KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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: 05/23/2014 TIME: 10:51 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 SAINTS MARY & ELIZABETH MED (14-0180) {(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		2,394,153	755,078	-201,168		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		6,254	-26			3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		21,094	-30			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		2,421,501	755,022	-201,168		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 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: 2233 WEST DIVISION STREET	P.O. BOX:		1
2	CITY: CHICAGO	STATE: IL	ZIP CODE: 60622	COUNTY: COOK 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 SAINTS MARY & ELIZABETH MED	14-0180	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF	ST. MARY OF NAZARETH REHAB UNIT	14-T180	16974	5	01/01/1984	N	P	O	5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	ST. ELIZABETH'S SNF	14-5541	16974		01/28/1986	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19

20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 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.	45,446	8,768			1,420	396	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.	922	146					25

26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	1		26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.	1		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS 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	
	1	2	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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	Y	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.	Y			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE 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)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE 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.	N			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, 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.				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.	Y			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.	N	N		76

	LONG TERM CARE HOSPITAL PPS			
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		80
	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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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	Y	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				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.					118
			PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			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
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		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 HEALTH	CONTRACTOR'S NAME: NGS		CONTRACTOR'S NUMBER: 00131	141
142	STREET: 200 SOUTH WACKER DRIVE	P.O. BOX:			142
143	CITY: CHICAGO	STATE: IL	ZIP CODE: 60606		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.	Y		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			156
157	SUBPROVIDER - IRF	N	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)	02/17/2013	05/16/2013	170

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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 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		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?		Y	Y	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		Y		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		Y		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
				Y/N	
BAD DEBTS					
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)	Y	04/08/2014	Y	04/08/2014	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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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 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: ALICIA	LAST NAME: JUMPER	TITLE: DIR. OF REIMBURSEMENT	41
42	EMPLOYER: PRESENCE HEALTHCARE			42
43	PHONE NUMBER: (847) 813-3713	E-MAIL ADDRESS: ALICIA.JUMPER@PRESENCEHEALTH.ORG		43

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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	420	153,300			29,245	52,430	96,959	1
2	HMO AND OTHER (see instructions)						2,902			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)		420	153,300			29,245	52,430	96,959	7
8	INTENSIVE CARE UNIT	31	32	11,680			2,474	1,533	6,059	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						2,067	4,038	13
14	TOTAL (see instructions)		452	164,980			31,719	56,030	107,056	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	15	5,475			1,664	1,068	3,414	17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	28	10,220			4,042		5,130	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)		495							27
28	OBSERVATION BED DAYS							1,078	3,604	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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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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)					5,304	9,455	19,085	1
2	HMO AND OTHER (see instructions)					517			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)	48.13	1,675.71			5,304	9,455	19,085	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF		19.46			122	68	286	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY		25.90						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)	48.13	1,721.07						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	94,877,091	3,000	94,880,091	3,544,926.00	26.77	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE		999,681		999,681	12,265.00	81.51	4
4.01	PHYSICIAN-PART A - TEACHING		450,146		450,146	5,948.00	75.68	4.01
5	PHYSICIAN-PART B		1,793,037		1,793,037	25,073.00	71.51	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21	4,877,445	-1,013,165	3,864,280	85,817.00	45.03	7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44	1,400,992		1,400,992	53,880.00	26.00	9
10	EXCLUDED AREA SALARIES (see instructions)		932,710	20,612	953,322	40,697.00	23.42	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		10,858,707		10,858,707	271,110.68	40.05	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		12,546,479		12,546,479	407,867.00	30.76	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)		19,680,146		19,680,146			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		542,348		542,348			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE		110,117		110,117			22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		225,112		225,112			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)		497,353		497,353			25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		-3,000	3,000				26
27	ADMINISTRATIVE & GENERAL		6,906,290		6,906,290	327,955.00	21.06	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		2,582,375	-20,612	2,561,763	89,228.00	28.71	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		1,918,949		1,918,949	156,044.00	12.30	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		1,952,316	-818,072	1,134,244	140,523.00	8.07	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA		362,468	818,072	1,180,540	28,364.00	41.62	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		4,395,213		4,395,213	112,906.00	38.93	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		3,573,551		3,573,551	93,870.00	38.07	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,900,865		1,900,865	93,576.00	20.31	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		87,756,463	1,016,165	88,772,628	3,428,088.00	25.90	1
2	EXCLUDED AREA SALARIES (see instructions)		2,333,702	20,612	2,354,314	94,577.00	24.89	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		85,422,761	995,553	86,418,314	3,333,511.00	25.92	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		23,405,186		23,405,186	678,977.68	34.47	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		19,790,263		19,790,263		22.90%	5
6	TOTAL (sum of lines 3 through 5)		128,618,210	995,553	129,613,763	4,012,488.68	32.30	6
7	TOTAL OVERHEAD COST (see instructions)		23,589,027	-17,612	23,571,415	1,042,466.00	22.61	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)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	3,868,843	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	8,176,377	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	233,129	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	-39,232	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	462,964	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	1,053,146	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	6,846,932	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	208,711	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	229,692	22
23	TUITION REIMBURSEMENT	63,921	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	21,104,483	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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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

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	2,340,458		1
2	HOSPITAL	2,340,458		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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	N	/ /	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL	23		23	4
5	RVX				5
6	RVL	14		14	6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	103		103	12
13	RUB	1,152		1,152	13
14	RUA	492		492	14
15	RVC	225		225	15
16	RVB	1,070		1,070	16
17	RVA	176		176	17
18	RHC	14		14	18
19	RHB	213		213	19
20	RHA				20
21	RMC	31		31	21
22	RMB	399		399	22
23	RMA	22		22	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1	11		11	32
33	HC2				33
34	HC1	11		11	34
35	HB2				35
36	HB1	1		1	36
37	LE2				37
38	LE1	2		2	38
39	LD2				39
40	LD1	12		12	40
41	LC2				41
42	LC1	5		5	42
43	LB2				43
44	LB1	18		18	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	1		1	48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1	7		7	52
53	CA2				53
54	CA1	23		23	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA	17		17	199
200	TOTAL	4,042		4,042	200

SNF SERVICES

		CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable).	16974	16974	201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (see instructions)

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)	4,592,745			207

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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)	0.217880	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	73,526,466	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID	34,781,416	5
6	MEDICAID CHARGES	347,516,771	6
7	MEDICAID COST (line 1 times line 6)	75,716,954	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		8

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

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

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

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

UNCOMPENSATED 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)		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	36,421,509	961,368	37,382,877	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	7,935,518	209,463	8,144,981	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	68,182	1,755	69,937	22
23	COST OF CHARITY CARE (line 21 minus line 22)	7,867,336	207,708	8,075,044	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)	27,300,677	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	3,201,322	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	24,099,355	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	5,250,767	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	13,325,811	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	13,325,811	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		1,736,880	1,736,880	2,952,198	4,689,078	90,037	4,779,115	1
2	00200	CAP REL COSTS-MVBLE EQUIP		9,453,664	9,453,664	3,689,963	13,143,627	-4,406,754	8,736,873	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,000	14,200,993	14,197,993	6,860,750	21,058,743	671,682	21,730,425	4
5	00500	ADMINISTRATIVE & GENERAL	6,906,290	51,239,723	58,146,013	-2,030,102	56,115,911	-6,822,889	49,293,022	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	2,582,375	8,346,820	10,929,195	-261,376	10,667,819		10,667,819	7
8	00800	LAUNDRY & LINEN SERVICE		1,423,197	1,423,197	-767	1,422,430		1,422,430	8
9	00900	HOUSEKEEPING	1,918,949	1,302,384	3,221,333	-208,217	3,013,116		3,013,116	9
10	01000	DIETARY	1,952,316	2,155,806	4,108,122	-2,057,963	2,050,159	-786	2,049,373	10
11	01100	CAFETERIA	362,468	28,635	391,103	1,875,218	2,266,321	-1,013,743	1,252,578	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	4,395,213	1,228,629	5,623,842	-326,492	5,297,350	-16,734	5,280,616	13
14	01400	CENTRAL SERVICES & SUPPLY		-1,347,024	-1,347,024	911,640	-435,384	1,104,689	669,305	14
15	01500	PHARMACY	3,573,551	11,531,564	15,105,115	-10,369,456	4,735,659		4,735,659	15
16	01600	MEDICAL RECORDS & LIBRARY	1,900,865	876,777	2,777,642	-145,737	2,631,905	-21,984	2,609,921	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL		-126	-126	-576	-702		-702	20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD	4,877,445	2,760,358	7,637,803	-1,308,839	6,328,964	-3,099,284	3,229,680	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				1,013,165	1,013,165		1,013,165	22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	26,655,046	10,655,219	37,310,265	-3,104,881	34,205,384		34,205,384	30
31	03100	INTENSIVE CARE UNIT	5,227,255	1,028,968	6,256,223	-861,572	5,394,651	-169,195	5,225,456	31
41	04100	SUBPROVIDER - IRF	931,411	123,753	1,055,164	-85,324	969,840	-2,500	967,340	41
43	04300	NURSERY	734,923	508,569	1,243,492	-128,707	1,114,785	-64,000	1,050,785	43
44	04400	SKILLED NURSING FACILITY	1,400,992	245,376	1,646,368	-193,915	1,452,453	-6,000	1,446,453	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	4,585,601	11,748,049	16,333,650	-8,212,296	8,121,354	-50,000	8,071,354	50
51	05100	RECOVERY ROOM	758,029	101,189	859,218	-91,742	767,476		767,476	51
52	05200	DELIVERY ROOM & LABOR ROOM	4,480,631	885,642	5,366,273	-821,670	4,544,603	-555,699	3,988,904	52
53	05300	ANESTHESIOLOGY	143,071	1,222,917	1,365,988	-453,476	912,512	-423,000	489,512	53
54	05400	RADIOLOGY-DIAGNOSTIC	5,151,671	2,437,865	7,589,536	-1,601,333	5,988,203	-4,664	5,983,539	54
54.01	03190	OUTPATIENT ONCOLOGY	319,697	156,710	476,407	-76,918	399,489		399,489	54.01
55	05500	RADIOLOGY-THERAPEUTIC	167,866	214,868	382,734	-104,518	278,216		278,216	55
59	05900	CARDIAC CATHETERIZATION	570,164	980,604	1,550,768	-941,689	609,079		609,079	59
60	06000	LABORATORY		9,033,004	9,033,004		9,033,004	-74,532	8,958,472	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.		20,109	20,109	-3,875	16,234		16,234	63
65	06500	RESPIRATORY THERAPY	1,615,971	426,503	2,042,474	-277,283	1,765,191	-5,625	1,759,566	65
66	06600	PHYSICAL THERAPY	1,846,740	222,949	2,069,689	-168,249	1,901,440		1,901,440	66
67	06700	OCCUPATIONAL THERAPY	947,354	107,951	1,055,305	-71,785	983,520		983,520	67
68	06800	SPEECH PATHOLOGY	229,956	19,582	249,538	-17,468	232,070		232,070	68
69	06900	ELECTROCARDIOLOGY	946,756	450,388	1,397,144	-226,531	1,170,613	-69,150	1,101,463	69
70	07000	ELECTROENCEPHALOGRAPHY	207,037	904,816	1,111,853	-18,349	1,093,504	-225,520	867,984	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				7,744,389	7,744,389		7,744,389	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				3,604,808	3,604,808		3,604,808	72
73	07300	DRUGS CHARGED TO PATIENTS				10,954,062	10,954,062	-89,247	10,864,815	73
74	07400	RENAL DIALYSIS	475,940	226,181	702,121	-144,545	557,576		557,576	74
75	07500	ASC (NON-DISTINCT PART)	1,195,175	1,085,971	2,281,146	-935,974	1,345,172		1,345,172	75
76	03550	MENTAL HEALTH OUTPATIENT	1,164	2,643,154	2,644,318	-21,974	2,622,344	-90,000	2,532,344	76
76.97	07697	CARDIAC REHABILITATION	165,363	35,821	201,184	-13,448	187,736	-26,397	161,339	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	1,259,518	1,302,834	2,562,352	-142,648	2,419,704	-517,125	1,902,579	90
91	09100	EMERGENCY	6,391,989	4,293,986	10,685,975	-1,469,269	9,216,706	-825,765	8,390,941	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		2,794,975	2,794,975	-2,794,975				113
114	11400	UTILIZATION REVIEW-SNF				12,000	12,000	-12,000		114
192	19200	PHYSICIANS' PRIVATE OFFICES								192
193	19300	NONPAID WORKERS		33,943	33,943		33,943		33,943	193
194	07950	CONVENT	1,299	2,449	3,748	75,746	79,494		79,494	194
194.01	07951	OUTPATIENT PHARMACY		329	329		329		329	194.01
194.02	07952	FUND DEVELOPMENT		5,494	5,494		5,494		5,494	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE								194.03
200		TOTAL (sum of lines 118-199)	94,877,091	158,858,448	253,735,539		253,735,539	-16,726,185	237,009,354	200

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	EMPLOYEE BENEFITS	A	EMPLOYEE BENEFITS DEPARTMENT	4	3,000	6,861,444	1
2	EMPLOYEE BENEFITS	A					2
3	EMPLOYEE BENEFITS	A					3
4	EMPLOYEE BENEFITS	A					4
5	EMPLOYEE BENEFITS	A					5
6	EMPLOYEE BENEFITS	A					6
7	EMPLOYEE BENEFITS	A					7
8	EMPLOYEE BENEFITS	A					8
9	EMPLOYEE BENEFITS	A					9
10	EMPLOYEE BENEFITS	A					10
11	EMPLOYEE BENEFITS	A					11
12	EMPLOYEE BENEFITS	A					12
13	EMPLOYEE BENEFITS	A					13
14	EMPLOYEE BENEFITS	A					14
15	EMPLOYEE BENEFITS	A					15
16	EMPLOYEE BENEFITS	A					16
17	EMPLOYEE BENEFITS	A					17
18	EMPLOYEE BENEFITS	A					18
19	EMPLOYEE BENEFITS	A					19
20	EMPLOYEE BENEFITS	A					20
21	EMPLOYEE BENEFITS	A					21
22	EMPLOYEE BENEFITS	A					22
23	EMPLOYEE BENEFITS	A					23
24	EMPLOYEE BENEFITS	A					24
25	EMPLOYEE BENEFITS	A					25
26	EMPLOYEE BENEFITS	A					26
27	EMPLOYEE BENEFITS	A					27
28	EMPLOYEE BENEFITS	A					28
29	EMPLOYEE BENEFITS	A					29
30	EMPLOYEE BENEFITS	A					30
31	EMPLOYEE BENEFITS	A					31
32	EMPLOYEE BENEFITS	A					32
33	EMPLOYEE BENEFITS	A					33
34	EMPLOYEE BENEFITS	A					34
35	EMPLOYEE BENEFITS	A					35
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70							70
71	EMPLOYEE BENEFITS	A					71
500	TOTAL RECLASSIFICATIONS				3,000	6,861,444	500
	CODE LETTER - A						
1	DRUGS	B	DRUGS CHARGED TO PATIENTS	73		10,954,062	1
2	DRUGS	B					2

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	DRUGS	B					3
4	DRUGS	B					4
5	DRUGS	B					5
6	DRUGS	B					6
7	DRUGS	B					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							21
22							22
23	DRUGS	B					23
500	TOTAL RECLASSIFICATIONS					10,954,062	500
	CODE LETTER - B						
1	SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		7,744,389	1
2	SUPPLIES	C					2
3	SUPPLIES	C					3
4	SUPPLIES	C					4
5	SUPPLIES	C					5
6	SUPPLIES	C					6
7	SUPPLIES	C					7
8	SUPPLIES	C					8
9	SUPPLIES	C					9
10	SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		1,026,058	10
11	SUPPLIES	C					11
12	SUPPLIES	C	NURSING SCHOOL	20		3	12
13	SUPPLIES	C					13
14	SUPPLIES	C					14
15	SUPPLIES	C					15
16	SUPPLIES	C					16
17	SUPPLIES	C					17
18	SUPPLIES	C					18
19	SUPPLIES	C					19
20	SUPPLIES	C					20
21	SUPPLIES	C					21
22	SUPPLIES	C					22
23	SUPPLIES	C					23
24	SUPPLIES	C					24
25	SUPPLIES	C					25
26	SUPPLIES	C					26
27	SUPPLIES	C					27
28	SUPPLIES	C					28
29	SUPPLIES	C					29
30	SUPPLIES	C					30
31	SUPPLIES	C					31
32	SUPPLIES	C					32
33	SUPPLIES	C					33
34	SUPPLIES	C					34
35	SUPPLIES	C					35
36	SUPPLIES	C					36
37	SUPPLIES	C					37
38	SUPPLIES	C					38
500	TOTAL RECLASSIFICATIONS					8,770,450	500
	CODE LETTER - C						
1	IMPLANTS	D	IMPL. DEV. CHARGED TO PATIENT	72		3,604,808	1
2	IMPLANTS	D					2
3	IMPLANTS	D					3
4	IMPLANTS	D					4
5	IMPLANTS	D					5
6	IMPLANTS	D					6
7	IMPLANTS	D					7
8	IMPLANTS	D					8
9	IMPLANTS	D					9
500	TOTAL RECLASSIFICATIONS					3,604,808	500
	CODE LETTER - D						

