	DRUGS CHARGED TO PATIENTS	42,132,135	30,049,318	72,181,453	0.180716	0.180716	0.180716	73
74	RENAL DIALYSIS	1,195,656	34,348,779	35,544,435	0.196905	0.196905	0.198952	74
76	OTHER							76
76.97	CARDIAC REHABILITATION	4,429	317,519	321,948	1.665837	1.665837	1.665837	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH		1,426,128	1,426,128	1.308667	1.308667	1.308667	90.01
91	EMERGENCY	13,753,652	40,563,401	54,317,053	0.122822	0.122822	0.123510	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,055,323	5,781,607	6,836,930	0.309651	0.309651	0.309651	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	261,952,345	338,227,552	600,179,897				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	261,952,345	338,227,552	600,179,897				202

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,552,181		1,552,181	21,448	72.37	11,756	850,782	30
31	INTENSIVE CARE UNIT	251,671		251,671	1,329	189.37	761	144,111	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT	172,257		172,257	636	270.84	394	106,711	34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF	209,247		209,247	3,127	66.92			40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY				1,077				43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,185,356		2,185,356	27,617		12,911	1,101,604	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0155** **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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,115,950	40,440,952	0.027595	7,458,666	205,822	50
50.01	SPECIAL PROCEDURES						50.01
51	RECOVERY ROOM	118,304	8,987,376	0.013163	998,222	13,140	51
51.01	OP ONCOLOGY	626,530	3,090,162	0.202750			51.01
52.02	SUBSTANCE ABUSE	106,648	853,355	0.124975	11,619	1,452	52.02
52.04	DIABETES EDUCATION	22,167	1,812,527	0.012230	929,731	11,371	52.04
52.05	PODIATRY						52.05
52.06	INFUSION CLINIC	58,109	3,626,004	0.016026	228,870	3,668	52.06
53	ANESTHESIOLOGY	64,888	9,348,742	0.006941	1,062,299	7,373	53
54	RADIOLOGY-DIAGNOSTIC	1,065,823	98,337,239	0.010838	13,775,098	149,295	54
56	RADIOISOTOPE	296,618	10,947,803	0.027094	928,058	25,145	56
59	CARDIAC CATHETERIZATION	375,323	14,983,011	0.025050	4,967,232	124,429	59
60	LABORATORY	499,722	59,238,938	0.008436	13,205,963	111,406	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,981	11,455,998	0.011084	4,738,925	52,526	65
66	PHYSICAL THERAPY	178,296	6,603,759	0.026999	1,345,748	36,334	66
66.01	WOUND CARE	95,681	7,299,745	0.013107	141,720	1,858	66.01
67	OCCUPATIONAL THERAPY	10,371	1,696,047	0.006115	473,138	2,893	67
68	SPEECH PATHOLOGY	6,546	469,027	0.013957	104,086	1,453	68
69	ELECTROCARDIOLOGY	108,803	11,950,149	0.009105	3,178,588	28,941	69
70	ELECTROENCEPHALOGRAPHY	20,075	526,994	0.038093	116,939	4,455	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,323	49,250,288	0.000514	15,268,231	7,848	71
72	IMPL. DEV. CHARGED TO PATIENTS	20,856	15,001,246	0.001390	320,453	445	72
73	DRUGS CHARGED TO PATIENTS	106,109	72,181,453	0.001470	24,076,424	35,392	73
74	RENAL DIALYSIS	419,580	35,544,435	0.011804	884,168	10,437	74
76	OTHER						76
76.97	CARDIAC REHABILITATION	152,752	321,948	0.474462	1,817	862	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OCCUPATIONAL HEALTH	184,087	1,426,128	0.129082			90.01
91	EMERGENCY	420,165	54,317,053	0.007735	6,883,325	53,243	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	167,027	6,836,930	0.024430	583,860	14,264	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	6,392,734	526,547,309		101,683,180	904,052	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)		25,464			25,464	30
31	INTENSIVE CARE UNIT		28,949			28,949	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		3,485			3,485	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)		57,898			57,898	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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**

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	21,448	1.19	11,756	13,990	30
31	INTENSIVE CARE UNIT	1,329	21.78	761	16,575	31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT	636		394		34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	3,127	1.11			40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	1,077				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	27,617		12,911	30,565	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0155** **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			28,949		28,949	28,949	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM			19,299		19,299	19,299	51
51.01	OP ONCOLOGY							51.01
52.02	SUBSTANCE ABUSE							52.02
52.04	DIABETES EDUCATION							52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC							52.06
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC			9,650		9,650	9,650	54
56	RADIOISOTOPE							56
59	CARDIAC CATHETERIZATION			9,650		9,650	9,650	59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			19,299		19,299	19,299	65
66	PHYSICAL THERAPY							66
66.01	WOUND CARE							66.01
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			9,650		9,650	9,650	69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS			9,650		9,650	9,650	74
76	OTHER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH							90.01
91	EMERGENCY			142,327		142,327	142,327	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			2,739		2,739	2,739	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)			251,213		251,213	251,213	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0155** **WORKSHEET D PART IV**

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

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	40,440,952	0.000716	0.000716	7,458,666	5,340	10,604,807	7,593	50
50.01	SPECIAL PROCEDURES								50.01
51	RECOVERY ROOM	8,987,376	0.002147	0.002147	998,222	2,143	2,016,091	4,329	51
51.01	OP ONCOLOGY	3,090,162					1,817,438		51.01
52.02	SUBSTANCE ABUSE	853,355			11,619		67,483		52.02
52.04	DIABETES EDUCATION	1,812,527			929,731		138,845		52.04
52.05	PODIATRY								52.05
52.06	INFUSION CLINIC	3,626,004			228,870		1,808,627		52.06
53	ANESTHESIOLOGY	9,348,742			1,062,299		1,620,332		53
54	RADIOLOGY-DIAGNOSTIC	98,337,239	0.000098	0.000098	13,775,098	1,350	20,434,432	2,003	54
56	RADIOISOTOPE	10,947,803			928,058		4,923,415		56
59	CARDIAC CATHETERIZATION	14,983,011	0.000644	0.000644	4,967,232	3,199	5,316,594	3,424	59
60	LABORATORY	59,238,938			13,205,963		412,775		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	11,455,998	0.001685	0.001685	4,738,925	7,985	1,208,444	2,036	65
66	PHYSICAL THERAPY	6,603,759			1,345,748		360,693		66
66.01	WOUND CARE	7,299,745			141,720		4,096,295		66.01
67	OCCUPATIONAL THERAPY	1,696,047			473,138		54,107		67
68	SPEECH PATHOLOGY	469,027			104,086		23,505		68
69	ELECTROCARDIOLOGY	11,950,149	0.000808	0.000808	3,178,588	2,568	2,105,097	1,701	69
70	ELECTROENCEPHALOGRAPHY	526,994			116,939		81,313		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,250,288			15,268,231		8,380,222		71
72	IMPL. DEV. CHARGED TO PATIENTS	15,001,246			320,453		355,656		72
73	DRUGS CHARGED TO PATIENTS	72,181,453			24,076,424		12,187,442		73
74	RENAL DIALYSIS	35,544,435	0.000271	0.000271	884,168	240	58,152	16	74
76	OTHER								76
76.97	CARDIAC REHABILITATION	321,948			1,817		129,264		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OCCUPATIONAL HEALTH	1,426,128					16,790		90.01
91	EMERGENCY	54,317,053	0.002620	0.002620	6,883,325	18,034	7,052,373	18,477	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,836,930	0.000401	0.000401	583,860	234	1,997,370	801	92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
200	TOTAL (sum of lines 50-199)	526,547,309			101,683,180	41,093	87,267,562	40,380	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0155** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.162057	10,604,807			1,718,583			50
50.01	SPECIAL PROCEDURES								50.01
51	RECOVERY ROOM	0.283063	2,016,091			570,681			51
51.01	OP ONCOLOGY	0.990429	1,817,438			1,800,043			51.01
52.02	SUBSTANCE ABUSE	0.816450	67,483			55,096			52.02
52.04	DIABETES EDUCATION	0.080243	138,845			11,141			52.04
52.05	PODIATRY								52.05
52.06	INFUSION CLINIC	0.182506	1,808,627			330,085			52.06
53	ANESTHESIOLOGY	0.596244	1,620,332			966,113			53
54	RADIOLOGY-DIAGNOSTIC	0.068502	20,434,432			1,399,799			54
56	RADIOISOTOPE	0.150953	4,923,415			743,204			56
59	CARDIAC CATHETERIZATION	0.105966	5,316,594			563,378			59
60	LABORATORY	0.108013	412,775			44,585			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.241030	1,208,444			291,271			65
66	PHYSICAL THERAPY	0.277723	360,693			100,173			66
66.01	WOUND CARE	0.271542	4,096,295			1,112,316			66.01
67	OCCUPATIONAL THERAPY	0.180764	54,107			9,781			67
68	SPEECH PATHOLOGY	0.618384	23,505			14,535			68
69	ELECTROCARDIOLOGY	0.065799	2,105,097			138,513			69
70	ELECTROENCEPHALOGRAPHY	0.173579	81,313			14,114			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136310	8,380,222			1,142,308			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.362224	355,656			128,827			72
73	DRUGS CHARGED TO PATIENTS	0.180716	12,187,442		56,300	2,202,466		10,174	73
74	RENAL DIALYSIS	0.196905	58,152			11,450			74
76	OTHER								76
76.97	CARDIAC REHABILITATION	1.665837	129,264			215,333			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OCCUPATIONAL HEALTH	1.308667	16,790			21,973			90.01
91	EMERGENCY	0.122822	7,052,373			866,187			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.309651	1,997,370			618,488			92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
200	SUBTOTAL (see instructions)		87,267,562		56,300	15,090,443		10,174	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		87,267,562		56,300	15,090,443		10,174	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S155** **WORKSHEET D PART II**

