KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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: 05/22/2014 TIME: 09:15 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 SAINT JOSEPH HOSPITAL ELGIN (14-0217) {(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		505,961	147,719	-112,030		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		20,360	963			3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		526,321	148,682	-112,030		200

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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:

1	STREET: 77 NORTH AIRLITE ST.	P.O. BOX:		1
2	CITY: ELGIN	STATE: IL	ZIP CODE: 60123	COUNTY: KANE 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 SAINT JOSEPH HOSPITAL ELGIN	14-0217	16974	1	09/01/1966	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF	PRESENCE SAINT JOSEPH REHAB UNIT	14-T217	16974	5	09/01/1997	N	P	N	5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19

20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 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.	1	N	23

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	2,432	923			205	274	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.		40					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	

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	Y			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
		1	2	3	4	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)						
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)					62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)					62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS						
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N				63

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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			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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

				V	XIX	
TITLE V AND XIX SERVICES				1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97
RURAL PROVIDERS				1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N		108
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N				109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'		N			115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			2		118
			PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:			1,448,673	1,166,496	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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	148003	140

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

141	NAME: PRESENCE HEALTHCARE	CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES CONTRACTOR'S NUMBER: 06101		141
142	STREET: 9223 W ST. FRANCIS ROAD	P.O. BOX:		142
143	CITY: FRANKFORT	STATE: IL	ZIP CODE: 60423	143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	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			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

MULTICAMPUS

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

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)				168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00			169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)		05/01/2013	07/30/2013	170

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	Y		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

	BAD DEBTS	Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N	14

	BED COMPLEMENT		
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	05/01/2014	Y	05/01/2014	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

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

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

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

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

COST REORT PREPARER INFORMATION				
41	FIRST NAME: JENNIFER	LAST NAME: HANES	TITLE: MGR OF REIMBURSEMENT	41
42	EMPLOYER: PRESENCE HEALTH			42
43	PHONE NUMBER: (815) 806-2333	E-MAIL ADDRESS: JENNIFER.HANES@PRESENCEHEALTH.ORG		43

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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	132	48,180			12,180	2,857	24,393	1
2	HMO AND OTHER (see instructions)						1,060	1,042		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER						256			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)		132	48,180			12,180	2,857	24,393	7
8	INTENSIVE CARE UNIT	31	12	4,380			1,381	261	2,607	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		144	52,560			13,561	3,118	27,000	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	40	14,600			11,819		13,712	17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		184							27
28	OBSERVATION BED DAYS							284	2,810	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)								111	30
31	EMPLOYEE DISCOUNT DAYS-IRF								5	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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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)					2,681	562	5,796	1
2	HMO AND OTHER (see instructions)					215			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)		696.54			2,681	562	5,796	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF		67.13			1,031		1,221	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		763.67						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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	47,518,687	3,929	47,522,616	1,588,431.29	29.92	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		4,543,536	48,605	4,592,141	164,176.00	27.97	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		2,833,425		2,833,425	83,527.00	33.92	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		409,829		409,829	3,270.00	125.33	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		9,951,860		9,951,860	178,636.00	55.71	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)		11,446,014		11,446,014			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		1,266,757		1,266,757			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		287,376	26,804	314,180	7,826.00	40.15	26
27	ADMINISTRATIVE & GENERAL		3,726,067	-2,593	3,723,474	139,578.00	26.68	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		39,829		39,829	1,482.00	26.88	28
29	MAINTENANCE & REPAIRS		517,357		517,357	16,799.00	30.80	29
30	OPERATION OF PLANT		788,360		788,360	35,413.00	22.26	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		1,023,099		1,023,099	82,764.00	12.36	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		1,104,635	-677,833	426,802	30,295.00	14.09	34
35	DIETARY UNDER CONTRACT (see instructions)		352,184		352,184	8,800.00	40.02	35
36	CAFETERIA			677,833	677,833	48,115.00	14.09	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		2,516,554		2,516,554	57,644.00	43.66	38
39	CENTRAL SERVICES AND SUPPLY		305,473	-1,138	304,335	15,884.00	19.16	39
40	PHARMACY		1,954,821		1,954,821	43,595.00	44.84	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,354,773	-19,144	1,335,629	46,673.00	28.62	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		47,910,700	3,929	47,914,629	1,598,713.29	29.97	1
2	EXCLUDED AREA SALARIES (see instructions)		4,543,536	48,605	4,592,141	164,176.00	27.97	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		43,367,164	-44,676	43,322,488	1,434,537.29	30.20	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		13,195,114		13,195,114	265,433.00	49.71	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		11,446,014		11,446,014		26.42%	5
6	TOTAL (sum of lines 3 through 5)		68,008,292	-44,676	67,963,616	1,699,970.29	39.98	6
7	TOTAL OVERHEAD COST (see instructions)		13,970,528	3,929	13,974,457	534,868.00	26.13	7