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	CAFETERIA	E	CAFETERIA	11	818,072	1,084,501	1
500	TOTAL RECLASSIFICATIONS				818,072	1,084,501	500
	CODE LETTER - E						
1	DEFAULT	F	I&R SERVICES-OTHER PRGM COSTS	22	1,013,165		1
500	TOTAL RECLASSIFICATIONS				1,013,165		500
	CODE LETTER - F						
1	CONVENT MAINT	G	CONVENT	194	20,612	55,378	1
500	TOTAL RECLASSIFICATIONS				20,612	55,378	500
	CODE LETTER - G						
1	BUILDING INSURANCE	I	CAP REL COSTS-BLDG & FIXT	1		157,223	1
500	TOTAL RECLASSIFICATIONS					157,223	500
	CODE LETTER - I						
1	SNF UTILIZATION REVIEW	J	UTILIZATION REVIEW-SNF	114		12,000	1
500	TOTAL RECLASSIFICATIONS					12,000	500
	CODE LETTER - J						
1	MORTGAGE INTEREST	K	CAP REL COSTS-BLDG & FIXT	1		2,794,975	1
500	TOTAL RECLASSIFICATIONS					2,794,975	500
	CODE LETTER - K						
1	DEPRECIATION	L	CAP REL COSTS-MVBLE EQUIP	2		14,880,507	1
2							2
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32							32
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34							34
500	TOTAL RECLASSIFICATIONS					14,880,507	500
	CODE LETTER - L						
1	PHONE	M	OPERATION OF PLANT	7		552,570	1
2	PHONE	M	EMPLOYEE BENEFITS DEPARTMENT	4		75	2
3	PHONE	M					3
4	PHONE	M					4
5	PHONE	M					5
6	PHONE	M					6
7	PHONE	M					7
8	PHONE	M					8
9	PHONE	M					9
10	PHONE	M					10
11	PHONE	M					11
500	TOTAL RECLASSIFICATIONS					552,645	500
	CODE LETTER - M						

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
	GRAND TOTAL (INCREASES)				1,854,849	49,727,993	

(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.

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	EMPLOYEE BENEFITS	A	ADMINISTRATIVE & GENERAL	5		534,680		1
2	EMPLOYEE BENEFITS	A	OPERATION OF PLANT	7		187,104		2
3	EMPLOYEE BENEFITS	A	HOUSEKEEPING	9		134,682		3
4	EMPLOYEE BENEFITS	A	DIETARY	10		142,248		4
5	EMPLOYEE BENEFITS	A	CAFETERIA	11		25,824		5
6	EMPLOYEE BENEFITS	A	NURSING ADMINISTRATION	13		317,321		6
7	EMPLOYEE BENEFITS	A	PHARMACY	15		257,238		7
8	EMPLOYEE BENEFITS	A	MEDICAL RECORDS & LIBRARY	16		135,775		8
9	EMPLOYEE BENEFITS	A	I&R SERVICES-SALARY & FRINGES	21		295,078		9
10	EMPLOYEE BENEFITS	A	ADULTS & PEDIATRICS	30		1,940,111		10
11	EMPLOYEE BENEFITS	A	INTENSIVE CARE UNIT	31		363,282		11
12	EMPLOYEE BENEFITS	A	SUBPROVIDER - IRF	41		67,875		12
13	EMPLOYEE BENEFITS	A	NURSERY	43		53,724		13
14	EMPLOYEE BENEFITS	A	SKILLED NURSING FACILITY	44		110,431		14
15	EMPLOYEE BENEFITS	A	OPERATING ROOM	50		337,848		15
16	EMPLOYEE BENEFITS	A	RECOVERY ROOM	51		55,551		16
17	EMPLOYEE BENEFITS	A	DELIVERY ROOM & LABOR ROOM	52		314,978		17
18	EMPLOYEE BENEFITS	A	ANESTHESIOLOGY	53		10,402		18
19	EMPLOYEE BENEFITS	A	RADIOLOGY-DIAGNOSTIC	54		375,681		19
20	EMPLOYEE BENEFITS	A	OUTPATIENT ONCOLOGY	54.01		23,029		20
21	EMPLOYEE BENEFITS	A	RADIOLOGY-THERAPEUTIC	55		12,510		21
22	EMPLOYEE BENEFITS	A	CARDIAC CATHETERIZATION	59		41,404		22
23	EMPLOYEE BENEFITS	A	RESPIRATORY THERAPY	65		117,433		23
24	EMPLOYEE BENEFITS	A	PHYSICAL THERAPY	66		134,892		24
25	EMPLOYEE BENEFITS	A	OCCUPATIONAL THERAPY	67		70,280		25
26	EMPLOYEE BENEFITS	A	SPEECH PATHOLOGY	68		17,468		26
27	EMPLOYEE BENEFITS	A	ELECTROCARDIOLOGY	69		69,151		27
28	EMPLOYEE BENEFITS	A	ELECTROENCEPHALOGRAPHY	70		14,224		28
29	EMPLOYEE BENEFITS	A	RENAL DIALYSIS	74		36,026		29
30	EMPLOYEE BENEFITS	A	ASC (NON-DISTINCT PART)	75		89,190		30
31	EMPLOYEE BENEFITS	A	CARDIAC REHABILITATION	76.97		12,020		31
32	EMPLOYEE BENEFITS	A	CLINIC	90		91,582		32
33	EMPLOYEE BENEFITS	A	EMERGENCY	91		472,243		33
34	EMPLOYEE BENEFITS	A	CONVENT	194		72		34
35	EMPLOYEE BENEFITS	A	EMPLOYEE BENEFITS DEPARTMENT	4		3,000		35
36								36
37								37
38								38
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68								68
69								69
70								70
71	EMPLOYEE BENEFITS	A	MENTAL HEALTH OUTPATIENT	76		87		71
500	TOTAL RECLASSIFICATIONS					6,864,444		500
	CODE LETTER - A							
1	DRUGS	B	PHARMACY	15		9,871,580		1

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	
2	DRUGS	B	ADULTS & PEDIATRICS	30		207,411		2
3	DRUGS	B	INTENSIVE CARE UNIT	31		57,029		3
4	DRUGS	B	SUBPROVIDER - IRF	41		1,857		4
5	DRUGS	B	NURSERY	43		5,497		5
6	DRUGS	B	SKILLED NURSING FACILITY	44		12,836		6
7	DRUGS	B	OPERATING ROOM	50		91,510		7
8	DRUGS	B	RECOVERY ROOM	51		7,750		8
9	DRUGS	B	DELIVERY ROOM & LABOR ROOM	52		35,516		9
10	DRUGS	B	ANESTHESIOLOGY	53		90,734		10
11	DRUGS	B	RADIOLOGY-DIAGNOSTIC	54		167,466		11
12	DRUGS	B	OUTPATIENT ONCOLOGY	54.01		19,255		12
13	DRUGS	B						13
14	DRUGS	B	CARDIAC CATHETERIZATION	59		15,201		14
15	DRUGS	B	RESPIRATORY THERAPY	65		700		15
16	DRUGS	B	ELECTROCARDIOLOGY	69		2,569		16
17	DRUGS	B	RENAL DIALYSIS	74		6,868		17
18	DRUGS	B	ASC (NON-DISTINCT PART)	75		48,778		18
19	DRUGS	B	CLINIC	90		22,994		19
20	DRUGS	B	CENTRAL SERVICES & SUPPLY	14		7,538		20
21			BLOOD STORING, PROCESSING & T	63		3,670		21
22			MENTAL HEALTH OUTPATIENT	76		16,225		22
23	DRUGS	B	EMERGENCY	91		261,078		23
500	TOTAL RECLASSIFICATIONS					10,954,062		500
	CODE LETTER - B							
1	SUPPLIES	C						1
2	SUPPLIES	C	EMPLOYEE BENEFITS DEPARTMENT	4		769		2
3	SUPPLIES	C	ADMINISTRATIVE & GENERAL	5		36,734		3
4	SUPPLIES	C	OPERATION OF PLANT	7		128		4
5	SUPPLIES	C	LAUNDRY & LINEN SERVICE	8		16		5
6	SUPPLIES	C	HOUSEKEEPING	9		67,039		6
7	SUPPLIES	C	DIETARY	10		1,870		7
8	SUPPLIES	C	CAFETERIA	11		133		8
9	SUPPLIES	C	NURSING ADMINISTRATION	13		1,260		9
10	SUPPLIES	C						10
11	SUPPLIES	C	PHARMACY	15		208,334		11
12	SUPPLIES	C						12
13	SUPPLIES	C	MEDICAL RECORDS & LIBRARY	16		38		13
14	SUPPLIES	C	I&R SERVICES-SALARY & FRINGES	21		41		14
15	SUPPLIES	C	ADULTS & PEDIATRICS	30		875,340		15
16	SUPPLIES	C	INTENSIVE CARE UNIT	31		355,330		16
17	SUPPLIES	C	SUBPROVIDER - IRF	41		14,813		17
18	SUPPLIES	C	NURSERY	43		62,212		18
19	SUPPLIES	C	SKILLED NURSING FACILITY	44		58,648		19
20	SUPPLIES	C	OPERATING ROOM	50		4,455,804		20
21	SUPPLIES	C	RECOVERY ROOM	51		22,645		21
22	SUPPLIES	C	DELIVERY ROOM & LABOR ROOM	52		451,965		22
23	SUPPLIES	C	ANESTHESIOLOGY	53		257,372		23
24	SUPPLIES	C	RADIOLOGY-DIAGNOSTIC	54		172,482		24
25	SUPPLIES	C	OUTPATIENT ONCOLOGY	54.01		34,634		25
26	SUPPLIES	C	RADIOLOGY-THERAPEUTIC	55		616		26
27	SUPPLIES	C	CARDIAC CATHETERIZATION	59		127,543		27
28	SUPPLIES	C	RESPIRATORY THERAPY	65		121,813		28
29	SUPPLIES	C	PHYSICAL THERAPY	66		30,793		29
30	SUPPLIES	C	OCCUPATIONAL THERAPY	67		1,505		30
31	SUPPLIES	C	ELECTROCARDIOLOGY	69		16,381		31
32	SUPPLIES	C	ELECTROENCEPHALOGRAPHY	70		2,603		32
33	SUPPLIES	C	RENAL DIALYSIS	74		88,072		33
34	SUPPLIES	C	ASC (NON-DISTINCT PART)	75		688,947		34
35	SUPPLIES	C	MENTAL HEALTH OUTPATIENT	76		5,662		35
36	SUPPLIES	C	CARDIAC REHABILITATION	76.97		781		36
37	SUPPLIES	C	CLINIC	90		16,799		37
38	SUPPLIES	C	EMERGENCY	91		591,328		38
500	TOTAL RECLASSIFICATIONS					8,770,450		500
	CODE LETTER - C							
1	IMPLANTS	D						1
2	IMPLANTS	D	OPERATING ROOM	50		3,011,127		2
3	IMPLANTS	D	ANESTHESIOLOGY	53		2,993		3
4	IMPLANTS	D	RADIOLOGY-DIAGNOSTIC	54		3,097		4
5	IMPLANTS	D	CARDIAC CATHETERIZATION	59		567,034		5
6	IMPLANTS	D						6
7	IMPLANTS	D	ASC (NON-DISTINCT PART)	75		13,617		7
8	IMPLANTS	D	CLINIC	90		6,753		8
9	IMPLANTS	D	INTENSIVE CARE UNIT	31		187		9

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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	
500	TOTAL RECLASSIFICATIONS					3,604,808		500
	CODE LETTER - D							
1	CAFETERIA	E	DIETARY	10	818,072	1,084,501		1
500	TOTAL RECLASSIFICATIONS				818,072	1,084,501		500
	CODE LETTER - E							
1	DEFAULT	F	I&R SERVICES-SALARY & FRINGES	21	1,013,165			1
500	TOTAL RECLASSIFICATIONS				1,013,165			500
	CODE LETTER - F							
1	CONVENT MAINT	G	OPERATION OF PLANT	7	20,612	55,378		1
500	TOTAL RECLASSIFICATIONS				20,612	55,378		500
	CODE LETTER - G							
1	BUILDING INSURANCE	I	ADMINISTRATIVE & GENERAL	5		157,223	12	1
500	TOTAL RECLASSIFICATIONS					157,223		500
	CODE LETTER - I							
1	SNF UTILIZATION REVIEW	J	SKILLED NURSING FACILITY	44		12,000		1
500	TOTAL RECLASSIFICATIONS					12,000		500
	CODE LETTER - J							
1	MORTGAGE INTEREST	K	INTEREST EXPENSE	113		2,794,975	11	1
500	TOTAL RECLASSIFICATIONS					2,794,975		500
	CODE LETTER - K							
1	DEPRECIATION	L	CAP REL COSTS-MVBLE EQUIP	2		11,190,544	9	1
2			ADMINISTRATIVE & GENERAL	5		757,285		2
3			OPERATION OF PLANT	7		549,887		3
4			LAUNDRY & LINEN SERVICE	8		751		4
5			HOUSEKEEPING	9		6,013		5
6			DIETARY	10		10,472		6
7			CAFETERIA	11		1,398		7
8			NURSING ADMINISTRATION	13		7,065		8
9			CENTRAL SERVICES & SUPPLY	14		106,880		9
10			PHARMACY	15		32,304		10
11			MEDICAL RECORDS & LIBRARY	16		9,331		11
12			I&R SERVICES-SALARY & FRINGES	21		555		12
13			ADULTS & PEDIATRICS	30		80,617		13
14			INTENSIVE CARE UNIT	31		85,744		14
15			SUBPROVIDER - IRF	41		779		15
16			NURSERY	43		7,274		16
17			OPERATING ROOM	50		316,007		17
18			RECOVERY ROOM	51		5,796		18
19			DELIVERY ROOM & LABOR ROOM	52		19,211		19
20			ANESTHESIOLOGY	53		91,975		20
21			RADIOLOGY-DIAGNOSTIC	54		882,607		21
22			RADIOLOGY-THERAPEUTIC	55		91,392		22
23			CARDIAC CATHETERIZATION	59		190,507		23
24			BLOOD STORING, PROCESSING & T	63		205		24
25			RESPIRATORY THERAPY	65		37,337		25
26			PHYSICAL THERAPY	66		2,564		26
27			ELECTROCARDIOLOGY	69		138,430		27
28			ELECTROENCEPHALOGRAPHY	70		1,522		28
29			RENAL DIALYSIS	74		13,579		29
30			ASC (NON-DISTINCT PART)	75		95,442		30
31			CARDIAC REHABILITATION	76.97		647		31
32			CLINIC	90		1,595		32
33			EMERGENCY	91		144,620		33
34			CONVENT	194		172		34
500	TOTAL RECLASSIFICATIONS					14,880,507		500
	CODE LETTER - L							
1	PHONE	M						1
2	PHONE	M						2
3	PHONE	M	ADMINISTRATIVE & GENERAL	5		544,180		3
4	PHONE	M	OPERATION OF PLANT	7		837		4
5	PHONE	M	HOUSEKEEPING	9		483		5
6	PHONE	M	DIETARY	10		800		6
7	PHONE	M	NURSING ADMINISTRATION	13		846		7
8	PHONE	M	MEDICAL RECORDS & LIBRARY	16		593		8
9	PHONE	M	NURSING SCHOOL	20		579		9
10	PHONE	M	ADULTS & PEDIATRICS	30		1,402		10
11	PHONE	M	CLINIC	90		2,925		11