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,115,950	40,440,952	0.027595			50
50.01	SPECIAL PROCEDURES						50.01
51	RECOVERY ROOM	118,304	8,987,376	0.013163			51
51.01	OP ONCOLOGY	626,530	3,090,162	0.202750			51.01
52.02	SUBSTANCE ABUSE	106,648	853,355	0.124975			52.02
52.04	DIABETES EDUCATION	22,167	1,812,527	0.012230			52.04
52.05	PODIATRY						52.05
52.06	INFUSION CLINIC	58,109	3,626,004	0.016026			52.06
53	ANESTHESIOLOGY	64,888	9,348,742	0.006941			53
54	RADIOLOGY-DIAGNOSTIC	1,065,823	98,337,239	0.010838			54
56	RADIOISOTOPE	296,618	10,947,803	0.027094			56
59	CARDIAC CATHETERIZATION	375,323	14,983,011	0.025050			59
60	LABORATORY	499,722	59,238,938	0.008436			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,981	11,455,998	0.011084			65
66	PHYSICAL THERAPY	178,296	6,603,759	0.026999			66
66.01	WOUND CARE	95,681	7,299,745	0.013107			66.01
67	OCCUPATIONAL THERAPY	10,371	1,696,047	0.006115			67
68	SPEECH PATHOLOGY	6,546	469,027	0.013957			68
69	ELECTROCARDIOLOGY	108,803	11,950,149	0.009105			69
70	ELECTROENCEPHALOGRAPHY	20,075	526,994	0.038093			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,323	49,250,288	0.000514			71
72	IMPL. DEV. CHARGED TO PATIENTS	20,856	15,001,246	0.001390			72
73	DRUGS CHARGED TO PATIENTS	106,109	72,181,453	0.001470			73
74	RENAL DIALYSIS	419,580	35,544,435	0.011804			74
76	OTHER						76
76.97	CARDIAC REHABILITATION	152,752	321,948	0.474462			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OCCUPATIONAL HEALTH	184,087	1,426,128	0.129082			90.01
91	EMERGENCY	420,165	54,317,053	0.007735			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		6,836,930				92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	6,225,707	526,547,309				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S155** | **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			28,949		28,949	28,949	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM			19,299		19,299	19,299	51
51.01	OP ONCOLOGY							51.01
52.02	SUBSTANCE ABUSE							52.02
52.04	DIABETES EDUCATION							52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC							52.06
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC			9,650		9,650	9,650	54
56	RADIOISOTOPE							56
59	CARDIAC CATHETERIZATION			9,650		9,650	9,650	59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			19,299		19,299	19,299	65
66	PHYSICAL THERAPY							66
66.01	WOUND CARE							66.01
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			9,650		9,650	9,650	69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS			9,650		9,650	9,650	74
76	OTHER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH							90.01
91	EMERGENCY			142,327		142,327	142,327	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)			248,474		248,474	248,474	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S155** | **WORKSHEET D PART IV**

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

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	40,440,952	0.000716	0.000716					50
50.01	SPECIAL PROCEDURES								50.01
51	RECOVERY ROOM	8,987,376	0.002147	0.002147					51
51.01	OP ONCOLOGY	3,090,162							51.01
52.02	SUBSTANCE ABUSE	853,355							52.02
52.04	DIABETES EDUCATION	1,812,527							52.04
52.05	PODIATRY								52.05
52.06	INFUSION CLINIC	3,626,004							52.06
53	ANESTHESIOLOGY	9,348,742							53
54	RADIOLOGY-DIAGNOSTIC	98,337,239	0.000098	0.000098					54
56	RADIOISOTOPE	10,947,803							56
59	CARDIAC CATHETERIZATION	14,983,011	0.000644	0.000644					59
60	LABORATORY	59,238,938							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	11,455,998	0.001685	0.001685					65
66	PHYSICAL THERAPY	6,603,759							66
66.01	WOUND CARE	7,299,745							66.01
67	OCCUPATIONAL THERAPY	1,696,047							67
68	SPEECH PATHOLOGY	469,027							68
69	ELECTROCARDIOLOGY	11,950,149	0.000808	0.000808					69
70	ELECTROENCEPHALOGRAPHY	526,994							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,250,288							71
72	IMPL. DEV. CHARGED TO PATIENTS	15,001,246							72
73	DRUGS CHARGED TO PATIENTS	72,181,453							73
74	RENAL DIALYSIS	35,544,435	0.000271	0.000271					74
76	OTHER								76
76.97	CARDIAC REHABILITATION	321,948							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OCCUPATIONAL HEALTH	1,426,128							90.01
91	EMERGENCY	54,317,053	0.002620	0.002620					91
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,836,930							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
200	TOTAL (sum of lines 50-199)	526,547,309							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S155** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.162057							50
50.01	SPECIAL PROCEDURES								50.01
51	RECOVERY ROOM	0.283063							51
51.01	OP ONCOLOGY	0.990429							51.01
52.02	SUBSTANCE ABUSE	0.816450							52.02
52.04	DIABETES EDUCATION	0.080243							52.04
52.05	PODIATRY								52.05
52.06	INFUSION CLINIC	0.182506							52.06
53	ANESTHESIOLOGY	0.596244							53
54	RADIOLOGY-DIAGNOSTIC	0.068502							54
56	RADIOISOTOPE	0.150953							56
59	CARDIAC CATHETERIZATION	0.105966							59
60	LABORATORY	0.108013							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.241030							65
66	PHYSICAL THERAPY	0.277723							66
66.01	WOUND CARE	0.271542							66.01
67	OCCUPATIONAL THERAPY	0.180764							67
68	SPEECH PATHOLOGY	0.618384							68
69	ELECTROCARDIOLOGY	0.065799							69
70	ELECTROENCEPHALOGRAPHY	0.173579							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136310							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.362224							72
73	DRUGS CHARGED TO PATIENTS	0.180716							73
74	RENAL DIALYSIS	0.196905							74
76	OTHER								76
76.97	CARDIAC REHABILITATION	1.665837							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OCCUPATIONAL HEALTH	1.308667							90.01
91	EMERGENCY	0.122822							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.309651							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
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

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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 SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,552,181		1,552,181	21,448	72.37	3,500	253,295	30
31	INTENSIVE CARE UNIT	251,671		251,671	1,329	189.37	188	35,602	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT	172,257		172,257	636	270.84	101	27,355	34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF	209,247		209,247	3,127	66.92	901	60,295	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY				1,077		523		43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	2,185,356		2,185,356	27,617		5,213	376,547	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0155** **WORKSHEET D PART II**