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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	856,649	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	1,122,483	2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,364,945	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	4,342,672	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	124,682	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	116,421	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	153,344	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	777,025	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	3,411,529	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	195,757	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	247,264	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	12,712,771	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE	12/31/2013		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	01/01/2013	12/31/2013	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	7/01/2013		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	1/01/2012		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	1/01/2015		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	1/01/2012		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	1/01/2015		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
11.01		07/01/2012		11.01
11.02		07/01/2013		11.02
11.03		07/01/2014		11.03
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		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	12		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)	1,364,945		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	1,364,945		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	1,364,945		19

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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)	0.205333	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	7,079,799	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	67,605,164	6
7	MEDICAID COST (line 1 times line 6)	13,881,571	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.	6,801,772	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)	6,801,772	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	20,068,884	515,124	20,584,008	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	4,120,804	105,772	4,226,576	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	141,763	94,975	236,738	22
23	COST OF CHARITY CARE (line 21 minus line 22)	3,979,041	10,797	3,989,838	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)	8,216,083	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	555,526	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	7,660,557	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,572,965	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	5,562,803	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	12,364,575	31

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		6,266,175	6,266,175	832,449	7,098,624	2,155,432	9,254,056	1
2	00200	CAP REL COSTS-MVBLE EQUIP				2,020,625	2,020,625	2,004,796	4,025,421	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	287,376	11,319,613	11,606,989	-720	11,606,269	3,009,250	14,615,519	4
5.01	01160	COMMUNICATIONS	152,016	201,400	353,416		353,416	-21,956	331,460	5.01
5.02	00560	PURCH, RCVING, STORING	497	199,178	199,675	-9,778	189,897	-2,679	187,218	5.02
5.03	00570	ADMITTING	937,587	46,144	983,731	-11,145	972,586		972,586	5.03
5.04	00580	CASHIERING	129,776	905,711	1,035,487	-4,539	1,030,948	-216	1,030,732	5.04
5.05	00590	OTHER ADMIN AND GENERAL	2,506,191	27,556,462	30,062,653	-47,466	30,015,187	-4,668,392	25,346,795	5.05
6	00600	MAINTENANCE & REPAIRS	517,357	2,367,858	2,885,215	-27	2,885,188		2,885,188	6
7	00700	OPERATION OF PLANT	788,360	2,420,822	3,209,182	-14,532	3,194,650		3,194,650	7
8	00800	LAUNDRY & LINEN SERVICE		397,637	397,637		397,637		397,637	8
9	00900	HOUSEKEEPING	1,023,099	147,170	1,170,269	-17,378	1,152,891		1,152,891	9
10	01000	DIETARY	1,104,635	1,214,569	2,319,204	-1,433,563	885,641		885,641	10
11	01100	CAFETERIA				1,423,125	1,423,125	-576,545	846,580	11
13	01300	NURSING ADMINISTRATION	2,516,554	484,371	3,000,925	-371	3,000,554	-3,085	2,997,469	13
14	01400	CENTRAL SERVICES & SUPPLY	305,473	1,905,647	2,211,120	-1,608,289	602,831		602,831	14
15	01500	PHARMACY	1,954,821	7,822,452	9,777,273	-111,783	9,665,490	-2,200	9,663,290	15
16	01600	MEDICAL RECORDS & LIBRARY	1,354,773	1,733,294	3,088,067	-4	3,088,063	-10,855	3,077,208	16
23	02300	PARAMED ED PRGM-(SPECIFY)	221,323	58,731	280,054	47,638	327,692	-90,020	237,672	23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	8,644,839	715,274	9,360,113	-662,534	8,697,579	-110,014	8,587,565	30
31	03100	INTENSIVE CARE UNIT	2,025,462	662,431	2,687,893	-59,508	2,628,385	-457,200	2,171,185	31
41	04100	SUBPROVIDER - IRF	3,903,712	1,302,470	5,206,182	-83,972	5,122,210	-3,619	5,118,591	41
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	2,170,458	5,218,790	7,389,248	-4,158,297	3,230,951		3,230,951	50
51	05100	RECOVERY ROOM	1,978,543	96,164	2,074,707	-38,722	2,035,985		2,035,985	51
53	05300	ANESTHESIOLOGY	108,246	646,952	755,198	-28,314	726,884	-600,000	126,884	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,144,811	691,460	2,836,271	-335,113	2,501,158	-22,157	2,479,001	54
54.01	03650	VASCULAR LAB	387,065	23,345	410,410	-10,836	399,574		399,574	54.01
55	05500	RADIOLOGY-THERAPEUTIC	1,319,701	888,661	2,208,362	-129,961	2,078,401	-173,853	1,904,548	55
57	05700	CT SCAN	456,839	188,087	644,926	-162,906	482,020	-66	481,954	57
58	05800	MRI	195,930	49,142	245,072	-39,748	205,324		205,324	58
59	05900	CARDIAC CATHETERIZATION	1,019,551	2,660,194	3,679,745	-2,570,772	1,108,973	-377	1,108,596	59
60	06000	LABORATORY	82,713	5,121,126	5,203,839	-152,138	5,051,701	85,402	5,137,103	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		647,390	647,390	-42	647,348		647,348	62
65	06500	RESPIRATORY THERAPY	931,343	167,286	1,098,629	-67,724	1,030,905		1,030,905	65
66	06600	PHYSICAL THERAPY	2,181,362	43,210	2,224,572	-7,358	2,217,214		2,217,214	66
67	06700	OCCUPATIONAL THERAPY	839,079	154,545	993,624	-1,361	992,263		992,263	67
68	06800	SPEECH PATHOLOGY	429,377	3,368	432,745	-829	431,916		431,916	68
69	06900	ELECTROCARDIOLOGY	739,120	71,076	810,196	-10,289	799,907	-3,839	796,068	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				4,446,671	4,446,671		4,446,671	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				5,840,649	5,840,649		5,840,649	72
73	07300	DRUGS CHARGED TO PATIENTS								73
74	07400	RENAL DIALYSIS		376,618	376,618	-11	376,607		376,607	74
76	03950	OTHER ANCILLARY SERVICES COST CENTE								76
76.02	03550	PSYCH	333,757	30,726	364,483		364,483	-4,784	359,699	76.02
76.03	03951	OCCUPATIONAL HEALTH	351,593	420,724	772,317	-9,685	762,632	-288,371	474,261	76.03
76.97	07697	CARDIAC REHABILITATION	87,506	4,503	92,009		92,009		92,009	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		720,118	720,118	-362,593	357,525	-924	356,601	76.98
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES				452,185	452,185		452,185	90.01
91	09100	EMERGENCY	2,470,578	2,268,822	4,739,400	-223,925	4,515,475	-1,172,523	3,342,952	91
91.01	09101	C'VILLE OUT	100,085	165,293	265,378	-1,166	264,212	-83,612	180,600	91.01
91.02	09102	LAKE HILL OUT								91.02
91.03	09103	NUTRITION COUNSELING	368,319	7,570	375,889	-11	375,878	-5,823	370,055	91.03
91.04	09104	HUNTLEY OP	30,359	60,486	90,845	11,528	102,373	-7,220	95,153	91.04
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		5,061,208	5,061,208	-2,681,140	2,380,068	-2,380,068		113
118		SUBTOTALS (sum of lines 1-117)	47,100,186	93,514,273	140,614,459	16,320	140,630,779	-3,435,518	137,195,261	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,667	67,847	84,514	-14,368	70,146		70,146	190
194	07950	OTHER NONREIMBURSABLE COST CENTER	74,247	203,671	277,918		277,918		277,918	194
194.01	07951	MOB	12,061		12,061		12,061		12,061	194.01
194.02	07952	COMMUNITY WELLNESS	105,861	3,191	109,052	-1,952	107,100		107,100	194.02
194.03	07953	FUND DEVELOPMENT	209,665	66,571	276,236		276,236		276,236	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT								194.04
200		TOTAL (sum of lines 118-199)	47,518,687	93,855,553	141,374,240		141,374,240	-3,435,518	137,938,722	200