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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	
500	TOTAL RECLASSIFICATIONS					552,645		500
	CODE LETTER - M							
	GRAND TOTAL (DECREASES)				1,851,849	49,730,993		

(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	4,491,770	411,122		411,122		4,902,892		1
2	LAND IMPROVEMENTS	758,289	2,611,432		2,611,432		3,369,721		2
3	BUILDINGS AND FIXTURES	107,493,465	15,692,296		15,692,296		123,185,761		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	58,343,378	3,033,247		3,033,247		61,376,625		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	171,086,902	21,748,097		21,748,097		192,834,999		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	171,086,902	21,748,097		21,748,097		192,834,999		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	1,736,880						1,736,880	1
2	CAP REL COSTS-MVBLE EQUIP	4,691,917	4,761,747					9,453,664	2
3	TOTAL (sum of lines 1-2)	6,428,797	4,761,747					11,190,544	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	131,458,374		131,458,374	0.681714					1
2	CAP REL COSTS-MVBLE EQU	61,376,625		61,376,625	0.318286					2
3	TOTAL (sum of lines 1-2)	192,834,999		192,834,999	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	1,826,917		2,794,975	157,223			4,779,115	1
2	CAP REL COSTS-MVBLE EQUIP	9,016,740	4,761,747	-5,041,614				8,736,873	2
3	TOTAL (sum of lines 1-2)	10,843,657	4,761,747	-2,246,639	157,223			13,515,988	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)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)	B	-5,041,614	CAP REL COSTS-MVBLE EQUIP	2	11	2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-6,225,807				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-3,337,765				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,013,743	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						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)	A	-12,000	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	NON-OPERATING REV	B	-890	EMPLOYEE BENEFITS DEPARTMENT	4		33
34	OTHER OPERATING REV	B	-786	DIETARY	10		34
35	OTHER OPERATING REV	B	-568,387	ADMINISTRATIVE & GENERAL	5		35
36	OTHER OPERATING REV	B	-12,438	CARDIAC REHABILITATION	76.97		36
37	OTHER OPERATING REV	B	-28	CLINIC	90		37
38	OTHER OPERATING REV	B	-21,984	MEDICAL RECORDS & LIBRARY	16		38
39	OTHER OPERATING REV	B	-11,954	DRUGS CHARGED TO PATIENTS	73		39
40	OTHER OPERATING REV	B	-77,293	DRUGS CHARGED TO PATIENTS	73		40
41	OTHER OPERATING REV	B	-3,224	RADIOLOGY-DIAGNOSTIC	54		41
42	OTHER OPERATING REV	B	-2,000	ELECTROCARDIOLOGY	69		42
43	OTHER OPERATING REV	B	-49,532	LABORATORY	60		43
44	OTHER OPERATING REV	B	-605	ADMINISTRATIVE & GENERAL	5		44
45	OTHER OPERATING REV	B	-90,000	MENTAL HEALTH OUTPATIENT	76		45
46	OTHER OPERATING REV	B	-3,834	CARDIAC REHABILITATION	76.97		46
47	OTHER OPERATING REV	B	-223,173	CLINIC	90		47
48	OTHER OPERATING REV	B	-29,128	ADMINISTRATIVE & GENERAL	5		48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-16,726,185				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	4	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	862,686		862,686		1
2	5	ADMINISTRATIVE & GENERAL	HOME OFFICE	28,213,806	34,361,830	-6,148,024		2
3	14	CENTRAL SERVICES & SUPPLY	HOME OFFICE	1,104,689		1,104,689		3
3.01	31	INTENSIVE CARE UNIT	HOME OFFICE	117,987		117,987		3.01
3.02	2	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	634,860		634,860	9	3.02
3.03	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	90,037		90,037	9	3.03
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			31,024,065	34,361,830	-3,337,765		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		100.00	RESURRECTION HEALTHCARE	100.00	SOLE CORPORATE MEMBER	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	81,005	74,755	6,250	177,200	50	4,260	213	1
2	13	NURSING ADMINISTRATI NURSING ADMINIS	106,016		106,016	177,200	1,048	89,282	4,464	2
3	21	I&R SERVICES-SALARY I&R SRVCES-SALA	3,786,950	3,099,284	687,666	177,200	8,689	740,236	37,012	3
5	31	INTENSIVE CARE UNIT INTENSIVE CARE	287,182	287,182						5
6	41	SUBPROVIDER - IRF SUBPROVIDER - I	2,500	2,500						6
7	43	NURSERY NURSERY	64,000	64,000						7
8	44	SKILLED NURSING FACI SKILLED NURSING	6,000	6,000						8
9	50	OPERATING ROOM OPERATING ROOM	50,000	50,000						9
10	52	DELIVERY ROOM & LABO DELIVERY ROOM &	555,699	555,699						10
11	53	ANESTHESIOLOGY ANESTHESIOLOGY	423,000	423,000						11
12	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN	1,440	1,440						12
14	60	LABORATORY LABORATORY	25,000	25,000						14
15	65	RESPIRATORY THERAPY RESPIRATORY THE	5,625	5,625						15
16	69	ELECTROCARDIOLOGY ELECTROCARDIOLO	67,150	67,150						16
17	70	ELECTROENCEPHALOGRAP ELECTROENCEPHAL	225,520	225,520						17
18	76.97	CARDIAC REHABILITATI CARDIAC REHABIL	10,125	10,125						18
19	90	CLINIC CLINIC	293,924	293,924						19
20	91	EMERGENCY EMERGENCY	825,765	825,765						20
21	4	EMPLOYEE BENEFITS DE EMPLOYEE BENEFI	190,114	190,114						21
200		TOTAL	7,007,015	6,207,083	799,932		9,787	833,778	41,689	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 EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	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					4,260	1,990	76,745	1
2	13	NURSING ADMINISTRATI NURSING ADMINIS					89,282	16,734	16,734	2
3	21	I&R SERVICES-SALARY I&R SRVCES-SALA					740,236		3,099,284	3
5	31	INTENSIVE CARE UNIT INTENSIVE CARE							287,182	5
6	41	SUBPROVIDER - IRF SUBPROVIDER - I							2,500	6
7	43	NURSERY NURSERY							64,000	7
8	44	SKILLED NURSING FACI SKILLED NURSING							6,000	8
9	50	OPERATING ROOM OPERATING ROOM							50,000	9
10	52	DELIVERY ROOM & LABO DELIVERY ROOM &							555,699	10
11	53	ANESTHESIOLOGY ANESTHESIOLOGY							423,000	11
12	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN							1,440	12
14	60	LABORATORY LABORATORY							25,000	14
15	65	RESPIRATORY THERAPY RESPIRATORY THE							5,625	15
16	69	ELECTROCARDIOLOGY ELECTROCARDIOLO							67,150	16
17	70	ELECTROENCEPHALOGRAP ELECTROENCEPHAL							225,520	17
18	76.97	CARDIAC REHABILITATI CARDIAC REHABIL							10,125	18
19	90	CLINIC CLINIC							293,924	19
20	91	EMERGENCY EMERGENCY							825,765	20
21	4	EMPLOYEE BENEFITS DE EMPLOYEE BENEFI							190,114	21
200		TOTAL					833,778	18,724	6,225,807	200

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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

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.		
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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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.		
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

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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.		
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

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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.		
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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	4,779,115	4,779,115					1
2	CAP REL COSTS-MVBLE EQUIP	8,736,873		8,736,873				2
4	EMPLOYEE BENEFITS DEPARTMENT	21,730,425	50,228	91,823	21,872,476			4
5	ADMINISTRATIVE & GENERAL	49,293,022	337,757	617,466	1,592,093	51,840,338	51,840,338	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	10,667,819	1,117,335	2,042,640	590,558	14,418,352	4,036,576	7
8	LAUNDRY & LINEN SERVICE	1,422,430	24,332	44,482		1,491,244	417,490	8
9	HOUSEKEEPING	3,013,116	73,210	133,838	442,371	3,662,535	1,025,367	9
10	DIETARY	2,049,373	145,297	265,622	261,475	2,721,767	761,989	10
11	CAFETERIA	1,252,578	21,731	39,728	272,148	1,586,185	444,070	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	5,280,616	13,669	24,989	1,013,220	6,332,494	1,772,851	13
14	CENTRAL SERVICES & SUPPLY	669,305	114,095	208,582		991,982	277,716	14
15	PHARMACY	4,735,659	37,526	68,603	823,804	5,665,592	1,586,145	15
16	MEDICAL RECORDS & LIBRARY	2,609,921	70,494	128,872	438,203	3,247,490	909,171	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL	-702				-702		20
21	I&R SERVICES-SALARY & FRINGES APPRVD	3,229,680	16,536	30,230	890,825	4,167,271	1,166,673	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,013,165	17,162	31,374	233,563	1,295,264	362,623	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	34,205,384	1,229,546	2,247,780	6,144,693	43,827,403	12,270,001	30
31	INTENSIVE CARE UNIT	5,225,456	59,124	108,087	1,205,029	6,597,696	1,847,098	31
41	SUBPROVIDER - IRF	967,340	47,963	87,683	214,716	1,317,702	368,905	41
43	NURSERY	1,050,785	10,738	19,631	169,420	1,250,574	350,112	43
44	SKILLED NURSING FACILITY	1,446,453	62,814	114,832	322,968	1,947,067	545,103	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	8,071,354	302,843	553,639	1,057,109	9,984,945	2,795,395	50
51	RECOVERY ROOM	767,476	21,181	38,722	174,747	1,002,126	280,556	51
52	DELIVERY ROOM & LABOR ROOM	3,988,904	141,607	258,877	1,032,911	5,422,299	1,518,032	52
53	ANESTHESIOLOGY	489,512	2,977	5,442	32,982	530,913	148,635	53
54	RADIOLOGY-DIAGNOSTIC	5,983,539	140,449	256,759	1,187,604	7,568,351	2,118,843	54
54.01	OUTPATIENT ONCOLOGY	399,489			73,699	473,188	132,474	54.01
55	RADIOLOGY-THERAPEUTIC	278,216	7,472	13,659	38,698	338,045	94,639	55
59	CARDIAC CATHETERIZATION	609,079	32,504	59,422	131,439	832,444	233,052	59
60	LABORATORY	8,958,472	109,091	199,434		9,266,997	2,594,398	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	16,234	9,064	16,571		41,869	11,722	63
65	RESPIRATORY THERAPY	1,759,566	6,545	11,965	372,527	2,150,603	602,085	65
66	PHYSICAL THERAPY	1,901,440	44,650	81,626	425,725	2,453,441	686,868	66
67	OCCUPATIONAL THERAPY	983,520	6,528	11,933	218,392	1,220,373	341,657	67
68	SPEECH PATHOLOGY	232,070	2,323	4,246	53,011	291,650	81,651	68
69	ELECTROCARDIOLOGY	1,101,463	48,820	89,250	218,254	1,457,787	408,124	69
70	ELECTROENCEPHALOGRAPHY	867,984			47,728	915,712	256,364	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,744,389				7,744,389	2,168,127	71
72	IMPL. DEV. CHARGED TO PATIENTS	3,604,808				3,604,808	1,009,206	72
73	DRUGS CHARGED TO PATIENTS	10,864,815				10,864,815	3,041,724	73
74	RENAL DIALYSIS	557,576	5,213	9,530	109,717	682,036	190,943	74
75	ASC (NON-DISTINCT PART)	1,345,172			275,521	1,620,693	453,731	75
76	MENTAL HEALTH OUTPATIENT	2,532,344	69,909	127,803	268	2,730,324	764,384	76
76.97	CARDIAC REHABILITATION	161,339	20,446	37,377	38,121	257,283	72,029	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,902,579	182,655	333,918	290,354	2,709,506	758,556	90
91	EMERGENCY	8,390,941	170,526	311,745	1,473,532	10,346,744	2,896,685	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)	236,890,094	4,774,360	8,728,180	21,867,425	236,871,595	51,801,770	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS	33,943				33,943	9,503	193
194	CONVENT	79,494			5,051	84,545	23,669	194
194.01	OUTPATIENT PHARMACY	329	3,168	5,792		9,289	2,601	194.01
194.02	FUND DEVELOPMENT	5,494	1,587	2,901		9,982	2,795	194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201