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,115,950	40,440,952	0.027595			50
50.01	SPECIAL PROCEDURES						50.01
51	RECOVERY ROOM	118,304	8,987,376	0.013163			51
51.01	OP ONCOLOGY	626,530	3,090,162	0.202750			51.01
52.02	SUBSTANCE ABUSE	106,648	853,355	0.124975			52.02
52.04	DIABETES EDUCATION	22,167	1,812,527	0.012230			52.04
52.05	PODIATRY						52.05
52.06	INFUSION CLINIC	58,109	3,626,004	0.016026			52.06
53	ANESTHESIOLOGY	64,888	9,348,742	0.006941			53
54	RADIOLOGY-DIAGNOSTIC	1,065,823	98,337,239	0.010838			54
56	RADIOISOTOPE	296,618	10,947,803	0.027094			56
59	CARDIAC CATHETERIZATION	375,323	14,983,011	0.025050			59
60	LABORATORY	499,722	59,238,938	0.008436			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,981	11,455,998	0.011084			65
66	PHYSICAL THERAPY	178,296	6,603,759	0.026999			66
66.01	WOUND CARE	95,681	7,299,745	0.013107			66.01
67	OCCUPATIONAL THERAPY	10,371	1,696,047	0.006115			67
68	SPEECH PATHOLOGY	6,546	469,027	0.013957			68
69	ELECTROCARDIOLOGY	108,803	11,950,149	0.009105			69
70	ELECTROENCEPHALOGRAPHY	20,075	526,994	0.038093			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,323	49,250,288	0.000514			71
72	IMPL. DEV. CHARGED TO PATIENTS	20,856	15,001,246	0.001390			72
73	DRUGS CHARGED TO PATIENTS	106,109	72,181,453	0.001470			73
74	RENAL DIALYSIS	419,580	35,544,435	0.011804			74
76	OTHER						76
76.97	CARDIAC REHABILITATION	152,752	321,948	0.474462			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OCCUPATIONAL HEALTH	184,087	1,426,128	0.129082			90.01
91	EMERGENCY	420,165	54,317,053	0.007735			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	167,027	6,836,930	0.024430			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	6,392,734	526,547,309				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)		25,464			25,464	30
31	INTENSIVE CARE UNIT		28,949			28,949	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		3,485			3,485	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)		57,898			57,898	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	21,448	1.19	3,500	4,165	30
31	INTENSIVE CARE UNIT	1,329	21.78	188	4,095	31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT	636		101		34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	3,127	1.11	901	1,000	40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	1,077		523		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	27,617		5,213	9,260	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0155** **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			28,949		28,949	28,949	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM			19,299		19,299	19,299	51
51.01	OP ONCOLOGY							51.01
52.02	SUBSTANCE ABUSE							52.02
52.04	DIABETES EDUCATION							52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC							52.06
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC			9,650		9,650	9,650	54
56	RADIOISOTOPE							56
59	CARDIAC CATHETERIZATION			9,650		9,650	9,650	59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			19,299		19,299	19,299	65
66	PHYSICAL THERAPY							66
66.01	WOUND CARE							66.01
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			9,650		9,650	9,650	69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS			9,650		9,650	9,650	74
76	OTHER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH							90.01
91	EMERGENCY			142,327		142,327	142,327	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)			248,474		248,474	248,474	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0155** **WORKSHEET D PART IV**

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

		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	40,440,952	0.000716	0.000716					50
50.01	SPECIAL PROCEDURES								50.01
51	RECOVERY ROOM	8,987,376	0.002147	0.002147					51
51.01	OP ONCOLOGY	3,090,162							51.01
52.02	SUBSTANCE ABUSE	853,355							52.02
52.04	DIABETES EDUCATION	1,812,527							52.04
52.05	PODIATRY								52.05
52.06	INFUSION CLINIC	3,626,004							52.06
53	ANESTHESIOLOGY	9,348,742							53
54	RADIOLOGY-DIAGNOSTIC	98,337,239	0.000098	0.000098					54
56	RADIOISOTOPE	10,947,803							56
59	CARDIAC CATHETERIZATION	14,983,011	0.000644	0.000644					59
60	LABORATORY	59,238,938							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	11,455,998	0.001685	0.001685					65
66	PHYSICAL THERAPY	6,603,759							66
66.01	WOUND CARE	7,299,745							66.01
67	OCCUPATIONAL THERAPY	1,696,047							67
68	SPEECH PATHOLOGY	469,027							68
69	ELECTROCARDIOLOGY	11,950,149	0.000808	0.000808					69
70	ELECTROENCEPHALOGRAPHY	526,994							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,250,288							71
72	IMPL. DEV. CHARGED TO PATIENTS	15,001,246							72
73	DRUGS CHARGED TO PATIENTS	72,181,453							73
74	RENAL DIALYSIS	35,544,435	0.000271	0.000271					74
76	OTHER								76
76.97	CARDIAC REHABILITATION	321,948							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OCCUPATIONAL HEALTH	1,426,128							90.01
91	EMERGENCY	54,317,053	0.002620	0.002620					91
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,836,930							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
200	TOTAL (sum of lines 50-199)	526,547,309							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0155** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.162057							50
50.01	SPECIAL PROCEDURES								50.01
51	RECOVERY ROOM	0.283063							51
51.01	OP ONCOLOGY	0.990429							51.01
52.02	SUBSTANCE ABUSE	0.816450							52.02
52.04	DIABETES EDUCATION	0.080243							52.04
52.05	PODIATRY								52.05
52.06	INFUSION CLINIC	0.182506							52.06
53	ANESTHESIOLOGY	0.596244							53
54	RADIOLOGY-DIAGNOSTIC	0.068502							54
56	RADIOISOTOPE	0.150953							56
59	CARDIAC CATHETERIZATION	0.105966							59
60	LABORATORY	0.108013							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.241030							65
66	PHYSICAL THERAPY	0.277723							66
66.01	WOUND CARE	0.271542							66.01
67	OCCUPATIONAL THERAPY	0.180764							67
68	SPEECH PATHOLOGY	0.618384							68
69	ELECTROCARDIOLOGY	0.065799							69
70	ELECTROENCEPHALOGRAPHY	0.173579							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136310							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.362224							72
73	DRUGS CHARGED TO PATIENTS	0.180716							73
74	RENAL DIALYSIS	0.196905							74
76	OTHER								76
76.97	CARDIAC REHABILITATION	1.665837							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OCCUPATIONAL HEALTH	1.308667							90.01
91	EMERGENCY	0.122822							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.309651							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
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

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S155** **WORKSHEET D PART II**

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,115,950	40,440,952	0.027595			50
50.01	SPECIAL PROCEDURES						50.01
51	RECOVERY ROOM	118,304	8,987,376	0.013163			51
51.01	OP ONCOLOGY	626,530	3,090,162	0.202750			51.01
52.02	SUBSTANCE ABUSE	106,648	853,355	0.124975			52.02
52.04	DIABETES EDUCATION	22,167	1,812,527	0.012230			52.04
52.05	PODIATRY						52.05
52.06	INFUSION CLINIC	58,109	3,626,004	0.016026			52.06
53	ANESTHESIOLOGY	64,888	9,348,742	0.006941			53
54	RADIOLOGY-DIAGNOSTIC	1,065,823	98,337,239	0.010838			54
56	RADIOISOTOPE	296,618	10,947,803	0.027094			56
59	CARDIAC CATHETERIZATION	375,323	14,983,011	0.025050			59
60	LABORATORY	499,722	59,238,938	0.008436			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,981	11,455,998	0.011084			65
66	PHYSICAL THERAPY	178,296	6,603,759	0.026999			66
66.01	WOUND CARE	95,681	7,299,745	0.013107			66.01
67	OCCUPATIONAL THERAPY	10,371	1,696,047	0.006115			67
68	SPEECH PATHOLOGY	6,546	469,027	0.013957			68
69	ELECTROCARDIOLOGY	108,803	11,950,149	0.009105			69
70	ELECTROENCEPHALOGRAPHY	20,075	526,994	0.038093			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,323	49,250,288	0.000514			71
72	IMPL. DEV. CHARGED TO PATIENTS	20,856	15,001,246	0.001390			72
73	DRUGS CHARGED TO PATIENTS	106,109	72,181,453	0.001470			73
74	RENAL DIALYSIS	419,580	35,544,435	0.011804			74
76	OTHER						76
76.97	CARDIAC REHABILITATION	152,752	321,948	0.474462			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OCCUPATIONAL HEALTH	184,087	1,426,128	0.129082			90.01
91	EMERGENCY	420,165	54,317,053	0.007735			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		6,836,930				92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	6,225,707	526,547,309				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S155** **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			28,949		28,949	28,949	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM			19,299		19,299	19,299	51
51.01	OP ONCOLOGY							51.01
52.02	SUBSTANCE ABUSE							52.02
52.04	DIABETES EDUCATION							52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC							52.06
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC			9,650		9,650	9,650	54
56	RADIOISOTOPE							56
59	CARDIAC CATHETERIZATION			9,650		9,650	9,650	59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			19,299		19,299	19,299	65
66	PHYSICAL THERAPY							66
66.01	WOUND CARE							66.01
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			9,650		9,650	9,650	69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS			9,650		9,650	9,650	74
76	OTHER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH							90.01
91	EMERGENCY			142,327		142,327	142,327	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)			248,474		248,474	248,474	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S155** | **WORKSHEET D PART IV**