KPMG LLP COMPU-MAX

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
202	TOTAL (sum of lines 118-201)	237,009,354	4,779,115	8,736,873	21,872,476	237,009,354	51,840,338	202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	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	18,454,928						7
8	LAUNDRY & LINEN SERVICE	137,163	2,045,897					8
9	HOUSEKEEPING	412,698	114,178	5,214,778				9
10	DIETARY	819,061		238,548	4,541,365			10
11	CAFETERIA	122,503		35,679		2,188,437		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	77,054		22,442		118,486	8,323,327	13
14	CENTRAL SERVICES & SUPPLY	643,175	136	187,322				14
15	PHARMACY	211,540		61,610		96,336		15
16	MEDICAL RECORDS & LIBRARY	397,385		115,737		51,244	24,562	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	93,216		27,149		104,173		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	96,742		28,176		27,313		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,931,163	668,037	2,018,672	3,809,050	718,600	5,296,610	30
31	INTENSIVE CARE UNIT	333,292	149,538	97,070	238,029	140,916	399,136	31
41	SUBPROVIDER - IRF	270,376	203,931	78,746	134,120	25,109		41
43	NURSERY	60,533	52,818	17,630	158,633	19,812		43
44	SKILLED NURSING FACILITY	354,091	64,589	103,127	201,533	37,768	200,144	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,707,177	172,830	497,208		123,619	798,272	50
51	RECOVERY ROOM	119,402	35,957	34,775		20,435	400,671	51
52	DELIVERY ROOM & LABOR ROOM	798,263	58,009	232,491		120,789		52
53	ANESTHESIOLOGY	16,782		4,888		3,857		53
54	RADIOLOGY-DIAGNOSTIC	791,733	93,305	230,589		138,879		54
54.01	OUTPATIENT ONCOLOGY					8,618		54.01
55	RADIOLOGY-THERAPEUTIC	42,119	2,515	12,267		4,525		55
59	CARDIAC CATHETERIZATION	183,233	6,784	53,366		15,370		59
60	LABORATORY	614,965		179,106				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	51,097		14,882				63
65	RESPIRATORY THERAPY	36,895		10,745		43,563		65
66	PHYSICAL THERAPY	251,700	40,958	73,307		49,784		66
67	OCCUPATIONAL THERAPY	36,797		10,717		25,539		67
68	SPEECH PATHOLOGY	13,093		3,813		6,199		68
69	ELECTROCARDIOLOGY	275,208	11,540	80,153		25,523		69
70	ELECTROENCEPHALOGRAPHY		667			5,581		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	29,385	7,614	8,558		12,830		74
75	ASC (NON-DISTINCT PART)					32,220	379,179	75
76	MENTAL HEALTH OUTPATIENT	394,087		114,776		31		76
76.97	CARDIAC REHABILITATION	115,255	272	33,568		4,458		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,029,654	7,472	299,883		33,954	406,812	90
91	EMERGENCY	961,285	351,567	279,970		172,315	417,941	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)	18,428,122	2,042,717	5,206,970	4,541,365	2,187,846	8,323,327	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		3,180					192
193	NONPAID WORKERS							193
194	CONVENT					591		194
194.01	OUTPATIENT PHARMACY	17,860		5,202				194.01
194.02	FUND DEVELOPMENT	8,946		2,606				194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	18,454,928	2,045,897	5,214,778	4,541,365	2,188,437	8,323,327	202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		14	15	16	20	21	22	
	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
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	2,100,331						14
15	PHARMACY		7,621,223					15
16	MEDICAL RECORDS & LIBRARY			4,745,589				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL				-702			20
21	I&R SERVICES-SALARY & FRINGES APPRVD					5,558,482		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						1,810,118	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	620,154	2,249,704	3,980,342		5,027,040	1,637,054	30
31	INTENSIVE CARE UNIT	69,491	252,181	248,733		395,173	128,688	31
41	SUBPROVIDER - IRF	19,940	72,361	140,151				41
43	NURSERY	19,635	71,255	165,767		136,269	44,376	43
44	SKILLED NURSING FACILITY	14,458	52,467	210,596				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	114,229	414,532					50
51	RECOVERY ROOM	21,889	79,434					51
52	DELIVERY ROOM & LABOR ROOM	73,615	267,145					52
53	ANESTHESIOLOGY	27,074	98,250					53
54	RADIOLOGY-DIAGNOSTIC	97,443	353,619					54
54.01	OUTPATIENT ONCOLOGY							54.01
55	RADIOLOGY-THERAPEUTIC	1,048	3,804					55
59	CARDIAC CATHETERIZATION	31,677	114,956					59
60	LABORATORY	212,174	769,975					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	17,648	64,045					63
65	RESPIRATORY THERAPY	113,810	413,014					65
66	PHYSICAL THERAPY	18,497	67,124					66
67	OCCUPATIONAL THERAPY	14,077	51,084					67
68	SPEECH PATHOLOGY	3,051	11,073					68
69	ELECTROCARDIOLOGY	46,544	168,906					69
70	ELECTROENCEPHALOGRAPHY	685	2,487					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,720	187,691					71
72	IMPL. DEV. CHARGED TO PATIENTS	37,463	135,951					72
73	DRUGS CHARGED TO PATIENTS	333,928	1,211,813					73
74	RENAL DIALYSIS	12,271	44,533					74
75	ASC (NON-DISTINCT PART)	14,066	51,044					75
76	MENTAL HEALTH OUTPATIENT	13	47					76
76.97	CARDIAC REHABILITATION	181	657					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	101	368					90
91	EMERGENCY	113,449	411,703					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)	2,100,331	7,621,223	4,745,589		5,558,482	1,810,118	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	CONVENT							194
194.01	OUTPATIENT PHARMACY							194.01
194.02	FUND DEVELOPMENT							194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER				-702			201
202	TOTAL (sum of lines 118-201)	2,100,331	7,621,223	4,745,589	-702	5,558,482	1,810,118	202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		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
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	89,053,830	-6,664,094	82,389,736				30
31	INTENSIVE CARE UNIT	10,897,041	-523,861	10,373,180				31
41	SUBPROVIDER - IRF	2,631,341		2,631,341				41
43	NURSERY	2,347,414	-180,645	2,166,769				43
44	SKILLED NURSING FACILITY	3,730,943		3,730,943				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	16,608,207		16,608,207				50
51	RECOVERY ROOM	1,995,245		1,995,245				51
52	DELIVERY ROOM & LABOR ROOM	8,490,643		8,490,643				52
53	ANESTHESIOLOGY	830,399		830,399				53
54	RADIOLOGY-DIAGNOSTIC	11,392,762		11,392,762				54
54.01	OUTPATIENT ONCOLOGY	614,280		614,280				54.01
55	RADIOLOGY-THERAPEUTIC	498,962		498,962				55
59	CARDIAC CATHETERIZATION	1,470,882		1,470,882				59
60	LABORATORY	13,637,615		13,637,615				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	201,263		201,263				63
65	RESPIRATORY THERAPY	3,370,715		3,370,715				65
66	PHYSICAL THERAPY	3,641,679		3,641,679				66
67	OCCUPATIONAL THERAPY	1,700,244		1,700,244				67
68	SPEECH PATHOLOGY	410,530		410,530				68
69	ELECTROCARDIOLOGY	2,473,785		2,473,785				69
70	ELECTROENCEPHALOGRAPHY	1,181,496		1,181,496				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,151,927		10,151,927				71
72	IMPL. DEV. CHARGED TO PATIENTS	4,787,428		4,787,428				72
73	DRUGS CHARGED TO PATIENTS	15,452,280		15,452,280				73
74	RENAL DIALYSIS	988,170		988,170				74
75	ASC (NON-DISTINCT PART)	2,550,933		2,550,933				75
76	MENTAL HEALTH OUTPATIENT	4,003,662		4,003,662				76
76.97	CARDIAC REHABILITATION	483,703		483,703				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	5,246,306		5,246,306				90
91	EMERGENCY	15,951,659		15,951,659				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)	236,795,344	-7,368,600	229,426,744				118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	3,180		3,180				192
193	NONPAID WORKERS	43,446		43,446				193
194	CONVENT	108,805		108,805				194
194.01	OUTPATIENT PHARMACY	34,952		34,952				194.01
194.02	FUND DEVELOPMENT	24,329		24,329				194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER	-702		-702				201
202	TOTAL (sum of lines 118-201)	237,009,354	-7,368,600	229,640,754				202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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		50,228	91,823	142,051	142,051		4
5	ADMINISTRATIVE & GENERAL		337,757	617,466	955,223	10,339	965,562	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		1,117,335	2,042,640	3,159,975	3,835	75,177	7
8	LAUNDRY & LINEN SERVICE		24,332	44,482	68,814		7,775	8
9	HOUSEKEEPING		73,210	133,838	207,048	2,873	19,096	9
10	DIETARY		145,297	265,622	410,919	1,698	14,191	10
11	CAFETERIA		21,731	39,728	61,459	1,767	8,270	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		13,669	24,989	38,658	6,580	33,018	13
14	CENTRAL SERVICES & SUPPLY		114,095	208,582	322,677		5,172	14
15	PHARMACY		37,526	68,603	106,129	5,350	29,540	15
16	MEDICAL RECORDS & LIBRARY		70,494	128,872	199,366	2,846	16,932	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		16,536	30,230	46,766	5,785	21,728	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		17,162	31,374	48,536	1,517	6,754	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		1,229,546	2,247,780	3,477,326	39,916	228,609	30
31	INTENSIVE CARE UNIT		59,124	108,087	167,211	7,825	34,400	31
41	SUBPROVIDER - IRF		47,963	87,683	135,646	1,394	6,870	41
43	NURSERY		10,738	19,631	30,369	1,100	6,520	43
44	SKILLED NURSING FACILITY		62,814	114,832	177,646	2,097	10,152	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		302,843	553,639	856,482	6,865	52,062	50
51	RECOVERY ROOM		21,181	38,722	59,903	1,135	5,225	51
52	DELIVERY ROOM & LABOR ROOM		141,607	258,877	400,484	6,708	28,272	52
53	ANESTHESIOLOGY		2,977	5,442	8,419	214	2,768	53
54	RADIOLOGY-DIAGNOSTIC		140,449	256,759	397,208	7,712	39,461	54
54.01	OUTPATIENT ONCOLOGY					479	2,467	54.01
55	RADIOLOGY-THERAPEUTIC		7,472	13,659	21,131	251	1,763	55
59	CARDIAC CATHETERIZATION		32,504	59,422	91,926	854	4,340	59
60	LABORATORY		109,091	199,434	308,525		48,318	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		9,064	16,571	25,635		218	63
65	RESPIRATORY THERAPY		6,545	11,965	18,510	2,419	11,213	65
66	PHYSICAL THERAPY		44,650	81,626	126,276	2,765	12,792	66
67	OCCUPATIONAL THERAPY		6,528	11,933	18,461	1,418	6,363	67
68	SPEECH PATHOLOGY		2,323	4,246	6,569	344	1,521	68
69	ELECTROCARDIOLOGY		48,820	89,250	138,070	1,417	7,601	69
70	ELECTROENCEPHALOGRAPHY					310	4,775	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						40,379	71
72	IMPL. DEV. CHARGED TO PATIENTS						18,795	72
73	DRUGS CHARGED TO PATIENTS						56,649	73
74	RENAL DIALYSIS		5,213	9,530	14,743	712	3,556	74
75	ASC (NON-DISTINCT PART)					1,789	8,450	75
76	MENTAL HEALTH OUTPATIENT		69,909	127,803	197,712	2	14,236	76
76.97	CARDIAC REHABILITATION		20,446	37,377	57,823	248	1,341	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		182,655	333,918	516,573	1,885	14,127	90
91	EMERGENCY		170,526	311,745	482,271	9,569	53,948	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)		4,774,360	8,728,180	13,502,540	142,018	964,844	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS						177	193
194	CONVENT					33	441	194
194.01	OUTPATIENT PHARMACY		3,168	5,792	8,960		48	194.01
194.02	FUND DEVELOPMENT		1,587	2,901	4,488		52	194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		4,779,115	8,736,873	13,515,988	142,051	965,562	202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	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	3,238,987						7
8	LAUNDRY & LINEN SERVICE	24,073	100,662					8
9	HOUSEKEEPING	72,432	5,618	307,067				9
10	DIETARY	143,752		14,047	584,607			10
11	CAFETERIA	21,500		2,101		95,097		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	13,524		1,321		5,147	98,248	13
14	CENTRAL SERVICES & SUPPLY	112,882	7	11,030				14
15	PHARMACY	37,127		3,628		4,185		15
16	MEDICAL RECORDS & LIBRARY	69,744		6,815		2,226	290	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	16,360		1,599		4,525		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	16,979		1,659		1,186		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,216,478	32,866	118,867	490,337	31,247	62,522	30
31	INTENSIVE CARE UNIT	58,495	7,358	5,716	30,641	6,121	4,711	31
41	SUBPROVIDER - IRF	47,453	10,034	4,637	17,265	1,091		41
43	NURSERY	10,624	2,599	1,038	20,421	861		43
44	SKILLED NURSING FACILITY	62,146	3,178	6,073	25,943	1,641	2,362	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	299,623	8,504	29,278		5,370	9,423	50
51	RECOVERY ROOM	20,956	1,769	2,048		888	4,729	51
52	DELIVERY ROOM & LABOR ROOM	140,101	2,854	13,690		5,247		52
53	ANESTHESIOLOGY	2,945		288		168		53
54	RADIOLOGY-DIAGNOSTIC	138,955	4,591	13,578		6,033		54
54.01	OUTPATIENT ONCOLOGY					374		54.01
55	RADIOLOGY-THERAPEUTIC	7,392	124	722		197		55
59	CARDIAC CATHETERIZATION	32,159	334	3,142		668		59
60	LABORATORY	107,931		10,546				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	8,968		876				63
65	RESPIRATORY THERAPY	6,475		633		1,892		65
66	PHYSICAL THERAPY	44,175	2,015	4,317		2,163		66
67	OCCUPATIONAL THERAPY	6,458		631		1,109		67
68	SPEECH PATHOLOGY	2,298		225		269		68
69	ELECTROCARDIOLOGY	48,301	568	4,720		1,109		69
70	ELECTROENCEPHALOGRAPHY		33			242		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	5,157	375	504		557		74
75	ASC (NON-DISTINCT PART)					1,400	4,476	75
76	MENTAL HEALTH OUTPATIENT	69,165		6,758		1		76
76.97	CARDIAC REHABILITATION	20,228	13	1,977		194		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	180,713	368	17,658		1,475	4,802	90
91	EMERGENCY	168,713	17,298	16,486		7,485	4,933	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)	3,234,282	100,506	306,608	584,607	95,071	98,248	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		156					192
193	NONPAID WORKERS							193
194	CONVENT					26		194
194.01	OUTPATIENT PHARMACY	3,135		306				194.01
194.02	FUND DEVELOPMENT	1,570		153				194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,238,987	100,662	307,067	584,607	95,097	98,248	202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	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
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	451,768						14
15	PHARMACY		185,959					15
16	MEDICAL RECORDS & LIBRARY			298,219				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				96,763			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					76,631		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	133,445	54,775	250,130			6,136,518	30
31	INTENSIVE CARE UNIT	14,945	6,159	15,631			359,213	31
41	SUBPROVIDER - IRF	4,288	1,767	8,807			239,252	41
43	NURSERY	4,223	1,740	10,417			89,912	43
44	SKILLED NURSING FACILITY	3,109	1,281	13,234			308,862	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	24,566	10,124				1,302,297	50
51	RECOVERY ROOM	4,707	1,940				103,300	51
52	DELIVERY ROOM & LABOR ROOM	15,831	6,524				619,711	52
53	ANESTHESIOLOGY	5,822	2,399				23,023	53
54	RADIOLOGY-DIAGNOSTIC	20,956	8,636				637,130	54
54.01	OUTPATIENT ONCOLOGY						3,320	54.01
55	RADIOLOGY-THERAPEUTIC	225	93				31,898	55
59	CARDIAC CATHETERIZATION	6,812	2,807				143,042	59
60	LABORATORY	45,630	18,805				539,755	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	3,795	1,564				41,056	63
65	RESPIRATORY THERAPY	24,476	10,087				75,705	65
66	PHYSICAL THERAPY	3,978	1,639				200,120	66
67	OCCUPATIONAL THERAPY	3,027	1,248				38,715	67
68	SPEECH PATHOLOGY	656	270				12,152	68
69	ELECTROCARDIOLOGY	10,010	4,125				215,921	69
70	ELECTROENCEPHALOGRAPHY	147	61				5,568	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,123	4,584				56,086	71
72	IMPL. DEV. CHARGED TO PATIENTS	8,057	3,320				30,172	72
73	DRUGS CHARGED TO PATIENTS	71,814	29,595				158,058	73
74	RENAL DIALYSIS	2,639	1,088				29,331	74
75	ASC (NON-DISTINCT PART)	3,025	1,247				20,387	75
76	MENTAL HEALTH OUTPATIENT	3	1				287,878	76
76.97	CARDIAC REHABILITATION	39	16				81,879	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	22	9				737,632	90
91	EMERGENCY	24,398	10,055				795,156	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)	451,768	185,959	298,219			13,323,049	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES						156	192
193	NONPAID WORKERS						177	193
194	CONVENT						500	194
194.01	OUTPATIENT PHARMACY						12,449	194.01
194.02	FUND DEVELOPMENT						6,263	194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS				96,763	76,631	173,394	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	451,768	185,959	298,219	96,763	76,631	13,515,988	202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		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
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		6,136,518					30
31	INTENSIVE CARE UNIT		359,213					31
41	SUBPROVIDER - IRF		239,252					41
43	NURSERY		89,912					43
44	SKILLED NURSING FACILITY		308,862					44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		1,302,297					50
51	RECOVERY ROOM		103,300					51
52	DELIVERY ROOM & LABOR ROOM		619,711					52
53	ANESTHESIOLOGY		23,023					53
54	RADIOLOGY-DIAGNOSTIC		637,130					54
54.01	OUTPATIENT ONCOLOGY		3,320					54.01
55	RADIOLOGY-THERAPEUTIC		31,898					55
59	CARDIAC CATHETERIZATION		143,042					59
60	LABORATORY		539,755					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		41,056					63
65	RESPIRATORY THERAPY		75,705					65
66	PHYSICAL THERAPY		200,120					66
67	OCCUPATIONAL THERAPY		38,715					67
68	SPEECH PATHOLOGY		12,152					68
69	ELECTROCARDIOLOGY		215,921					69
70	ELECTROENCEPHALOGRAPHY		5,568					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		56,086					71
72	IMPL. DEV. CHARGED TO PATIENTS		30,172					72
73	DRUGS CHARGED TO PATIENTS		158,058					73
74	RENAL DIALYSIS		29,331					74
75	ASC (NON-DISTINCT PART)		20,387					75
76	MENTAL HEALTH OUTPATIENT		287,878					76
76.97	CARDIAC REHABILITATION		81,879					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		737,632					90
91	EMERGENCY		795,156					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)		13,323,049					118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		156					192
193	NONPAID WORKERS		177					193
194	CONVENT		500					194
194.01	OUTPATIENT PHARMACY		12,449					194.01
194.02	FUND DEVELOPMENT		6,263					194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS		173,394					200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		13,515,988					202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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 GROSS SALARIES	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	825,132						1
2	CAP REL COSTS-MVBLE EQUIP		825,132					2
4	EMPLOYEE BENEFITS DEPARTMENT	8,672	8,672	94,880,091				4
5	ADMINISTRATIVE & GENERAL	58,315	58,315	6,906,290	-51,840,338	185,169,718		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	192,912	192,912	2,561,763		14,418,352	565,233	7
8	LAUNDRY & LINEN SERVICE	4,201	4,201			1,491,244	4,201	8
9	HOUSEKEEPING	12,640	12,640	1,918,949		3,662,535	12,640	9
10	DIETARY	25,086	25,086	1,134,244		2,721,767	25,086	10
11	CAFETERIA	3,752	3,752	1,180,540		1,586,185	3,752	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,360	2,360	4,395,213		6,332,494	2,360	13
14	CENTRAL SERVICES & SUPPLY	19,699	19,699			991,982	19,699	14
15	PHARMACY	6,479	6,479	3,573,551		5,665,592	6,479	15
16	MEDICAL RECORDS & LIBRARY	12,171	12,171	1,900,865		3,247,490	12,171	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL				702			20
21	I&R SERVICES-SALARY & FRINGES APPRVD	2,855	2,855	3,864,280		4,167,271	2,855	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,963	2,963	1,013,165		1,295,264	2,963	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	212,286	212,286	26,655,046		43,827,403	212,286	30
31	INTENSIVE CARE UNIT	10,208	10,208	5,227,255		6,597,696	10,208	31
41	SUBPROVIDER - IRF	8,281	8,281	931,411		1,317,702	8,281	41
43	NURSERY	1,854	1,854	734,923		1,250,574	1,854	43
44	SKILLED NURSING FACILITY	10,845	10,845	1,400,992		1,947,067	10,845	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	52,287	52,287	4,585,601		9,984,945	52,287	50
51	RECOVERY ROOM	3,657	3,657	758,029		1,002,126	3,657	51
52	DELIVERY ROOM & LABOR ROOM	24,449	24,449	4,480,631		5,422,299	24,449	52
53	ANESTHESIOLOGY	514	514	143,071		530,913	514	53
54	RADIOLOGY-DIAGNOSTIC	24,249	24,249	5,151,671		7,568,351	24,249	54
54.01	OUTPATIENT ONCOLOGY			319,697		473,188		54.01
55	RADIOLOGY-THERAPEUTIC	1,290	1,290	167,866		338,045	1,290	55
59	CARDIAC CATHETERIZATION	5,612	5,612	570,164		832,444	5,612	59
60	LABORATORY	18,835	18,835			9,266,997	18,835	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,565	1,565			41,869	1,565	63
65	RESPIRATORY THERAPY	1,130	1,130	1,615,971		2,150,603	1,130	65
66	PHYSICAL THERAPY	7,709	7,709	1,846,740		2,453,441	7,709	66
67	OCCUPATIONAL THERAPY	1,127	1,127	947,354		1,220,373	1,127	67
68	SPEECH PATHOLOGY	401	401	229,956		291,650	401	68
69	ELECTROCARDIOLOGY	8,429	8,429	946,756		1,457,787	8,429	69
70	ELECTROENCEPHALOGRAPHY			207,037		915,712		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					7,744,389		71
72	IMPL. DEV. CHARGED TO PATIENTS					3,604,808		72
73	DRUGS CHARGED TO PATIENTS					10,864,815		73
74	RENAL DIALYSIS	900	900	475,940		682,036	900	74
75	ASC (NON-DISTINCT PART)			1,195,175		1,620,693		75
76	MENTAL HEALTH OUTPATIENT	12,070	12,070	1,164		2,730,324	12,070	76
76.97	CARDIAC REHABILITATION	3,530	3,530	165,363		257,283	3,530	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	31,536	31,536	1,259,518		2,709,506	31,536	90
91	EMERGENCY	29,442	29,442	6,391,989		10,346,744	29,442	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	824,311	824,311	94,858,180	-51,839,636	185,031,959	564,412	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS					33,943		193
194	CONVENT			21,911		84,545		194
194.01	OUTPATIENT PHARMACY	547	547			9,289	547	194.01
194.02	FUND DEVELOPMENT	274	274			9,982	274	194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	4,779,115	8,736,873	21,872,476		51,840,338	18,454,928	202
203	UNIT COST MULT-WS B PT I	5.791940	10.588455	0.230528		0.279961	32.650125	203
204	COST TO BE ALLOC PER B PT II			142,051		965,562	3,238,987	204

KPMG LLP

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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 GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
205	UNIT COST MULT-WS B PT II			0.001497		0.005214	5.730357	205

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINIS-TRATION NURSING HO URS	CENTRAL SERVICES & SUPPLY INPATIENT REVENUE	
		8	9	10	11	13	14	
	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
8	LAUNDRY & LINEN SERVICE	1,202,368						8
9	HOUSEKEEPING	67,102	548,392					9
10	DIETARY		25,086	115,600				10
11	CAFETERIA		3,752		81,178,305			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,360		4,395,213	43,375		13
14	CENTRAL SERVICES & SUPPLY	80	19,699				667,130,463	14
15	PHARMACY		6,479		3,573,551			15
16	MEDICAL RECORDS & LIBRARY		12,171		1,900,865	128		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		2,855		3,864,280			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		2,963		1,013,165			22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	392,602	212,286	96,959	26,655,046	27,602	196,934,445	30
31	INTENSIVE CARE UNIT	87,883	10,208	6,059	5,227,255	2,080	22,074,698	31
41	SUBPROVIDER - IRF	119,850	8,281	3,414	931,411		6,334,101	41
43	NURSERY	31,041	1,854	4,038	734,923		6,237,304	43
44	SKILLED NURSING FACILITY	37,959	10,845	5,130	1,400,992	1,043	4,592,742	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	101,572	52,287		4,585,601	4,160	36,286,076	50
51	RECOVERY ROOM	21,132	3,657		758,029	2,088	6,953,296	51
52	DELIVERY ROOM & LABOR ROOM	34,092	24,449		4,480,631		23,384,565	52
53	ANESTHESIOLOGY		514		143,071		8,600,308	53
54	RADIOLOGY-DIAGNOSTIC	54,835	24,249		5,151,671		30,954,021	54
54.01	OUTPATIENT ONCOLOGY				319,697			54.01
55	RADIOLOGY-THERAPEUTIC	1,478	1,290		167,866		332,994	55
59	CARDIAC CATHETERIZATION	3,987	5,612		570,164		10,062,674	59
60	LABORATORY		18,835				67,399,744	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		1,565				5,606,153	63
65	RESPIRATORY THERAPY		1,130		1,615,971		36,153,189	65
66	PHYSICAL THERAPY	24,071	7,709		1,846,740		5,875,682	66
67	OCCUPATIONAL THERAPY		1,127		947,354		4,471,675	67
68	SPEECH PATHOLOGY		401		229,956		969,244	68
69	ELECTROCARDIOLOGY	6,782	8,429		946,756		14,785,228	69
70	ELECTROENCEPHALOGRAPHY	392			207,037		217,676	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						16,429,524	71
72	IMPL. DEV. CHARGED TO PATIENTS						11,900,454	72
73	DRUGS CHARGED TO PATIENTS						106,076,089	73
74	RENAL DIALYSIS	4,475	900		475,940		3,898,182	74
75	ASC (NON-DISTINCT PART)				1,195,175	1,976	4,468,102	75
76	MENTAL HEALTH OUTPATIENT		12,070		1,164		4,125	76
76.97	CARDIAC REHABILITATION	160	3,530		165,363		57,527	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	4,391	31,536		1,259,518	2,120	32,232	90
91	EMERGENCY	206,615	29,442		6,391,989	2,178	36,038,413	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,200,499	547,571	115,600	81,156,394	43,375	667,130,463	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	1,869						192
193	NONPAID WORKERS							193
194	CONVENT				21,911			194
194.01	OUTPATIENT PHARMACY		547					194.01
194.02	FUND DEVELOPMENT		274					194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,045,897	5,214,778	4,541,365	2,188,437	8,323,327	2,100,331	202
203	UNIT COST MULT-WS B PT I	1.701556	9.509216	39.285164	0.026958	191.892265	0.003148	203
204	COST TO BE ALLOC PER B PT II	100,662	307,067	584,607	95,097	98,248	451,768	204

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINIS-TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY INPATIENT REVENUE	
		8	9	10	11	13	14	
205	UNIT COST MULT-WS B PT II	0.083720	0.559941	5.057154	0.001171	2.265084	0.000677	205

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY INPATIENT REVENUE	MEDICAL RECORDS & LIBRARY PATIENT DAYS	SOCIAL SERVICE INPATIENT REVENUE	I&R SALARY & FRINGES PATIENT DAYS	I&R PROGRAM COSTS PATIENT DAYS		
		15	16	17	21	22		
	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
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	667,130,463						15
16	MEDICAL RECORDS & LIBRARY		115,600					16
17	SOCIAL SERVICE			667,130,463				17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				105,607			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					105,607		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	196,934,445	96,959	196,934,445	95,510	95,510		30
31	INTENSIVE CARE UNIT	22,074,698	6,059	22,074,698	7,508	7,508		31
41	SUBPROVIDER - IRF	6,334,101	3,414	6,334,101				41
43	NURSERY	6,237,304	4,038	6,237,304	2,589	2,589		43
44	SKILLED NURSING FACILITY	4,592,742	5,130	4,592,742				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	36,286,076		36,286,076				50
51	RECOVERY ROOM	6,953,296		6,953,296				51
52	DELIVERY ROOM & LABOR ROOM	23,384,565		23,384,565				52
53	ANESTHESIOLOGY	8,600,308		8,600,308				53
54	RADIOLOGY-DIAGNOSTIC	30,954,021		30,954,021				54
54.01	OUTPATIENT ONCOLOGY							54.01
55	RADIOLOGY-THERAPEUTIC	332,994		332,994				55
59	CARDIAC CATHETERIZATION	10,062,674		10,062,674				59
60	LABORATORY	67,399,744		67,399,744				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,606,153		5,606,153				63
65	RESPIRATORY THERAPY	36,153,189		36,153,189				65
66	PHYSICAL THERAPY	5,875,682		5,875,682				66
67	OCCUPATIONAL THERAPY	4,471,675		4,471,675				67
68	SPEECH PATHOLOGY	969,244		969,244				68
69	ELECTROCARDIOLOGY	14,785,228		14,785,228				69
70	ELECTROENCEPHALOGRAPHY	217,676		217,676				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,429,524		16,429,524				71
72	IMPL. DEV. CHARGED TO PATIENTS	11,900,454		11,900,454				72
73	DRUGS CHARGED TO PATIENTS	106,076,089		106,076,089				73
74	RENAL DIALYSIS	3,898,182		3,898,182				74
75	ASC (NON-DISTINCT PART)	4,468,102		4,468,102				75
76	MENTAL HEALTH OUTPATIENT	4,125		4,125				76
76.97	CARDIAC REHABILITATION	57,527		57,527				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	32,232		32,232				90
91	EMERGENCY	36,038,413		36,038,413				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	667,130,463	115,600	667,130,463	105,607	105,607		118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	CONVENT							194
194.01	OUTPATIENT PHARMACY							194.01
194.02	FUND DEVELOPMENT							194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	7,621,223	4,745,589		5,558,482	1,810,118		202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY INPATIENT REVENUE	MEDICAL RECORDS & LIBRARY PATIENT DAYS	SOCIAL SERVICE INPATIENT REVENUE	I&R SALARY & FRINGES PATIENT DAYS	I&R PROGRAM COSTS PATIENT DAYS		
		15	16	17	21	22		
203	UNIT COST MULT-WS B PT I	0.011424	41.051808		52.633651	17.140133		203
204	COST TO BE ALLOC PER B PT II	185,959	298,219		96,763	76,631		204
205	UNIT COST MULT-WS B PT II	0.000279	2.579749		0.916256	0.725624		205

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	82,389,736		82,389,736		82,389,736	30
31	INTENSIVE CARE UNIT	10,373,180		10,373,180		10,373,180	31
41	SUBPROVIDER - IRF	2,631,341		2,631,341		2,631,341	41
43	NURSERY	2,166,769		2,166,769		2,166,769	43
44	SKILLED NURSING FACILITY	3,730,943		3,730,943		3,730,943	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	16,608,207		16,608,207		16,608,207	50
51	RECOVERY ROOM	1,995,245		1,995,245		1,995,245	51
52	DELIVERY ROOM & LABOR ROOM	8,490,643		8,490,643		8,490,643	52
53	ANESTHESIOLOGY	830,399		830,399		830,399	53
54	RADIOLOGY-DIAGNOSTIC	11,392,762		11,392,762		11,392,762	54
54.01	OUTPATIENT ONCOLOGY	614,280		614,280		614,280	54.01
55	RADIOLOGY-THERAPEUTIC	498,962		498,962		498,962	55
59	CARDIAC CATHETERIZATION	1,470,882		1,470,882		1,470,882	59
60	LABORATORY	13,637,615		13,637,615		13,637,615	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	201,263		201,263		201,263	63
65	RESPIRATORY THERAPY	3,370,715		3,370,715		3,370,715	65
66	PHYSICAL THERAPY	3,641,679		3,641,679		3,641,679	66
67	OCCUPATIONAL THERAPY	1,700,244		1,700,244		1,700,244	67
68	SPEECH PATHOLOGY	410,530		410,530		410,530	68
69	ELECTROCARDIOLOGY	2,473,785		2,473,785		2,473,785	69
70	ELECTROENCEPHALOGRAPHY	1,181,496		1,181,496		1,181,496	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,151,927		10,151,927		10,151,927	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,787,428		4,787,428		4,787,428	72
73	DRUGS CHARGED TO PATIENTS	15,452,280		15,452,280		15,452,280	73
74	RENAL DIALYSIS	988,170		988,170		988,170	74
75	ASC (NON-DISTINCT PART)	2,550,933		2,550,933		2,550,933	75
76	MENTAL HEALTH OUTPATIENT	4,003,662		4,003,662		4,003,662	76
76.97	CARDIAC REHABILITATION	483,703		483,703		483,703	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	5,246,306		5,246,306		5,246,306	90
91	EMERGENCY	15,951,659		15,951,659		15,951,659	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,952,685		2,952,685		2,952,685	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
114	UTILIZATION REVIEW-SNF						114
200	SUBTOTAL (SEE INSTRUCTIONS)	232,379,429		232,379,429		232,379,429	200
201	LESS OBSERVATION BEDS	2,952,685		2,952,685		2,952,685	201
202	TOTAL (SEE INSTRUCTIONS)	229,426,744		229,426,744		229,426,744	202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	196,934,445		196,934,445				30
31	INTENSIVE CARE UNIT	22,074,698		22,074,698				31
41	SUBPROVIDER - IRF	6,334,101		6,334,101				41
43	NURSERY	6,237,304		6,237,304				43
44	SKILLED NURSING FACILITY	4,592,742		4,592,742				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	36,286,076	36,047,277	72,333,353	0.229606	0.229606	0.229606	50
51	RECOVERY ROOM	6,953,296	6,949,441	13,902,737	0.143515	0.143515	0.143515	51
52	DELIVERY ROOM & LABOR ROOM	23,384,565	1,165,108	24,549,673	0.345856	0.345856	0.345856	52
53	ANESTHESIOLOGY	8,600,308	7,878,980	16,479,288	0.050390	0.050390	0.050390	53
54	RADIOLOGY-DIAGNOSTIC	30,954,021	68,163,381	99,117,402	0.114942	0.114942	0.114942	54
54.01	OUTPATIENT ONCOLOGY		4,489,068	4,489,068	0.136839	0.136839	0.136839	54.01
55	RADIOLOGY-THERAPEUTIC	332,994	4,507,341	4,840,335	0.103084	0.103084	0.103084	55
59	CARDIAC CATHETERIZATION	10,062,674	4,727,477	14,790,151	0.099450	0.099450	0.099450	59
60	LABORATORY	67,399,744	40,388,209	107,787,953	0.126523	0.126523	0.126523	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,606,153	495,057	6,101,210	0.032987	0.032987	0.032987	63
65	RESPIRATORY THERAPY	36,153,189	3,389,657	39,542,846	0.085242	0.085242	0.085242	65
66	PHYSICAL THERAPY	5,875,682	5,298,799	11,174,481	0.325892	0.325892	0.325892	66
67	OCCUPATIONAL THERAPY	4,471,675	754,801	5,226,476	0.325314	0.325314	0.325314	67
68	SPEECH PATHOLOGY	969,244	81,945	1,051,189	0.390539	0.390539	0.390539	68
69	ELECTROCARDIOLOGY	14,785,228	14,904,436	29,689,664	0.083321	0.083321	0.083321	69
70	ELECTROENCEPHALOGRAPHY	217,676	280,578	498,254	2.371272	2.371272	2.371272	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,429,524	6,326,631	22,756,155	0.446118	0.446118	0.446118	71
72	IMPL. DEV. CHARGED TO PATIENTS	11,900,454	4,867,767	16,768,221	0.285506	0.285506	0.285506	72
73	DRUGS CHARGED TO PATIENTS	106,076,089	57,300,891	163,376,980	0.094581	0.094581	0.094581	73
74	RENAL DIALYSIS	3,898,182	271,835	4,170,017	0.236970	0.236970	0.236970	74
75	ASC (NON-DISTINCT PART)	4,468,102	14,499,504	18,967,606	0.134489	0.134489	0.134489	75
76	MENTAL HEALTH OUTPATIENT	4,125	5,497,995	5,502,120	0.727658	0.727658	0.727658	76
76.97	CARDIAC REHABILITATION	57,527	195,344	252,871	1.912845	1.912845	1.912845	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	32,232	2,732,593	2,764,825	1.897518	1.897518	1.897518	90
91	EMERGENCY	36,038,413	81,811,183	117,849,596	0.135356	0.135356	0.135356	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		12,840,751	12,840,751	0.229946	0.229946	0.229946	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
200	SUBTOTAL (SEE INSTRUCTIONS)	667,130,463	385,866,049	1,052,996,512				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	667,130,463	385,866,049	1,052,996,512				202