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

		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	40,440,952	0.000716	0.000716					50
50.01	SPECIAL PROCEDURES								50.01
51	RECOVERY ROOM	8,987,376	0.002147	0.002147					51
51.01	OP ONCOLOGY	3,090,162							51.01
52.02	SUBSTANCE ABUSE	853,355							52.02
52.04	DIABETES EDUCATION	1,812,527							52.04
52.05	PODIATRY								52.05
52.06	INFUSION CLINIC	3,626,004							52.06
53	ANESTHESIOLOGY	9,348,742							53
54	RADIOLOGY-DIAGNOSTIC	98,337,239	0.000098	0.000098					54
56	RADIOISOTOPE	10,947,803							56
59	CARDIAC CATHETERIZATION	14,983,011	0.000644	0.000644					59
60	LABORATORY	59,238,938							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	11,455,998	0.001685	0.001685					65
66	PHYSICAL THERAPY	6,603,759							66
66.01	WOUND CARE	7,299,745							66.01
67	OCCUPATIONAL THERAPY	1,696,047							67
68	SPEECH PATHOLOGY	469,027							68
69	ELECTROCARDIOLOGY	11,950,149	0.000808	0.000808					69
70	ELECTROENCEPHALOGRAPHY	526,994							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,250,288							71
72	IMPL. DEV. CHARGED TO PATIENTS	15,001,246							72
73	DRUGS CHARGED TO PATIENTS	72,181,453							73
74	RENAL DIALYSIS	35,544,435	0.000271	0.000271					74
76	OTHER								76
76.97	CARDIAC REHABILITATION	321,948							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OCCUPATIONAL HEALTH	1,426,128							90.01
91	EMERGENCY	54,317,053	0.002620	0.002620					91
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,836,930							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
200	TOTAL (sum of lines 50-199)	526,547,309							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S155** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.162057							50
50.01	SPECIAL PROCEDURES								50.01
51	RECOVERY ROOM	0.283063							51
51.01	OP ONCOLOGY	0.990429							51.01
52.02	SUBSTANCE ABUSE	0.816450							52.02
52.04	DIABETES EDUCATION	0.080243							52.04
52.05	PODIATRY								52.05
52.06	INFUSION CLINIC	0.182506							52.06
53	ANESTHESIOLOGY	0.596244							53
54	RADIOLOGY-DIAGNOSTIC	0.068502							54
56	RADIOISOTOPE	0.150953							56
59	CARDIAC CATHETERIZATION	0.105966							59
60	LABORATORY	0.108013							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.241030							65
66	PHYSICAL THERAPY	0.277723							66
66.01	WOUND CARE	0.271542							66.01
67	OCCUPATIONAL THERAPY	0.180764							67
68	SPEECH PATHOLOGY	0.618384							68
69	ELECTROCARDIOLOGY	0.065799							69
70	ELECTROENCEPHALOGRAPHY	0.173579							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136310							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.362224							72
73	DRUGS CHARGED TO PATIENTS	0.180716							73
74	RENAL DIALYSIS	0.196905							74
76	OTHER								76
76.97	CARDIAC REHABILITATION	1.665837							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OCCUPATIONAL HEALTH	1.308667							90.01
91	EMERGENCY	0.122822							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.309651							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
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

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0155** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[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)	21,448	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	21,448	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)	19,140	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,756	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	19,673,637	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	19,673,637	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	19,673,637	37

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0155** **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)					917.27	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					10,783,426	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)					10,783,426	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	4,930,039	1,329	3,709.59	761	2,822,998	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT	3,257,971	636	5,122.60	394	2,018,304	46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					14,983,198	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					30,607,926	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					1,132,169	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					945,145	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					2,077,314	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					28,530,612	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0155** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[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)	2,308	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)	917.27	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)	2,117,059	89

		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	1,552,181	19,673,637	0.078896	2,117,059	167,027	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST	25,464	19,673,637	0.001294	2,117,059	2,739	92
93	ALL OTHER MEDICAL EDUCATION						93

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S155** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**	
	[XX] TITLE XVIII, PART A	**[XX] 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)	3,127	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,127	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)	3,127	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)		9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,835,901	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	2,835,901	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,835,901	37

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S155** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	906.91	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)		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)		41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)		49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)		50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)		52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0155** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	21,448	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	21,448	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)	19,140	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	3,500	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	1,077	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	523	16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	19,671,571	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	19,671,571	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	19,671,571	37

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0155** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					917.18	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					3,210,130	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)					3,210,130	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)		1,077		523		42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,930,039	1,329	3,709.59	188	697,403	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT	3,257,971	636	5,122.60	101	517,383	46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					4,424,916	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	324,512	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	324,512	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0155** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					2,308	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S155** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,127	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,127	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)	3,127	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	901	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,833,865	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	2,833,865	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,833,865	37