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	6,136,518		6,136,518	100,563	61.02	29,245	1,784,530	30
31	INTENSIVE CARE UNIT	359,213		359,213	6,059	59.29	2,474	146,683	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	239,252		239,252	3,414	70.08	1,664	116,613	41
42	SUBPROVIDER I								42
43	NURSERY	89,912		89,912	4,038	22.27			43
44	SKILLED NURSING FACILITY	308,862		308,862	5,130	60.21	4,042	243,369	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	7,133,757		7,133,757	119,204		37,425	2,291,195	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0180** **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	1,302,297	72,333,353	0.018004	13,384,334	240,972	50
51	RECOVERY ROOM	103,300	13,902,737	0.007430	2,201,852	16,360	51
52	DELIVERY ROOM & LABOR ROOM	619,711	24,549,673	0.025243	58,755	1,483	52
53	ANESTHESIOLOGY	23,023	16,479,288	0.001397	2,823,729	3,945	53
54	RADIOLOGY-DIAGNOSTIC	637,130	99,117,402	0.006428	12,094,825	77,746	54
54.01	OUTPATIENT ONCOLOGY	3,320	4,489,068	0.000740			54.01
55	RADIOLOGY-THERAPEUTIC	31,898	4,840,335	0.006590	144,282	951	55
59	CARDIAC CATHETERIZATION	143,042	14,790,151	0.009671	4,282,047	41,412	59
60	LABORATORY	539,755	107,787,953	0.005008	24,976,116	125,080	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	41,056	6,101,210	0.006729	2,122,450	14,282	63
65	RESPIRATORY THERAPY	75,705	39,542,846	0.001915	8,482,056	16,243	65
66	PHYSICAL THERAPY	200,120	11,174,481	0.017909	931,479	16,682	66
67	OCCUPATIONAL THERAPY	38,715	5,226,476	0.007407	353,117	2,616	67
68	SPEECH PATHOLOGY	12,152	1,051,189	0.011560	390,023	4,509	68
69	ELECTROCARDIOLOGY	215,921	29,689,664	0.007273	6,264,538	45,562	69
70	ELECTROENCEPHALOGRAPHY	5,568	498,254	0.011175	84,875	948	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,086	22,756,155	0.002465	12,174,468	30,010	71
72	IMPL. DEV. CHARGED TO PATIENTS	30,172	16,768,221	0.001799	4,573,323	8,227	72
73	DRUGS CHARGED TO PATIENTS	158,058	163,376,980	0.000967	40,466,735	39,131	73
74	RENAL DIALYSIS	29,331	4,170,017	0.007034	1,882,002	13,238	74
75	ASC (NON-DISTINCT PART)	20,387	18,967,606	0.001075	1,945,931	2,092	75
76	MENTAL HEALTH OUTPATIENT	287,878	5,502,120	0.052321	825	43	76
76.97	CARDIAC REHABILITATION	81,879	252,871	0.323798	25,115	8,132	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	737,632	2,764,825	0.266792	11,418	3,046	90
91	EMERGENCY	795,156	117,849,596	0.006747	9,853,395	66,481	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	219,922	12,840,751	0.017127			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,409,214	816,823,222		149,527,690	779,191	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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

		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)	100,563		29,245		30
31	INTENSIVE CARE UNIT	6,059		2,474		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	3,414		1,664		41
42	SUBPROVIDER I					42
43	NURSERY	4,038				43
44	SKILLED NURSING FACILITY	5,130		4,042		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	119,204		37,425		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0180** **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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OUTPATIENT ONCOLOGY							54.01
55	RADIOLOGY-THERAPEUTIC							55
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
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
75	ASC (NON-DISTINCT PART)							75
76	MENTAL HEALTH OUTPATIENT							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0180** **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	72,333,353			13,384,334		8,501,465		50
51	RECOVERY ROOM	13,902,737			2,201,852		1,595,243		51
52	DELIVERY ROOM & LABOR ROOM	24,549,673			58,755		1,527		52
53	ANESTHESIOLOGY	16,479,288			2,823,729		2,100,333		53
54	RADIOLOGY-DIAGNOSTIC	99,117,402			12,094,825		15,730,730		54
54.01	OUTPATIENT ONCOLOGY	4,489,068					1,746,940		54.01
55	RADIOLOGY-THERAPEUTIC	4,840,335			144,282		1,702,576		55
59	CARDIAC CATHETERIZATION	14,790,151			4,282,047		2,114,131		59
60	LABORATORY	107,787,953			24,976,116		2,211,098		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,101,210			2,122,450		85,193		63
65	RESPIRATORY THERAPY	39,542,846			8,482,056		431,234		65
66	PHYSICAL THERAPY	11,174,481			931,479				66
67	OCCUPATIONAL THERAPY	5,226,476			353,117				67
68	SPEECH PATHOLOGY	1,051,189			390,023				68
69	ELECTROCARDIOLOGY	29,689,664			6,264,538		4,919,585		69
70	ELECTROENCEPHALOGRAPHY	498,254			84,875		51,354		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,756,155			12,174,468		2,863,024		71
72	IMPL. DEV. CHARGED TO PATIENTS	16,768,221			4,573,323		1,823,784		72
73	DRUGS CHARGED TO PATIENTS	163,376,980			40,466,735		22,594,988		73
74	RENAL DIALYSIS	4,170,017			1,882,002		157,883		74
75	ASC (NON-DISTINCT PART)	18,967,606			1,945,931		4,978,102		75
76	MENTAL HEALTH OUTPATIENT	5,502,120			825		1,470,713		76
76.97	CARDIAC REHABILITATION	252,871			25,115		86,593		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,764,825			11,418		773,919		90
91	EMERGENCY	117,849,596			9,853,395		10,533,465		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,840,751					4,559,731		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	816,823,222			149,527,690		91,033,611		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0180** **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	0.229606	8,501,465			1,951,987			50
51	RECOVERY ROOM	0.143515	1,595,243			228,941			51
52	DELIVERY ROOM & LABOR ROOM	0.345856	1,527			528			52
53	ANESTHESIOLOGY	0.050390	2,100,333			105,836			53
54	RADIOLOGY-DIAGNOSTIC	0.114942	15,730,730			1,808,122			54
54.01	OUTPATIENT ONCOLOGY	0.136839	1,746,940			239,050			54.01
55	RADIOLOGY-THERAPEUTIC	0.103084	1,702,576			175,508			55
59	CARDIAC CATHETERIZATION	0.099450	2,114,131			210,250			59
60	LABORATORY	0.126523	2,211,098			279,755			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987	85,193			2,810			63
65	RESPIRATORY THERAPY	0.085242	431,234			36,759			65
66	PHYSICAL THERAPY	0.325892							66
67	OCCUPATIONAL THERAPY	0.325314							67
68	SPEECH PATHOLOGY	0.390539							68
69	ELECTROCARDIOLOGY	0.083321	4,919,585			409,905			69
70	ELECTROENCEPHALOGRAPHY	2.371272	51,354			121,774			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118	2,863,024			1,277,247			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506	1,823,784			520,701			72
73	DRUGS CHARGED TO PATIENTS	0.094581	22,594,988		104,318	2,137,057		9,867	73
74	RENAL DIALYSIS	0.236970	157,883			37,414			74
75	ASC (NON-DISTINCT PART)	0.134489	4,978,102			669,500			75
76	MENTAL HEALTH OUTPATIENT	0.727658	1,470,713			1,070,176			76
76.97	CARDIAC REHABILITATION	1.912845	86,593			165,639			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.897518	773,919			1,468,525			90
91	EMERGENCY	0.135356	10,533,465			1,425,768			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946	4,559,731			1,048,492			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		91,033,611		104,318	15,391,744		9,867	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		91,033,611		104,318	15,391,744		9,867	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T180** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [ ] IPF [XX] 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	1,302,297	72,333,353	0.018004			50
51	RECOVERY ROOM	103,300	13,902,737	0.007430			51
52	DELIVERY ROOM & LABOR ROOM	619,711	24,549,673	0.025243			52
53	ANESTHESIOLOGY	23,023	16,479,288	0.001397			53
54	RADIOLOGY-DIAGNOSTIC	637,130	99,117,402	0.006428	83,732	538	54
54.01	OUTPATIENT ONCOLOGY	3,320	4,489,068	0.000740			54.01
55	RADIOLOGY-THERAPEUTIC	31,898	4,840,335	0.006590			55
59	CARDIAC CATHETERIZATION	143,042	14,790,151	0.009671			59
60	LABORATORY	539,755	107,787,953	0.005008	386,218	1,934	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	41,056	6,101,210	0.006729	5,536	37	63
65	RESPIRATORY THERAPY	75,705	39,542,846	0.001915	141,315	271	65
66	PHYSICAL THERAPY	200,120	11,174,481	0.017909	1,039,591	18,618	66
67	OCCUPATIONAL THERAPY	38,715	5,226,476	0.007407	975,710	7,227	67
68	SPEECH PATHOLOGY	12,152	1,051,189	0.011560	127,601	1,475	68
69	ELECTROCARDIOLOGY	215,921	29,689,664	0.007273	20,292	148	69
70	ELECTROENCEPHALOGRAPHY	5,568	498,254	0.011175			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,086	22,756,155	0.002465			71
72	IMPL. DEV. CHARGED TO PATIENTS	30,172	16,768,221	0.001799	301,738	543	72
73	DRUGS CHARGED TO PATIENTS	158,058	163,376,980	0.000967	980,229	948	73
74	RENAL DIALYSIS	29,331	4,170,017	0.007034	29,570	208	74
75	ASC (NON-DISTINCT PART)	20,387	18,967,606	0.001075	2,809	3	75
76	MENTAL HEALTH OUTPATIENT	287,878	5,502,120	0.052321			76
76.97	CARDIAC REHABILITATION	81,879	252,871	0.323798			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	737,632	2,764,825	0.266792			90
91	EMERGENCY	795,156	117,849,596	0.006747			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		12,840,751				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,189,292	816,823,222		4,094,341	31,950	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T180** **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST (1)	NURSING SCHOOL (2)	ALLIED HEALTH (3)	ALL OTHER MEDICAL EDUCATION COST (4)	TOTAL COST (sum of col. 1 through col. 4) (5)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) (6)	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OUTPATIENT ONCOLOGY							54.01
55	RADIOLOGY-THERAPEUTIC							55
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
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
75	ASC (NON-DISTINCT PART)							75
76	MENTAL HEALTH OUTPATIENT							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T180** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [ ] IPF [XX] 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	72,333,353							50
51	RECOVERY ROOM	13,902,737							51
52	DELIVERY ROOM & LABOR ROOM	24,549,673							52
53	ANESTHESIOLOGY	16,479,288							53
54	RADIOLOGY-DIAGNOSTIC	99,117,402			83,732				54
54.01	OUTPATIENT ONCOLOGY	4,489,068							54.01
55	RADIOLOGY-THERAPEUTIC	4,840,335							55
59	CARDIAC CATHETERIZATION	14,790,151							59
60	LABORATORY	107,787,953			386,218				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,101,210			5,536				63
65	RESPIRATORY THERAPY	39,542,846			141,315				65
66	PHYSICAL THERAPY	11,174,481			1,039,591				66
67	OCCUPATIONAL THERAPY	5,226,476			975,710				67
68	SPEECH PATHOLOGY	1,051,189			127,601				68
69	ELECTROCARDIOLOGY	29,689,664			20,292				69
70	ELECTROENCEPHALOGRAPHY	498,254							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,756,155							71
72	IMPL. DEV. CHARGED TO PATIENTS	16,768,221			301,738				72
73	DRUGS CHARGED TO PATIENTS	163,376,980			980,229				73
74	RENAL DIALYSIS	4,170,017			29,570				74
75	ASC (NON-DISTINCT PART)	18,967,606			2,809				75
76	MENTAL HEALTH OUTPATIENT	5,502,120							76
76.97	CARDIAC REHABILITATION	252,871							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,764,825							90
91	EMERGENCY	117,849,596							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,840,751							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	816,823,222			4,094,341				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T180** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES:
[ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[XX] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF
[ ] TITLE XIX - O/P [XX] 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	0.229606							50
51	RECOVERY ROOM	0.143515							51
52	DELIVERY ROOM & LABOR ROOM	0.345856							52
53	ANESTHESIOLOGY	0.050390							53
54	RADIOLOGY-DIAGNOSTIC	0.114942							54
54.01	OUTPATIENT ONCOLOGY	0.136839							54.01
55	RADIOLOGY-THERAPEUTIC	0.103084							55
59	CARDIAC CATHETERIZATION	0.099450							59
60	LABORATORY	0.126523							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987							63
65	RESPIRATORY THERAPY	0.085242							65
66	PHYSICAL THERAPY	0.325892							66
67	OCCUPATIONAL THERAPY	0.325314							67
68	SPEECH PATHOLOGY	0.390539							68
69	ELECTROCARDIOLOGY	0.083321							69
70	ELECTROENCEPHALOGRAPHY	2.371272							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506							72
73	DRUGS CHARGED TO PATIENTS	0.094581							73
74	RENAL DIALYSIS	0.236970							74
75	ASC (NON-DISTINCT PART)	0.134489							75
76	MENTAL HEALTH OUTPATIENT	0.727658							76
76.97	CARDIAC REHABILITATION	1.912845							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.897518							90
91	EMERGENCY	0.135356							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5541** **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OUTPATIENT ONCOLOGY							54.01
55	RADIOLOGY-THERAPEUTIC							55
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
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
75	ASC (NON-DISTINCT PART)							75
76	MENTAL HEALTH OUTPATIENT							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5541** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [XX] 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	72,333,353			24,596				50
51	RECOVERY ROOM	13,902,737							51
52	DELIVERY ROOM & LABOR ROOM	24,549,673							52
53	ANESTHESIOLOGY	16,479,288			1,711				53
54	RADIOLOGY-DIAGNOSTIC	99,117,402			163,753				54
54.01	OUTPATIENT ONCOLOGY	4,489,068							54.01
55	RADIOLOGY-THERAPEUTIC	4,840,335							55
59	CARDIAC CATHETERIZATION	14,790,151							59
60	LABORATORY	107,787,953			983,864				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,101,210			30,577				63
65	RESPIRATORY THERAPY	39,542,846			988,113				65
66	PHYSICAL THERAPY	11,174,481			1,396,740				66
67	OCCUPATIONAL THERAPY	5,226,476			1,397,119				67
68	SPEECH PATHOLOGY	1,051,189			42,885				68
69	ELECTROCARDIOLOGY	29,689,664			20,107				69
70	ELECTROENCEPHALOGRAPHY	498,254			1,168				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,756,155			1,437,871				71
72	IMPL. DEV. CHARGED TO PATIENTS	16,768,221			108				72
73	DRUGS CHARGED TO PATIENTS	163,376,980			3,748,111				73
74	RENAL DIALYSIS	4,170,017			277,446				74
75	ASC (NON-DISTINCT PART)	18,967,606							75
76	MENTAL HEALTH OUTPATIENT	5,502,120							76
76.97	CARDIAC REHABILITATION	252,871							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,764,825			9,670				90
91	EMERGENCY	117,849,596							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,840,751							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	816,823,222			10,523,839				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5541** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[XX] TITLE XVIII, PART B [ ] IPF [XX] SNF [ ] SWING BED NF
[ ] 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	0.229606							50
51	RECOVERY ROOM	0.143515							51
52	DELIVERY ROOM & LABOR ROOM	0.345856							52
53	ANESTHESIOLOGY	0.050390							53
54	RADIOLOGY-DIAGNOSTIC	0.114942							54
54.01	OUTPATIENT ONCOLOGY	0.136839							54.01
55	RADIOLOGY-THERAPEUTIC	0.103084							55
59	CARDIAC CATHETERIZATION	0.099450							59
60	LABORATORY	0.126523							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987							63
65	RESPIRATORY THERAPY	0.085242							65
66	PHYSICAL THERAPY	0.325892							66
67	OCCUPATIONAL THERAPY	0.325314							67
68	SPEECH PATHOLOGY	0.390539							68
69	ELECTROCARDIOLOGY	0.083321							69
70	ELECTROENCEPHALOGRAPHY	2.371272							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506							72
73	DRUGS CHARGED TO PATIENTS	0.094581			668			63	73
74	RENAL DIALYSIS	0.236970							74
75	ASC (NON-DISTINCT PART)	0.134489							75
76	MENTAL HEALTH OUTPATIENT	0.727658							76
76.97	CARDIAC REHABILITATION	1.912845							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.897518							90
91	EMERGENCY	0.135356							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)				668			63	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)				668			63	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	6,136,518		6,136,518	100,563	61.02	52,430	3,199,279	30
31	INTENSIVE CARE UNIT	359,213		359,213	6,059	59.29	1,533	90,892	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	239,252		239,252	3,414	70.08	1,068	74,845	41
42	SUBPROVIDER I								42
43	NURSERY	89,912		89,912	4,038	22.27	2,067	46,032	43
44	SKILLED NURSING FACILITY	308,862		308,862	5,130	60.21			44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	7,133,757		7,133,757	119,204		57,098	3,411,048	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0180** **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	1,302,297	72,333,353	0.018004			50
51	RECOVERY ROOM	103,300	13,902,737	0.007430			51
52	DELIVERY ROOM & LABOR ROOM	619,711	24,549,673	0.025243			52
53	ANESTHESIOLOGY	23,023	16,479,288	0.001397			53
54	RADIOLOGY-DIAGNOSTIC	637,130	99,117,402	0.006428			54
54.01	OUTPATIENT ONCOLOGY	3,320	4,489,068	0.000740			54.01
55	RADIOLOGY-THERAPEUTIC	31,898	4,840,335	0.006590			55
59	CARDIAC CATHETERIZATION	143,042	14,790,151	0.009671			59
60	LABORATORY	539,755	107,787,953	0.005008			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	41,056	6,101,210	0.006729			63
65	RESPIRATORY THERAPY	75,705	39,542,846	0.001915			65
66	PHYSICAL THERAPY	200,120	11,174,481	0.017909			66
67	OCCUPATIONAL THERAPY	38,715	5,226,476	0.007407			67
68	SPEECH PATHOLOGY	12,152	1,051,189	0.011560			68
69	ELECTROCARDIOLOGY	215,921	29,689,664	0.007273			69
70	ELECTROENCEPHALOGRAPHY	5,568	498,254	0.011175			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,086	22,756,155	0.002465			71
72	IMPL. DEV. CHARGED TO PATIENTS	30,172	16,768,221	0.001799			72
73	DRUGS CHARGED TO PATIENTS	158,058	163,376,980	0.000967			73
74	RENAL DIALYSIS	29,331	4,170,017	0.007034			74
75	ASC (NON-DISTINCT PART)	20,387	18,967,606	0.001075			75
76	MENTAL HEALTH OUTPATIENT	287,878	5,502,120	0.052321			76
76.97	CARDIAC REHABILITATION	81,879	252,871	0.323798			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	737,632	2,764,825	0.266792			90
91	EMERGENCY	795,156	117,849,596	0.006747			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	219,922	12,840,751	0.017127			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,409,214	816,823,222				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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**