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S155** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	906.26	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	816,540	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)	816,540	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	816,540	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	61,295	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	61,295	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0155** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		16,821,532		30
31	INTENSIVE CARE UNIT		12,889,907		31
34	SURGICAL INTENSIVE CARE UNIT		8,508,537		34
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.162057	7,458,666	1,208,729	50
50.01	SPECIAL PROCEDURES				50.01
51	RECOVERY ROOM	0.283063	998,222	282,560	51
51.01	OP ONCOLOGY	0.992044			51.01
52.02	SUBSTANCE ABUSE	0.816784	11,619	9,490	52.02
52.04	DIABETES EDUCATION	0.080243	929,731	74,604	52.04
52.05	PODIATRY				52.05
52.06	INFUSION CLINIC	0.182506	228,870	41,770	52.06
53	ANESTHESIOLOGY	0.596244	1,062,299	633,389	53
54	RADIOLOGY-DIAGNOSTIC	0.068502	13,775,098	943,622	54
56	RADIOISOTOPE	0.150953	928,058	140,093	56
59	CARDIAC CATHETERIZATION	0.106343	4,967,232	528,230	59
60	LABORATORY	0.108139	13,205,963	1,428,080	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.241172	4,738,925	1,142,896	65
66	PHYSICAL THERAPY	0.277723	1,345,748	373,745	66
66.01	WOUND CARE	0.271542	141,720	38,483	66.01
67	OCCUPATIONAL THERAPY	0.180764	473,138	85,526	67
68	SPEECH PATHOLOGY	0.618384	104,086	64,365	68
69	ELECTROCARDIOLOGY	0.065799	3,178,588	209,148	69
70	ELECTROENCEPHALOGRAPHY	0.173579	116,939	20,298	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136310	15,268,231	2,081,213	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.362224	320,453	116,076	72
73	DRUGS CHARGED TO PATIENTS	0.180716	24,076,424	4,350,995	73
74	RENAL DIALYSIS	0.198952	884,168	175,907	74
76	OTHER				76
76.97	CARDIAC REHABILITATION	1.665837	1,817	3,027	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OCCUPATIONAL HEALTH	1.308667			90.01
91	EMERGENCY	0.123510	6,883,325	850,159	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.309651	583,860	180,793	92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		101,683,180	14,983,198	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		101,683,180		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S155** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.162057			50
50.01	SPECIAL PROCEDURES				50.01
51	RECOVERY ROOM	0.283063			51
51.01	OP ONCOLOGY	0.992044			51.01
52.02	SUBSTANCE ABUSE	0.816784			52.02
52.04	DIABETES EDUCATION	0.080243			52.04
52.05	PODIATRY				52.05
52.06	INFUSION CLINIC	0.182506			52.06
53	ANESTHESIOLOGY	0.596244			53
54	RADIOLOGY-DIAGNOSTIC	0.068502			54
56	RADIOISOTOPE	0.150953			56
59	CARDIAC CATHETERIZATION	0.106343			59
60	LABORATORY	0.108139			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.241172			65
66	PHYSICAL THERAPY	0.277723			66
66.01	WOUND CARE	0.271542			66.01
67	OCCUPATIONAL THERAPY	0.180764			67
68	SPEECH PATHOLOGY	0.618384			68
69	ELECTROCARDIOLOGY	0.065799			69
70	ELECTROENCEPHALOGRAPHY	0.173579			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136310			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.362224			72
73	DRUGS CHARGED TO PATIENTS	0.180716			73
74	RENAL DIALYSIS	0.198952			74
76	OTHER				76
76.97	CARDIAC REHABILITATION	1.665837			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OCCUPATIONAL HEALTH	1.308667			90.01
91	EMERGENCY	0.123510			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.309651			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0155** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.162057			50
50.01	SPECIAL PROCEDURES				50.01
51	RECOVERY ROOM	0.283063			51
51.01	OP ONCOLOGY	0.990429			51.01
52.02	SUBSTANCE ABUSE	0.816450			52.02
52.04	DIABETES EDUCATION	0.080243			52.04
52.05	PODIATRY				52.05
52.06	INFUSION CLINIC	0.182506			52.06
53	ANESTHESIOLOGY	0.596244			53
54	RADIOLOGY-DIAGNOSTIC	0.068502			54
56	RADIOISOTOPE	0.150953			56
59	CARDIAC CATHETERIZATION	0.105966			59
60	LABORATORY	0.108013			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.241030			65
66	PHYSICAL THERAPY	0.277723			66
66.01	WOUND CARE	0.271542			66.01
67	OCCUPATIONAL THERAPY	0.180764			67
68	SPEECH PATHOLOGY	0.618384			68
69	ELECTROCARDIOLOGY	0.065799			69
70	ELECTROENCEPHALOGRAPHY	0.173579			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136310			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.362224			72
73	DRUGS CHARGED TO PATIENTS	0.180716			73
74	RENAL DIALYSIS	0.196905			74
76	OTHER				76
76.97	CARDIAC REHABILITATION	1.665837			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OCCUPATIONAL HEALTH	1.308667			90.01
91	EMERGENCY	0.122822			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.309651			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S155** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.162057			50
50.01	SPECIAL PROCEDURES				50.01
51	RECOVERY ROOM	0.283063			51
51.01	OP ONCOLOGY	0.990429			51.01
52.02	SUBSTANCE ABUSE	0.816450			52.02
52.04	DIABETES EDUCATION	0.080243			52.04
52.05	PODIATRY				52.05
52.06	INFUSION CLINIC	0.182506			52.06
53	ANESTHESIOLOGY	0.596244			53
54	RADIOLOGY-DIAGNOSTIC	0.068502			54
56	RADIOISOTOPE	0.150953			56
59	CARDIAC CATHETERIZATION	0.105966			59
60	LABORATORY	0.108013			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.241030			65
66	PHYSICAL THERAPY	0.277723			66
66.01	WOUND CARE	0.271542			66.01
67	OCCUPATIONAL THERAPY	0.180764			67
68	SPEECH PATHOLOGY	0.618384			68
69	ELECTROCARDIOLOGY	0.065799			69
70	ELECTROENCEPHALOGRAPHY	0.173579			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.136310			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.362224			72
73	DRUGS CHARGED TO PATIENTS	0.180716			73
74	RENAL DIALYSIS	0.196905			74
76	OTHER				76
76.97	CARDIAC REHABILITATION	1.665837			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OCCUPATIONAL HEALTH	1.308667			90.01
91	EMERGENCY	0.122822			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.309651			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	14,886,159			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	5,154,651			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	852,917			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	154.68			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				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				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0809			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1944			31
32	SUM OF LINES 30 AND 31	0.2753			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1288			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	2,083,317			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		1,929,477		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		486,334		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	486,334			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
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 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)				46
47	SUBTOTAL (see instructions)	23,463,378			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	23,463,378			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	1,750,078			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS	30,565			57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)	41,093			58
59	TOTAL (sum of amounts on lines 49 through 58)	25,285,114			59
60	PRIMARY PAYER PAYMENTS	1,132			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	25,283,982			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,118,660			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	87,024			63
64	ALLOWABLE BAD DEBTS (see instructions)	548,364			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	356,437			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	285,526			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	23,434,735			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-5,552			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-125,546			70.94
71	AMOUNT DUE PROVIDER (see instructions)	23,303,637			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	351,885			71.01
72	INTERIM PAYMENTS	23,137,419			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-185,667			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	40,577			75

TO BE COMPLETED BY CONTRACTOR

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

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0155** **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)	10,174			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	15,050,063			2
3	PPS PAYMENTS	11,711,215			3
4	OUTLIER PAYMENT (see instructions)	93,466			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	40,380			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	10,174			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	56,300			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	56,300			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)	56,300			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	46,126			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	10,174			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	11,845,061			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	2,561,629			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	9,293,606			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	9,293,606			30
31	PRIMARY PAYER PAYMENTS	870			31
32	SUBTOTAL (line 30 minus line 31)	9,292,736			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)	721,404			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	468,913			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	354,508			36
37	SUBTOTAL (see instructions)	9,761,649			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	9,761,649			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	147,401			40.01
41	INTERIM PAYMENTS	9,096,980			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	517,268			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S155** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [ ] HOSPITAL [XX] 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
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				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)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				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)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0155** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				22,805,437		9,100,942	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	12/17/2013	511,970			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	07/02/2013	179,988	12/17/2013	3,962	3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		331,982		-3,962	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)				23,137,419		9,096,980	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		166,218		664,669	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				23,303,637		9,761,649	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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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	5,563	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	12,911	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	400	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	21,105	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	600,179,897	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	17,865,267	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,874,108	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	37,482	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,836,626	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,805,637	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	30,989	32

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S155** **WORKSHEET E-3 PART II**

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

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)		1
2	NET IPF PPS OUTLIER PAYMENT		2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	8.567123	9
10	TEACHING ADJUSTMENT FACTOR {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)		12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)		16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)		18
19	DEDUCTIBLES		19
20	SUBTOTAL (line 18 minus line 19)		20
21	COINSURANCE		21
22	SUBTOTAL (line 20 minus line 21)		22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)		23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		25
26	SUBTOTAL (sum of lines 22 and 24)		26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)		31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)		31.01
32	INTERIM PAYMENTS		32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)		34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (see instructions)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)		52
53	TIME VALUE OF MONEY (see instructions)		53

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0155** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [ ] 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	4,424,916		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	4,424,916		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	4,424,916		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	4,424,916		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S155** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XIX** **[ ] 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	816,540		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	816,540		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	816,540		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	816,540		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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	7,838,671				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	27,719,580				4
5	OTHER RECEIVABLES	2,229,950				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	3,440,518				7
8	PREPAID EXPENSES	660,068				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS	1,421,055				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	43,309,842				11
	FIXED ASSETS					
12	LAND	5,113,245				12
13	LAND IMPROVEMENTS	1,933,152				13
14	ACCUMULATED DEPRECIATION	-1,750,909				14
15	BUILDINGS	86,900,444				15
16	ACCUMULATED DEPRECIATION	-55,016,416				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	43,992,630				23
24	ACCUMULATED DEPRECIATION	-32,450,345				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)	48,721,801				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	3,358,829				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	3,358,829				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	95,390,472				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	5,665,080				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE	3,600,960				39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME	22,879				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	7,779,235				43
44	OTHER CURRENT LIABILITIES	10,522,165				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	27,590,319				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	2,681,299				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	2,681,299				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	30,271,618				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	65,118,854				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	65,118,854				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	95,390,472				60

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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		71,577,956			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		398,369			2
3	TOTAL (sun of line 1 and line 2)		71,976,325			3
4	ADDITIONS (credit adjustments)					4
5						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)		71,976,325			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15	NET ASSET TRANSFER	6,857,471				15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		6,857,471			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		65,118,854			19

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

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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	33,546,894		33,546,894	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)	33,546,894		33,546,894	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	21,488,033		21,488,033	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT	15,160,914		15,160,914	14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	36,648,947		36,648,947	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	70,195,841		70,195,841	17
18	ANCILLARY SERVICES	187,271,753	341,615,643	528,887,396	18
19	OUTPATIENT SERVICES		1,426,128	1,426,128	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	257,467,594	343,041,771	600,509,365	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		127,989,637	29
30	ADD (SPECIFY)			30
31				31
32	RECONCILING ITEM			32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39	RECONCILING ITEM			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)		127,989,637	43