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions) 4	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.) 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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)	100,563		52,430		30
31	INTENSIVE CARE UNIT	6,059		1,533		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	3,414		1,068		41
42	SUBPROVIDER I					42
43	NURSERY	4,038		2,067		43
44	SKILLED NURSING FACILITY	5,130				44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	119,204		57,098		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0180** **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OUTPATIENT ONCOLOGY							54.01
55	RADIOLOGY-THERAPEUTIC							55
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
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
75	ASC (NON-DISTINCT PART)							75
76	MENTAL HEALTH OUTPATIENT							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0180** **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)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT 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	72,333,353							50
51	RECOVERY ROOM	13,902,737							51
52	DELIVERY ROOM & LABOR ROOM	24,549,673							52
53	ANESTHESIOLOGY	16,479,288							53
54	RADIOLOGY-DIAGNOSTIC	99,117,402							54
54.01	OUTPATIENT ONCOLOGY	4,489,068							54.01
55	RADIOLOGY-THERAPEUTIC	4,840,335							55
59	CARDIAC CATHETERIZATION	14,790,151							59
60	LABORATORY	107,787,953							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,101,210							63
65	RESPIRATORY THERAPY	39,542,846							65
66	PHYSICAL THERAPY	11,174,481							66
67	OCCUPATIONAL THERAPY	5,226,476							67
68	SPEECH PATHOLOGY	1,051,189							68
69	ELECTROCARDIOLOGY	29,689,664							69
70	ELECTROENCEPHALOGRAPHY	498,254							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,756,155							71
72	IMPL. DEV. CHARGED TO PATIENTS	16,768,221							72
73	DRUGS CHARGED TO PATIENTS	163,376,980							73
74	RENAL DIALYSIS	4,170,017							74
75	ASC (NON-DISTINCT PART)	18,967,606							75
76	MENTAL HEALTH OUTPATIENT	5,502,120							76
76.97	CARDIAC REHABILITATION	252,871							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,764,825							90
91	EMERGENCY	117,849,596							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,840,751							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	816,823,222							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0180** **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	0.229606							50
51	RECOVERY ROOM	0.143515							51
52	DELIVERY ROOM & LABOR ROOM	0.345856							52
53	ANESTHESIOLOGY	0.050390							53
54	RADIOLOGY-DIAGNOSTIC	0.114942							54
54.01	OUTPATIENT ONCOLOGY	0.136839							54.01
55	RADIOLOGY-THERAPEUTIC	0.103084							55
59	CARDIAC CATHETERIZATION	0.099450							59
60	LABORATORY	0.126523							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987							63
65	RESPIRATORY THERAPY	0.085242							65
66	PHYSICAL THERAPY	0.325892							66
67	OCCUPATIONAL THERAPY	0.325314							67
68	SPEECH PATHOLOGY	0.390539							68
69	ELECTROCARDIOLOGY	0.083321							69
70	ELECTROENCEPHALOGRAPHY	2.371272							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506							72
73	DRUGS CHARGED TO PATIENTS	0.094581							73
74	RENAL DIALYSIS	0.236970							74
75	ASC (NON-DISTINCT PART)	0.134489							75
76	MENTAL HEALTH OUTPATIENT	0.727658							76
76.97	CARDIAC REHABILITATION	1.912845							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.897518							90
91	EMERGENCY	0.135356							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T180** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [ ] IPF [XX] 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	1,302,297	72,333,353	0.018004			50
51	RECOVERY ROOM	103,300	13,902,737	0.007430			51
52	DELIVERY ROOM & LABOR ROOM	619,711	24,549,673	0.025243			52
53	ANESTHESIOLOGY	23,023	16,479,288	0.001397			53
54	RADIOLOGY-DIAGNOSTIC	637,130	99,117,402	0.006428			54
54.01	OUTPATIENT ONCOLOGY	3,320	4,489,068	0.000740			54.01
55	RADIOLOGY-THERAPEUTIC	31,898	4,840,335	0.006590			55
59	CARDIAC CATHETERIZATION	143,042	14,790,151	0.009671			59
60	LABORATORY	539,755	107,787,953	0.005008			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	41,056	6,101,210	0.006729			63
65	RESPIRATORY THERAPY	75,705	39,542,846	0.001915			65
66	PHYSICAL THERAPY	200,120	11,174,481	0.017909			66
67	OCCUPATIONAL THERAPY	38,715	5,226,476	0.007407			67
68	SPEECH PATHOLOGY	12,152	1,051,189	0.011560			68
69	ELECTROCARDIOLOGY	215,921	29,689,664	0.007273			69
70	ELECTROENCEPHALOGRAPHY	5,568	498,254	0.011175			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,086	22,756,155	0.002465			71
72	IMPL. DEV. CHARGED TO PATIENTS	30,172	16,768,221	0.001799			72
73	DRUGS CHARGED TO PATIENTS	158,058	163,376,980	0.000967			73
74	RENAL DIALYSIS	29,331	4,170,017	0.007034			74
75	ASC (NON-DISTINCT PART)	20,387	18,967,606	0.001075			75
76	MENTAL HEALTH OUTPATIENT	287,878	5,502,120	0.052321			76
76.97	CARDIAC REHABILITATION	81,879	252,871	0.323798			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	737,632	2,764,825	0.266792			90
91	EMERGENCY	795,156	117,849,596	0.006747			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		12,840,751				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,189,292	816,823,222				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T180** **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST (1)	NURSING SCHOOL (2)	ALLIED HEALTH (3)	ALL OTHER MEDICAL EDUCATION COST (4)	TOTAL COST (sum of col. 1 through col. 4) (5)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) (6)	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OUTPATIENT ONCOLOGY							54.01
55	RADIOLOGY-THERAPEUTIC							55
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
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
75	ASC (NON-DISTINCT PART)							75
76	MENTAL HEALTH OUTPATIENT							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T180** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] 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	72,333,353							50
51	RECOVERY ROOM	13,902,737							51
52	DELIVERY ROOM & LABOR ROOM	24,549,673							52
53	ANESTHESIOLOGY	16,479,288							53
54	RADIOLOGY-DIAGNOSTIC	99,117,402							54
54.01	OUTPATIENT ONCOLOGY	4,489,068							54.01
55	RADIOLOGY-THERAPEUTIC	4,840,335							55
59	CARDIAC CATHETERIZATION	14,790,151							59
60	LABORATORY	107,787,953							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,101,210							63
65	RESPIRATORY THERAPY	39,542,846							65
66	PHYSICAL THERAPY	11,174,481							66
67	OCCUPATIONAL THERAPY	5,226,476							67
68	SPEECH PATHOLOGY	1,051,189							68
69	ELECTROCARDIOLOGY	29,689,664							69
70	ELECTROENCEPHALOGRAPHY	498,254							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,756,155							71
72	IMPL. DEV. CHARGED TO PATIENTS	16,768,221							72
73	DRUGS CHARGED TO PATIENTS	163,376,980							73
74	RENAL DIALYSIS	4,170,017							74
75	ASC (NON-DISTINCT PART)	18,967,606							75
76	MENTAL HEALTH OUTPATIENT	5,502,120							76
76.97	CARDIAC REHABILITATION	252,871							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,764,825							90
91	EMERGENCY	117,849,596							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,840,751							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	816,823,222							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T180** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [ ] TITLE XVIII, PART B [XX] TITLE XIX - O/P [ ] HOSPITAL [ ] IPF [XX] 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	0.229606							50
51	RECOVERY ROOM	0.143515							51
52	DELIVERY ROOM & LABOR ROOM	0.345856							52
53	ANESTHESIOLOGY	0.050390							53
54	RADIOLOGY-DIAGNOSTIC	0.114942							54
54.01	OUTPATIENT ONCOLOGY	0.136839							54.01
55	RADIOLOGY-THERAPEUTIC	0.103084							55
59	CARDIAC CATHETERIZATION	0.099450							59
60	LABORATORY	0.126523							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987							63
65	RESPIRATORY THERAPY	0.085242							65
66	PHYSICAL THERAPY	0.325892							66
67	OCCUPATIONAL THERAPY	0.325314							67
68	SPEECH PATHOLOGY	0.390539							68
69	ELECTROCARDIOLOGY	0.083321							69
70	ELECTROENCEPHALOGRAPHY	2.371272							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506							72
73	DRUGS CHARGED TO PATIENTS	0.094581							73
74	RENAL DIALYSIS	0.236970							74
75	ASC (NON-DISTINCT PART)	0.134489							75
76	MENTAL HEALTH OUTPATIENT	0.727658							76
76.97	CARDIAC REHABILITATION	1.912845							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.897518							90
91	EMERGENCY	0.135356							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0180** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	100,563	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	100,563	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)	96,959	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)	29,245	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)	82,389,736	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	82,389,736	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)	82,389,736	37

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0180** **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)	819.28	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	23,959,844	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)	23,959,844	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	10,373,180	6,059	1,712.03	2,474	4,235,562	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	23,305,786	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	51,501,192	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	1,931,213	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	779,191	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	2,710,404	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	48,790,788	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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0180** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					3,604	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					819.28	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					2,952,685	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	6,136,518	82,389,736	0.074482	2,952,685	219,922	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T180** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,414	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,414	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)	3,414	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)	1,664	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)	2,631,341	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	2,631,341	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)	2,631,341	37

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T180** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [ ] HOSPITAL [ ] IPF [XX] 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)	770.75	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	1,282,528	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	1,282,528	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	964,692	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	2,247,220	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	116,613	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	31,950	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	148,563	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	2,098,657	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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5541** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	5,130	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,130	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)	5,130	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)	4,042	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)	3,730,943	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	3,730,943	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)	3,730,943	37

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5541** **WORKSHEET D-1 PARTS III & IV**

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

PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	3,730,943	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	727.28	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	2,939,666	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (line 14 x line 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (line 72 + line 73)	2,939,666	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 26, line 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (line 75 ÷ line 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (line 9 x line 76)		77
78	INPATIENT ROUTINE SERVICE COST (line 74 minus line 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (from provider records)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (line 78 minus line 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (line 9 x line 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (see instructions)	2,939,666	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	2,245,241	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)	12,000	85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	5,196,907	86

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0180** **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)	100,563	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	100,563	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)	96,959	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)	52,430	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)	4,038	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	2,067	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)	82,389,736	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	82,389,736	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)	82,389,736	37

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0180** **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)					819.28	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					42,954,850	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)					42,954,850	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)	2,166,769	4,038	536.59	2,067	1,109,132	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	10,373,180	6,059	1,712.03	1,533	2,624,542	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					46,688,524	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					3,336,203	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)					3,336,203	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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0180** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					3,604	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

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T180** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,414	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,414	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)	3,414	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)	1,068	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)	2,631,341	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	2,631,341	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)	2,631,341	37

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T180** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] TITLE XVIII, PART A [XX] TITLE XIX - I/P [ ] HOSPITAL [ ] IPF [XX] 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)	770.75	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	823,161	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)	823,161	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)	823,161	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	74,845	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)	74,845	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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0180** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/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		66,636,871		30
31	INTENSIVE CARE UNIT		10,979,037		31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.229606	13,384,334	3,073,123	50
51	RECOVERY ROOM	0.143515	2,201,852	315,999	51
52	DELIVERY ROOM & LABOR ROOM	0.345856	58,755	20,321	52
53	ANESTHESIOLOGY	0.050390	2,823,729	142,288	53
54	RADIOLOGY-DIAGNOSTIC	0.114942	12,094,825	1,390,203	54
54.01	OUTPATIENT ONCOLOGY	0.136839			54.01
55	RADIOLOGY-THERAPEUTIC	0.103084	144,282	14,873	55
59	CARDIAC CATHETERIZATION	0.099450	4,282,047	425,850	59
60	LABORATORY	0.126523	24,976,116	3,160,053	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987	2,122,450	70,013	63
65	RESPIRATORY THERAPY	0.085242	8,482,056	723,027	65
66	PHYSICAL THERAPY	0.325892	931,479	303,562	66
67	OCCUPATIONAL THERAPY	0.325314	353,117	114,874	67
68	SPEECH PATHOLOGY	0.390539	390,023	152,319	68
69	ELECTROCARDIOLOGY	0.083321	6,264,538	521,968	69
70	ELECTROENCEPHALOGRAPHY	2.371272	84,875	201,262	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118	12,174,468	5,431,249	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506	4,573,323	1,305,711	72
73	DRUGS CHARGED TO PATIENTS	0.094581	40,466,735	3,827,384	73
74	RENAL DIALYSIS	0.236970	1,882,002	445,978	74
75	ASC (NON-DISTINCT PART)	0.134489	1,945,931	261,706	75
76	MENTAL HEALTH OUTPATIENT	0.727658	825	600	76
76.97	CARDIAC REHABILITATION	1.912845	25,115	48,041	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.897518	11,418	21,666	90
91	EMERGENCY	0.135356	9,853,395	1,333,716	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		149,527,690	23,305,786	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		149,527,690		202

(A) Worksheet A line numbers

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T180** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] 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
41	SUBPROVIDER - IRF		3,083,033		41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.229606			50
51	RECOVERY ROOM	0.143515			51
52	DELIVERY ROOM & LABOR ROOM	0.345856			52
53	ANESTHESIOLOGY	0.050390			53
54	RADIOLOGY-DIAGNOSTIC	0.114942	83,732	9,624	54
54.01	OUTPATIENT ONCOLOGY	0.136839			54.01
55	RADIOLOGY-THERAPEUTIC	0.103084			55
59	CARDIAC CATHETERIZATION	0.099450			59
60	LABORATORY	0.126523	386,218	48,865	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987	5,536	183	63
65	RESPIRATORY THERAPY	0.085242	141,315	12,046	65
66	PHYSICAL THERAPY	0.325892	1,039,591	338,794	66
67	OCCUPATIONAL THERAPY	0.325314	975,710	317,412	67
68	SPEECH PATHOLOGY	0.390539	127,601	49,833	68
69	ELECTROCARDIOLOGY	0.083321	20,292	1,691	69
70	ELECTROENCEPHALOGRAPHY	2.371272			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506	301,738	86,148	72
73	DRUGS CHARGED TO PATIENTS	0.094581	980,229	92,711	73
74	RENAL DIALYSIS	0.236970	29,570	7,007	74
75	ASC (NON-DISTINCT PART)	0.134489	2,809	378	75
76	MENTAL HEALTH OUTPATIENT	0.727658			76
76.97	CARDIAC REHABILITATION	1.912845			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.897518			90
91	EMERGENCY	0.135356			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		4,094,341	964,692	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		4,094,341		202

(A) Worksheet A line numbers

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5541** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [XX] 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
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.229606	24,596	5,647	50
51	RECOVERY ROOM	0.143515			51
52	DELIVERY ROOM & LABOR ROOM	0.345856			52
53	ANESTHESIOLOGY	0.050390	1,711	86	53
54	RADIOLOGY-DIAGNOSTIC	0.114942	163,753	18,822	54
54.01	OUTPATIENT ONCOLOGY	0.136839			54.01
55	RADIOLOGY-THERAPEUTIC	0.103084			55
59	CARDIAC CATHETERIZATION	0.099450			59
60	LABORATORY	0.126523	983,864	124,481	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987	30,577	1,009	63
65	RESPIRATORY THERAPY	0.085242	988,113	84,229	65
66	PHYSICAL THERAPY	0.325892	1,396,740	455,186	66
67	OCCUPATIONAL THERAPY	0.325314	1,397,119	454,502	67
68	SPEECH PATHOLOGY	0.390539	42,885	16,748	68
69	ELECTROCARDIOLOGY	0.083321	20,107	1,675	69
70	ELECTROENCEPHALOGRAPHY	2.371272	1,168	2,770	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118	1,437,871	641,460	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506	108	31	72
73	DRUGS CHARGED TO PATIENTS	0.094581	3,748,111	354,500	73
74	RENAL DIALYSIS	0.236970	277,446	65,746	74
75	ASC (NON-DISTINCT PART)	0.134489			75
76	MENTAL HEALTH OUTPATIENT	0.727658			76
76.97	CARDIAC REHABILITATION	1.912845			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.897518	9,670	18,349	90
91	EMERGENCY	0.135356			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		10,523,839	2,245,241	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		10,523,839		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0180** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.229606			50
51	RECOVERY ROOM	0.143515			51
52	DELIVERY ROOM & LABOR ROOM	0.345856			52
53	ANESTHESIOLOGY	0.050390			53
54	RADIOLOGY-DIAGNOSTIC	0.114942			54
54.01	OUTPATIENT ONCOLOGY	0.136839			54.01
55	RADIOLOGY-THERAPEUTIC	0.103084			55
59	CARDIAC CATHETERIZATION	0.099450			59
60	LABORATORY	0.126523			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987			63
65	RESPIRATORY THERAPY	0.085242			65
66	PHYSICAL THERAPY	0.325892			66
67	OCCUPATIONAL THERAPY	0.325314			67
68	SPEECH PATHOLOGY	0.390539			68
69	ELECTROCARDIOLOGY	0.083321			69
70	ELECTROENCEPHALOGRAPHY	2.371272			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506			72
73	DRUGS CHARGED TO PATIENTS	0.094581			73
74	RENAL DIALYSIS	0.236970			74
75	ASC (NON-DISTINCT PART)	0.134489			75
76	MENTAL HEALTH OUTPATIENT	0.727658			76
76.97	CARDIAC REHABILITATION	1.912845			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.897518			90
91	EMERGENCY	0.135356			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T180** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:
[ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX
[ ] HOSPITAL [ ] IPF [XX] 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
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.229606			50
51	RECOVERY ROOM	0.143515			51
52	DELIVERY ROOM & LABOR ROOM	0.345856			52
53	ANESTHESIOLOGY	0.050390			53
54	RADIOLOGY-DIAGNOSTIC	0.114942			54
54.01	OUTPATIENT ONCOLOGY	0.136839			54.01
55	RADIOLOGY-THERAPEUTIC	0.103084			55
59	CARDIAC CATHETERIZATION	0.099450			59
60	LABORATORY	0.126523			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.032987			63
65	RESPIRATORY THERAPY	0.085242			65
66	PHYSICAL THERAPY	0.325892			66
67	OCCUPATIONAL THERAPY	0.325314			67
68	SPEECH PATHOLOGY	0.390539			68
69	ELECTROCARDIOLOGY	0.083321			69
70	ELECTROENCEPHALOGRAPHY	2.371272			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.446118			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.285506			72
73	DRUGS CHARGED TO PATIENTS	0.094581			73
74	RENAL DIALYSIS	0.236970			74
75	ASC (NON-DISTINCT PART)	0.134489			75
76	MENTAL HEALTH OUTPATIENT	0.727658			76
76.97	CARDIAC REHABILITATION	1.912845			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.897518			90
91	EMERGENCY	0.135356			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.229946			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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)	28,991,444			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	9,231,658			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)	1,083,396			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	4,156,017			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	442.13			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)	40.45			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	4.23			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)	44.68			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	45.13			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS	3.00			11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	47.68			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	46.14			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	35.81			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	43.21			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	43.21			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.097731			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.105741			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.097731			21
22	IME PAYMENT ADJUSTMENT (see instructions)	2,201,850			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)	0.45			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)	2,201,850			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.2097			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.5234			31
32	SUM OF LINES 30 AND 31	0.7331			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.5029			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	15,740,447			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
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)		17,728,346		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		4,468,518		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	4,468,518			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

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	
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)	61,717,313			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)	61,717,313			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	3,687,844			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)	1,285,178			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				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	66,690,335			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	66,690,335			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	3,739,564			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	590,282			63
64	ALLOWABLE BAD DEBTS (see instructions)	2,872,412			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	1,867,068			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	2,480,970			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	64,227,557			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)	75,617			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-254,950			70.94
71	AMOUNT DUE PROVIDER (see instructions)	64,048,224			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	967,128			71.01
72	INTERIM PAYMENTS	60,686,943			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	2,394,153			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	488,262			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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0180** **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)	9,867			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	15,391,744			2
3	PPS PAYMENTS	14,579,425			3
4	OUTLIER PAYMENT (see instructions)	29,058			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)	9,867			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	104,318			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)	104,318			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)	104,318			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	94,451			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)	9,867			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)	14,608,483			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	3,325,227			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	11,293,123			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	337,413			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	11,630,536			30
31	PRIMARY PAYER PAYMENTS	1,098			31
32	SUBTOTAL (line 30 minus line 31)	11,629,438			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)	2,022,838			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	1,314,845			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	1,864,013			36
37	SUBTOTAL (see instructions)	12,944,283			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	12,944,283			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	195,459			40.01
41	INTERIM PAYMENTS	11,993,746			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	755,078			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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T180** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [XX] 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	1,529			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)	1,529			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	369			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,160			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)	1,160			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	1,160			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)	1,160			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,160			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	18			40.01
41	INTERIM PAYMENTS	1,168			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-26			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

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5541** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	63			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)	63			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	668			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)	668			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)	668			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	605			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)	63			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)	63			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)	63			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	63			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)	63			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	63			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	1			40.01
41	INTERIM PAYMENTS	92			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-30			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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0180** **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				58,216,860		11,114,409	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				2,037,936		736,666	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	12/20/2013	1,084,086	12/20/2013	268,524	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	04/09/2013	651,939	07/09/2013	125,853	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		432,147		142,671	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)				60,686,943		11,993,746	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		3,361,281		950,537	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				64,048,224		12,944,283	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.

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-T180** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [XX] 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				2,677,746		1,168	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	12/20/2013	56,694			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	07/09/2013	731			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		57,425			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)				2,735,171		1,168	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		48,284			6.01
	BASED ON THE COST REPORT (1)		.02				-8	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				2,783,455		1,160	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.

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-5541** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER) [ ] IPF [XX] 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				1,832,718		92	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					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					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)				1,832,718		92	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		49,516			6.01
	BASED ON THE COST REPORT (1)		.02				-29	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,882,234		63	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.

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	19,085	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	31,719	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,902	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	103,018	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,052,996,512	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	37,382,877	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)	1,946,580	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	38,932	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,907,648	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	2,108,816	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-201,168	32

KPMG LLP COMPU-MAX

PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T180** **WORKSHEET E-3 PART III**

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	2,322,734		1
2	MEDICARE SSI RATIO (see instructions)	0.192800		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	482,664		3
4	OUTLIER PAYMENTS			4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (see instructions)			5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSUE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)			9
10	AVERAGE DAILY CENSUS (see instructions)	9.353425		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	2,805,398		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	2,805,398		17
18	PRIMARY PAYER PAYMENTS			18
19	SUBTOTAL (line 17 less line 18)	2,805,398		19
20	DEDUCTIBLES	16,576		20
21	SUBTOTAL (line 19 minus line 20)	2,788,822		21
22	COINSURANCE	15,096		22
23	SUBTOTAL (line 21 minus line 22)	2,773,726		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	14,967		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	9,729		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	13,560		26
27	SUBTOTAL (sum of lines 23 and 25)	2,783,455		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	2,783,455		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	42,030		32.01
33	INTERIM PAYMENTS	2,735,171		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	6,254		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	24,497		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (see instructions)	14,497		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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART VI**

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	1,971,357	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (sum of lines 1-3)	1,971,357	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	DO NOT USE THIS LINE		5
6	DEDUCTIBLES		6
7	COINSURANCE	110,803	7
8	ALLOWABLE BAD DEBTS (see instructions)	14,893	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	9,680	10
11	UTILIZATION REVIEW	12,000	11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	1,882,234	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		14
15	SUBTOTAL (line 12 minus 13 ± line 14)	1,882,234	15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	28,422	15.01
16	INTERIM PAYMENTS	1,832,718	16
17	TENTATIVE SETTLEMENT (for contractor use only)		17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)	21,094	18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0180** **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	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	46,688,524		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	46,688,524		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	46,688,524		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)	46,688,524		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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T180** **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	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	823,161		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	823,161		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	823,161		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)	823,161		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 SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			41.12	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			2.82	3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))			5.99	4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			44.29	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			45.13	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			44.29	7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	43.17	1.80	44.97	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	42.37	1.77	44.14	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	42.37	1.77		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	41.26	1.33		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	34.81	1.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	39.48	1.37		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	39.48	1.37		17
18	PER RESIDENT AMOUNT	117,841.32	117,841.32		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	4,652,375	161,443	4,813,818	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)			0.84	21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			4,813,818	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	33,383	2,902		26
27	TOTAL INPATIENT DAYS (see instructions)	106,432	106,432		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.313656	0.027266		28
29	PROGRAM DIRECT GME AMOUNT	1,509,883	131,254		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		18,546		30
31	NET PROGRAM DIRECT GME AMOUNT			1,622,591	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			4,170,017	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			58,659,435	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			58,659,435	41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			15,401,674	42
43	PRIMARY PAYER PAYMENTS (see instructions)			1,098	43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			15,400,576	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			74,060,011	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.792053	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			0.207947	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)			1,622,591	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			1,285,178	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			337,413	50

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX: **[ ] TITLE V** **[ ] TITLE XVIII** **[XX] TITLE XIX**

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	0.00	0.00	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00		17
18	PER RESIDENT AMOUNT	0.00	0.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	55,031			26
27	TOTAL INPATIENT DAYS (see instructions)	106,432			27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.517053	0.000000		28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)				37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)				42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)				44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)				46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)				48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)				49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)				50

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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	481,316				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	146,224,015				4
5	OTHER RECEIVABLES	830,398				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-107,529,712				6
7	INVENTORY	3,988,045				7
8	PREPAID EXPENSES	4,067,234				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	48,061,296				11
	FIXED ASSETS					
12	LAND	5,370,865				12
13	LAND IMPROVEMENTS	775,588				13
14	ACCUMULATED DEPRECIATION	-736,818				14
15	BUILDINGS	123,191,383				15
16	ACCUMULATED DEPRECIATION	-71,265,823				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	85,153,925				23
24	ACCUMULATED DEPRECIATION	-51,350,694				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)	91,138,426				30
	OTHER ASSETS					
31	INVESTMENTS	2,541,320				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	3,401,401				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	5,942,721				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	145,142,443				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	20,315,460				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	-176,554,038				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	-156,238,578				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	49,429,191				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	49,429,191				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	-106,809,387				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	251,951,830				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
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)	251,951,830				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	145,142,443				60

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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		234,235,610			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		10,716,209			2
3	TOTAL (sun of line 1 and line 2)		244,951,819			3
4	ADDITIONS (credit adjustments)					4
5		7,000,000				5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		7,000,000			10
11	SUBTOTAL (line 3 plus line 10)		251,951,819			11
12	DEDUCTIONS (debit adjustments)					12
13	RECONCILIATION	-11				13
14	TRANSFER TO AFFILIATE					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		-11			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		251,951,830			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	RECONCILIATION					13
14	TRANSFER TO AFFILIATE					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 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	236,355,987		236,355,987	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	6,338,471		6,338,471	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	4,592,745		4,592,745	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	247,287,203		247,287,203	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	19,926,668		19,926,668	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	19,926,668		19,926,668	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	267,213,871		267,213,871	17
18	ANCILLARY SERVICES	399,916,596	389,929,393	789,845,989	18
19	OUTPATIENT SERVICES				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)	667,130,467	389,929,393	1,057,059,860	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		253,735,539	29
30	ADD (SPECIFY)			30
31	ASSESSMENT TAX	23,803,127		31
32	POST GRADUATE PHYSICIANS EXTERNAL			32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		23,803,127	36
37	DEDUCT (SPECIFY)			37
38	FINANCE INCOME TAX	-46,509		38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)		-46,509	42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		277,492,157	43

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	1,057,059,860	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	782,940,525	2
3	NET PATIENT REVENUES (line 1 minus line 2)	274,119,335	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	277,492,157	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-3,372,822	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	5,015,436	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	1,013,743	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		22
23	GOVERNMENTAL APPROPRIATIONS	505,077	23
24	OTHER (REVENUE FROM OTHER SERVICES)	7,536,272	24
24.01	OTHER (NET ASSETS RELEASED FROM RESTRICTION)	18,503	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	14,089,031	25
26	TOTAL (line 5 plus line 25)	10,716,209	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	10,716,209	29

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PRESENCE SAINTS MARY & ELIZABETH MED Provider CCN: 14-0180	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:51 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0180** **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	3,043,250	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	22,858	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)	282.24	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	43.21	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	4.42	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	134,512	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.2097	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.5234	8
9	SUM OF LINES 7 AND 8	0.7331	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1601	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	487,224	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	3,687,844	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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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
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
41	SUBPROVIDER - IRF							41
43	NURSERY							43
44	SKILLED NURSING FACILITY							44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	OUTPATIENT ONCOLOGY							54.01
55	RADIOLOGY-THERAPEUTIC							55
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
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
75	ASC (NON-DISTINCT PART)							75
76	MENTAL HEALTH OUTPATIENT							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
114	UTILIZATION REVIEW-SNF							114
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	CONVENT							194
194.01	OUTPATIENT PHARMACY							194.01
194.02	FUND DEVELOPMENT							194.02
194.03	NURSING EDUC BLD UNUSED SPACE							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202