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	600,509,365	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	478,416,047	2
3	NET PATIENT REVENUES (line 1 minus line 2)	122,093,318	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	127,989,637	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-5,896,319	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	1,467,004	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		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	991,068	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (NET ASSETS RELEASED FROM RESTRICTION)	3,836,616	24
25	TOTAL OTHER INCOME (sum of lines 6-24)	6,294,688	25
26	TOTAL (line 5 plus line 25)	398,369	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	398,369	29

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS **WORKSHEET I-1**

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		TOTAL COSTS	BASIS	STATISTICS	FTEs PER 2080 HOURS	
		1	2	3	4	
1	REGISTERED NURSES	964,673	HOURS OF SERVICE	28,202.00	13.56	1
2	LICENSED PRACTICAL NURSES	58,038	HOURS OF SERVICE	2,780.00	1.34	2
3	NURSES AIDES		HOURS OF SERVICE			3
4	TECHNICIANS	376,775	HOURS OF SERVICE	21,392.00	10.28	4
5	SOCIAL WORKERS	119,846	HOURS OF SERVICE	4,136.00	1.99	5
6	DIETICIANS		HOURS OF SERVICE			6
7	PHYSICIANS		ACCUMULATED COST			7
8	NON-PATIENT CARE SALARY	185,937	ACCUMULATED COST			8
9	SUBTOTAL (sum of lines 1-8)	1,705,269				9
10	EMPLOYEE BENEFITS		SALARY			10
11	CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			11
12	CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			12
13	MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME			13
14	SUPPLIES		REQUISITIONS			14
15	DRUGS	1,414,659	REQUISITIONS			15
16	OTHER	683,671	ACCUMULATED COST			16
17	SUBTOTAL (sum of lines 9-16)	3,803,599				17
18	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	183,890	SQUARE FEET			18
19	CAPITAL RELATED COSTS-MOVABLE EQUIPMENT	74,686	PERCENTAGE OF TIME			19
20	EMPLOYEE BENEFITS DEPARTMENT	430,604	SALARY			20
21	ADMINISTRATIVE AND GENERAL	1,332,626	ACCUMULATED COST			21
22	MAINT./REPAIRS-OPERATION-HOUSEKEEPING	671,955	SQUARE FEET			22
23	MEDICAL EDUCATION PROGRAM COSTS	9,650				23
24	CENTRAL SERVICES & SUPPLIES	57,177	REQUISITIONS			24
25	PHARMACY		REQUISITIONS			25
26	OTHER ALLOCATED COSTS	434,679	ACCUMULATED COST			26
27	SUBTOTAL (sum of lines 17-26)	6,998,866				27
28	LABORATORY		CHARGES			28
29	RESPIRATORY THERAPY		CHARGES			29
30	OTHER		CHARGES			30
30.97	CARDIAC REHABILITATION		CHARGES			30.97
30.98	HYPERBARIC OXYGEN THERAPY		CHARGES			30.98
30.99	LITHOTRIPSY		CHARGES			30.99
31	TOTAL COSTS (sum of lines 27-30)	6,998,866				31

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES **WORKSHEET I-2**

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY				
	OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	BUILDING	EQUIPMENT	RNs	OTHER	EMPLOYEE BENEFITS DEPARTMENT	DRUGS	
		1	2	3	4	5	6	
1	TOTAL RENAL DEPARTMENT COSTS	855,845	74,686	964,673	554,659	430,604	1,414,659	1
	MAINTENANCE							
2	HEMODIALYSIS	515,434	44,982	580,998	334,077	263,916	852,022	2
3	INTERMITTENT PERITONEAL							3
	TRAINING							
4	HEMODIALYSIS	1,606	138	1,779	1,019		2,614	4
5	INTERMITTENT PERITONEAL							5
6	CAPD	3,340	291	3,763	2,155		5,506	6
7	CCPD	1,541	132	1,710	980		2,503	7
	HOME							
8	HEMODIALYSIS	29,031	2,534	32,734	18,811	13,891	47,999	8
9	INTERMITTENT PERITONEAL							9
10	CAPD	29,609	2,584	33,384	19,184	13,891	48,944	10
11	CCPD	248,051	21,647	279,589	160,778	125,015	410,020	11
	OTHER BILLABLE SERVICES							
12	INPATIENT DIALYSIS	27,233	2,378	30,716	17,655	13,891	45,051	12
13	METHOD II HOME PATIENT							13
14	EPO (included in renal department)							14
15	ARANESP (included in renal department)							15
16	OTHER							16
17	TOTAL (sum of lines 2-16)	855,845	74,686	964,673	554,659	430,604	1,414,659	17
18	MEDICAL EDUCATION PROGRAM COSTS							18
19	TOTAL RENAL COSTS (line 17 + line 18)							19

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES **WORKSHEET I-2**

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

	OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	MEDICAL SUPPLIES	ROUTINE ANCILLARY SERVICES	SUBTOTAL (sum of cols. 1-8)	OVERHEAD	TOTAL (col. 9 + col. 10)	
		7	8	9	10	11	
1	TOTAL RENAL DEPARTMENT COSTS	57,177		4,352,303	2,636,913	6,989,216	1
	MAINTENANCE						
2	HEMODIALYSIS	34,436		2,625,865	1,590,923	4,216,788	2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS	106		7,262	4,400	11,662	4
5	INTERMITTENT PERITONEAL						5
6	CAPD	223		15,278	9,256	24,534	6
7	CCPD	101		6,967	4,221	11,188	7
	HOME						
8	HEMODIALYSIS	1,940		146,940	89,026	235,966	8
9	INTERMITTENT PERITONEAL						9
10	CAPD	1,978		149,574	90,622	240,196	10
11	CCPD	16,572		1,261,672	764,404	2,026,076	11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS	1,821		138,745	84,061	222,806	12
13	METHOD II HOME PATIENT						13
14	EPO (included in renal department)						14
15	ARANESP (included in renal department)						15
16	OTHER						16
17	TOTAL (sum of lines 2-16)	57,177		4,352,303	2,636,913	6,989,216	17
18	MEDICAL EDUCATION PROGRAM COSTS					9,650	18
19	TOTAL RENAL COSTS (line 17 + line 18)					6,998,866	19

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS **WORKSHEET I-3**

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY			
	COMPOSITE PAYMENT SERVICES	BUILDING (Square Feet)	EQUIPMENT (% of Time)	RNs (Hours)	OTHERS (Hours)	EMPLOYEE BENEFITS DEPARTMENT (Salary)	
		1	2	3	4	5	
1	TOTAL RENAL DEPT COSTS	855,845	74,686	964,673	554,659	430,604	1
	MAINTENANCE						
2	HEMODIALYSIS	8,025	15,319.00	16,986.00	17,049.00	1,900,000	2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS	25	47.00	52.00	52.00		4
5	INTERMITTENT PERITONEAL						5
6	CAPD	52	99.00	110.00	110.00		6
7	CCPD	24	45.00	50.00	50.00		7
	HOME						
8	HEMODIALYSIS	452	863.00	957.00	960.00	100,000	8
9	INTERMITTENT PERITONEAL						9
10	CAPD	461	880.00	976.00	979.00	100,000	10
11	CCPD	3,862	7,372.00	8,174.00	8,205.00	900,000	11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS TREATMENTS	424	810.00	898.00	901.00	100,000	12
13	METHOD II HOME PATIENT						13
14	EPO						14
15	ARANESP						15
16	OTHER						16
17	TOTAL STATISTICAL BASIS	13,325	25,435.00	28,203.00	28,306.00	3,100,000	17
18	UNIT COST MULTIPLIER (line 1 ÷ line 17)	64.228518	2.936348	34.204624	19.595104	0.138905	18

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS **WORKSHEET I-3**

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

	COMPOSITE PAYMENT SERVICES	DRUGS (Requist.)	MEDICAL SUPPLIES (Requist.)	ROUTINE ANCILLARY SERVICES (Charges)	SUBTOTAL	OVERHEAD (Accum. Cost)	
		6	7	8	9	10	
1	TOTAL RENAL DEPT COSTS	1,414,659	57,177				1
	MAINTENANCE						
2	HEMODIALYSIS	15,319	569,243				2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS	47	1,746				4
5	INTERMITTENT PERITONEAL						5
6	CAPD	99	3,679				6
7	CCPD	45	1,672				7
	HOME						
8	HEMODIALYSIS	863	32,068				8
9	INTERMITTENT PERITONEAL						9
10	CAPD	880	32,700				10
11	CCPD	7,372	273,938				11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS TREATMENTS	810	30,099				12
13	METHOD II HOME PATIENT						13
14	EPO						14
15	ARANESP						15
16	OTHER						16
17	TOTAL STATISTICAL BASIS	25,435	945,145			4,352,303	17
18	UNIT COST MULTIPLIER (line 1 ÷ line 17)	55.618596	0.060495			0.605866	18

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS **WORKSHEET I-4**

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		NUMBER OF TOTAL TREATMENTS	TOTAL COST (from Wkst. I-2, col. 11)	AVERAGE COST OF PROGRAM TREATMENTS (col. 2 ÷ col. 1)	NUMBER OF PROGRAM TREATMENTS	NUMBER OF PROGRAM TREATMENTS	NUMBER OF PROGRAM TREATMENTS	TOTAL PROGRAM EXPENSES (see instr-uctions)	
		1	2	3	4	4.01	4.02	5	
1	MAINTENANCE - HEMODIALYSIS	15,319	4,216,788	275.27			13,097	3,605,211	1
2	MAINTENANCE - PERITONEAL DIALYSIS								2
3	TRAINING - HEMODIALYSIS	47	11,662	248.13			47	11,662	3
4	TRAINING - PERITONEAL DIALYSIS								4
5	TRAINING - CONTINUOUS AMBULATORY PERITONEAL DIALYSIS	99	24,534	247.82			73	18,091	5
6	TRAINING - CONTINUOUS CYCLING PERITONEAL DIALYSIS	45	11,188	248.62			18	4,475	6
7	HOME PROGRAM - HEMODIALYSIS								7
8	HOME PROGRAM - PERITONEAL DIALYSIS								8
		PATIENT WEEKS			PATIENT WEEKS	PATIENT WEEKS	PATIENT WEEKS		
9	HOME PROGRAM - CONTINUOUS AMBULATORY PERITONEAL DIALYSIS	880	240,196	272.95			177	48,312	9
10	HOME PROGRAM - CONTINUOUS CYCLING PERITONEAL DIALYSIS	7,372	2,026,076	274.83			6,062	1,666,019	10
11	TOTALS (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6)	15,510	6,530,444				19,474	5,353,770	11
12	TOTAL TREATMENTS (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))	15,510							12

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS **WORKSHEET I-4**

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	AVERAGE PAYMENT RATE (col. 6 ÷ col. 4)	AVERAGE PAYMENT RATE (col. 6.01 ÷ col. 4.01)	AVERAGE PAYMENT RATE (col. 6.02 ÷ col. 4.02)	
		6	6.01	6.02	7	7.01	7.02	
1	MAINTENANCE - HEMODIALYSIS			3,697,813			282.34	1
2	MAINTENANCE - PERITONEAL DIALYSIS							2
3	TRAINING - HEMODIALYSIS			13,129			279.34	3
4	TRAINING - PERITONEAL DIALYSIS							4
5	TRAINING - CONTINUOUS AMBULATORY PERITONEAL DIALYSIS			23,491			321.79	5
6	TRAINING - CONTINUOUS CYCLING PERITONEAL DIALYSIS			5,546			308.11	6
7	HOME PROGRAM - HEMODIALYSIS							7
8	HOME PROGRAM - PERITONEAL DIALYSIS							8
9	HOME PROGRAM - CONTINUOUS AMBULATORY PERITONEAL DIALYSIS			22,274			125.84	9
10	HOME PROGRAM - CONTINUOUS CYCLING PERITONEAL DIALYSIS			687,594			113.43	10
11	TOTALS (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6)			4,449,847				11
12	TOTAL TREATMENTS (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))							12

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B **WORKSHEET I-5**

	DESCRIPTION			
1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (see instructions)		5,353,770	1
		1	2	
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11) (see instructions)			2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11) (see instructions)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11) (see instructions)	4,449,847	4,449,847	2.02
2.03	TOTAL PAYMENT DUE (see instructions)	4,449,847	4,449,847	2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (Part B) PATIENTS (see instructions)	2,691	2,691	3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (Part B) PATIENTS (see instructions)	2,691	2,691	3.03
4	COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			4
4.01	COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)	889,442	889,443	4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)	889,442	889,443	4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (sum of line 5 through line 5.04)			5.05
6	ALLOWABLE BAD DEBTS (see instructions)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)		892,134	8
9	PROGRAM PAYMENT (see instructions)		3,557,725	9
10	UNRECOVERED FROM MEDICARE (Part B) PATIENTS (see instructions)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (transfer to Worksheet E, Part B, line 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12	TOTAL ALLOWABLE EXPENSES (see instructions)	6,530,444	12
13	TOTAL COMPOSITE COSTS (from Worksheet I-4, column 2, line 11)	6,530,444	13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (line 13 divided by line 12)	1.000000	14

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0155** **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	1,595,750	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	62,892	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)	57.82	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0809	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1944	8
9	SUM OF LINES 7 AND 8	0.2753	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0573	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	91,436	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,750,078	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	BIO MED							7.01
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
14.01	STERILE PROCESSING							14.01
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
34	SURGICAL INTENSIVE CARE UNIT							34
40	SUBPROVIDER - IPF							40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM							51
51.01	OP ONCOLOGY							51.01
52.02	SUBSTANCE ABUSE							52.02
52.04	DIABETES EDUCATION							52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC							52.06
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
56	RADIOISOTOPE							56
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
66.01	WOUND CARE							66.01
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OCCUPATIONAL HEALTH							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

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		
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
194	OTHER NRCC							194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	54.81		16.32				71.13	30
31	INTENSIVE CARE UNIT	57.26		14.15				71.41	31
34	SURGICAL INTENSIVE CARE UNIT	61.95		15.88				77.83	34
43	NURSERY			48.56				48.56	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	18.44	26.22					44.66	50
51	RECOVERY ROOM	11.11	22.43					33.54	51
51.01	OP ONCOLOGY		58.81					58.81	51.01
52.02	SUBSTANCE ABUSE	1.36	7.91					9.27	52.02
52.04	DIABETES EDUCATION	51.29	7.66					58.95	52.04
52.06	INFUSION CLINIC	6.31	49.88					56.19	52.06
53	ANESTHESIOLOGY	11.36	17.33					28.69	53
54	RADIOLOGY-DIAGNOSTIC	14.01	20.78					34.79	54
56	RADIOISOTOPE	8.48	44.97					53.45	56
59	CARDIAC CATHETERIZATION	33.15	35.48					68.63	59
60	LABORATORY	22.29	0.70					22.99	60
65	RESPIRATORY THERAPY	41.37	10.55					51.92	65
66	PHYSICAL THERAPY	20.38	5.46					25.84	66
66.01	WOUND CARE	1.94	56.12					58.06	66.01
67	OCCUPATIONAL THERAPY	27.90	3.19					31.09	67
68	SPEECH PATHOLOGY	22.19	5.01					27.20	68
69	ELECTROCARDIOLOGY	26.60	17.62					44.22	69
70	ELECTROENCEPHALOGRAPHY	22.19	15.43					37.62	70
71	MEDICAL SUPPLIES CHARGED TO PAT	31.00	17.02					48.02	71
72	IMPL. DEV. CHARGED TO PATIENTS	2.14	2.37					4.51	72
73	DRUGS CHARGED TO PATIENTS	33.36	16.96					50.32	73
74	RENAL DIALYSIS	2.49	0.16					2.65	74
76.97	CARDIAC REHABILITATION	0.56	40.15					40.71	76.97
90.01	OCCUPATIONAL HEALTH		1.18					1.18	90.01
91	EMERGENCY	12.67	12.98					25.65	91
92	OBSERVATION BEDS (NON-DISTINCT	8.54	29.21					37.75	92
200	TOTAL CHARGES	19.31	16.58					35.89	200

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REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	5,545,478	4.60	-5,545,478	-9.29			1
2	CAP REL COSTS-MVBLE EQUIP	3,528,670	2.93	-3,528,670	-5.91			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	10,358,271	8.59	-10,358,271	-17.36			4
5	ADMINISTRATIVE & GENERAL	26,242,246	21.77	-26,242,246	-43.98			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	3,646,395	3.03	-3,646,395	-6.11			7
7.01	BIO MED	1,680,196	1.39	-1,680,196	-2.82			7.01
8	LAUNDRY & LINEN SERVICE	363,074	0.30	-363,074	-0.61			8
9	HOUSEKEEPING	1,188,345	0.99	-1,188,345	-1.99			9
10	DIETARY	897,489	0.74	-897,489	-1.50			10
11	CAFETERIA	504,529	0.42	-504,529	-0.85			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	852,514	0.71	-852,514	-1.43			13
14	CENTRAL SERVICES & SUPPLY	155,691	0.13	-155,691	-0.26			14
14.01	STERILE PROCESSING	333,041	0.28	-333,041	-0.56			14.01
15	PHARMACY	1,631,625	1.35	-1,631,625	-2.73			15
16	MEDICAL RECORDS & LIBRARY	1,714,132	1.42	-1,714,132	-2.87			16
17	SOCIAL SERVICE	866,596	0.72	-866,596	-1.45			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)	159,562	0.13	-159,562	-0.27			23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	ADULTS & PEDIATRICS	6,490,463	5.38	13,181,108	22.09	19,671,571	16.32	30
31	INTENSIVE CARE UNIT	2,297,636	1.91	2,632,403	4.41	4,930,039	4.09	31
34	SURGICAL INTENSIVE CARE UNIT	1,535,722	1.27	1,722,249	2.89	3,257,971	2.70	34
40	SUBPROVIDER - IPF	1,018,893	0.85	1,814,972	3.04	2,833,865	2.35	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,404,742	2.00	4,148,984	6.95	6,553,726	5.44	50
50.01	SPECIAL PROCEDURES							50.01
51	RECOVERY ROOM	1,279,208	1.06	1,264,790	2.12	2,543,998	2.11	51
51.01	OP ONCOLOGY	1,006,186	0.83	2,054,401	3.44	3,060,587	2.54	51.01
52.02	SUBSTANCE ABUSE	287,821	0.24	408,901	0.69	696,722	0.58	52.02
52.04	DIABETES EDUCATION	54,310	0.05	91,132	0.15	145,442	0.12	52.04
52.05	PODIATRY							52.05
52.06	INFUSION CLINIC	313,173	0.26	348,593	0.58	661,766	0.55	52.06
53	ANESTHESIOLOGY	4,132,424	3.43	1,441,709	2.42	5,574,133	4.62	53
54	RADIOLOGY-DIAGNOSTIC	2,938,009	2.44	3,798,250	6.37	6,736,259	5.59	54
56	RADIOISOTOPE	822,156	0.68	830,443	1.39	1,652,599	1.37	56
59	CARDIAC CATHETERIZATION	535,236	0.44	1,052,453	1.76	1,587,689	1.32	59
60	LABORATORY	4,203,142	3.49	2,195,428	3.68	6,398,570	5.31	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,519,471	1.26	1,241,764	2.08	2,761,235	2.29	65
66	PHYSICAL THERAPY	892,068	0.74	941,945	1.58	1,834,013	1.52	66
66.01	WOUND CARE	1,289,584	1.07	692,601	1.16	1,982,185	1.64	66.01
67	OCCUPATIONAL THERAPY	175,682	0.15	130,903	0.22	306,585	0.25	67
68	SPEECH PATHOLOGY	177,575	0.15	112,464	0.19	290,039	0.24	68
69	ELECTROCARDIOLOGY	324,997	0.27	461,312	0.77	786,309	0.65	69
70	ELECTROENCEPHALOGRAPHY	35,899	0.03	55,576	0.09	91,475	0.08	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,170,495	4.29	1,542,820	2.59	6,713,315	5.57	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,183,942	3.47	1,249,874	2.09	5,433,816	4.51	72
73	DRUGS CHARGED TO PATIENTS	7,776,523	6.45	5,267,855	8.83	13,044,378	10.82	73
74	RENAL DIALYSIS	3,803,599	3.16	3,195,267	5.36	6,998,866	5.81	74
76	OTHER							76
76.97	CARDIAC REHABILITATION	2,792		533,521	0.89	536,313	0.44	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
76.99	LITHOTRIPSY							76.99
90.01	OCCUPATIONAL HEALTH	851,386	0.71	1,014,941	1.70	1,866,327	1.55	90.01
91	EMERGENCY	2,958,801	2.45	3,712,532	6.22	6,671,333	5.53	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	97,260	0.08	70,024	0.12	167,284	0.14	190
194	OTHER NRCC	2,283,036	1.89	2,458,639	4.12	4,741,675	3.93	194
194.01	SISTERS RESIDENCE							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	120,530,085	100.00			120,530,085	100.00	202

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,115,950	40,440,952	0.027595	7,458,666	205,822	50
50.01	SPECIAL PROCEDURES						50.01
51	RECOVERY ROOM	118,304	8,987,376	0.013163	998,222	13,140	51
51.01	OP ONCOLOGY	626,530	3,090,162	0.202750			51.01
52.02	SUBSTANCE ABUSE	106,648	853,355	0.124975	11,619	1,452	52.02
52.04	DIABETES EDUCATION	22,167	1,812,527	0.012230	929,731	11,371	52.04
52.05	PODIATRY						52.05
52.06	INFUSION CLINIC	58,109	3,626,004	0.016026	228,870	3,668	52.06
53	ANESTHESIOLOGY	64,888	9,348,742	0.006941	1,062,299	7,373	53
54	RADIOLOGY-DIAGNOSTIC	1,065,823	98,337,239	0.010838	13,775,098	149,295	54
56	RADIOISOTOPE	296,618	10,947,803	0.027094	928,058	25,145	56
59	CARDIAC CATHETERIZATION	375,323	14,983,011	0.025050	4,967,232	124,429	59
60	LABORATORY	499,722	59,238,938	0.008436	13,205,963	111,406	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,981	11,455,998	0.011084	4,738,925	52,526	65
66	PHYSICAL THERAPY	178,296	6,603,759	0.026999	1,345,748	36,334	66
66.01	WOUND CARE	95,681	7,299,745	0.013107	141,720	1,858	66.01
67	OCCUPATIONAL THERAPY	10,371	1,696,047	0.006115	473,138	2,893	67
68	SPEECH PATHOLOGY	6,546	469,027	0.013957	104,086	1,453	68
69	ELECTROCARDIOLOGY	108,803	11,950,149	0.009105	3,178,588	28,941	69
70	ELECTROENCEPHALOGRAPHY	20,075	526,994	0.038093	116,939	4,455	70
71	MEDICAL SUPPLIES CHARGED TO PAT	25,323	49,250,288	0.000514	15,268,231	7,848	71
72	IMPL. DEV. CHARGED TO PATIENTS	20,856	15,001,246	0.001390	320,453	445	72
73	DRUGS CHARGED TO PATIENTS	106,109	72,181,453	0.001470	24,076,424	35,392	73
74	RENAL DIALYSIS	419,580	35,544,435	0.011804	884,168	10,437	74
76	OTHER						76
76.97	CARDIAC REHABILITATION	152,752	321,948	0.474462	1,817	862	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OCCUPATIONAL HEALTH	184,087	1,426,128	0.129082			90.01
91	EMERGENCY	420,165	54,317,053	0.007735	6,883,325	53,243	91
92	OBSERVATION BEDS (NON-DISTINCT	167,027	6,836,930	0.024430	583,860	14,264	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL	6,392,734	526,547,309		101,683,180	904,052	200

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	1,552,181		1,552,181	21,448	72.37	11,756	850,782	30
31	INTENSIVE CARE UNIT	251,671		251,671	1,329	189.37	761	144,111	31
34	SURGICAL INTENSIVE CARE UNIT	172,257		172,257	636	270.84	394	106,711	34
200	TOTAL	1,976,109		1,976,109	23,413		12,911	1,101,604	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	1,101,604
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	904,052
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	2,005,656
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	2,576
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	12,911
PER DISCHARGE CAPITAL COSTS	778.59

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PRESENCE ST. MARY'S HOSPITAL Provider CCN: 14-0155	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/30/2014 Run Time: 08:22 Version: 2014.03

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	28,530,612
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	139,903,156
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.204

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	
3. RATIO OF COST TO CHARGES (line 1 / line 2)	

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	2,005,656
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.014

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01 & 2.02 x (Worksheet B, Part I, column 26 - columns 20 & 23 / Worksheet C, Part I, column 8) less lines 61, 66-68, 74, 94, 95 & 96) (see CR 5999)	13,801,805
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	82,674,810
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.167