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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	A	CAFETERIA	11	677,833	745,292	1
500	TOTAL RECLASSIFICATIONS				677,833	745,292	500
	CODE LETTER - A						
1	EQUIP DEPR	B	CAP REL COSTS-MVBLE EQUIP	2		2,020,625	1
2	EQUIP DEPR	B					2
3	EQUIP DEPR	B					3
500	TOTAL RECLASSIFICATIONS					2,020,625	500
	CODE LETTER - B						
1	DIRECTLY ASSOGNED DEPR	D	EMERGENCY	91		5,182	1
2	DIRECTLY ASSOGNED DEPR	D	C'VILLE OUT	91.01		666	2
3	DIRECTLY ASSOGNED DEPR	D	HUNTLEY OP	91.04		11,566	3
500	TOTAL RECLASSIFICATIONS					17,414	500
	CODE LETTER - D						
1	INTEREST EXPENSE	H	CAP REL COSTS-BLDG & FIXT	1		2,681,140	1
500	TOTAL RECLASSIFICATIONS					2,681,140	500
	CODE LETTER - H						
1	EMS TRAINING COSTS	I	PARAMED ED PRGM-(SPECIFY)	23	48,605		1
2	EMS TRAINING COSTS	I					2
3	EMS TRAINING COSTS	I					3
4	EMS TRAINING COSTS	I					4
5	EMS TRAINING COSTS	I					5
6	EMS TRAINING COSTS	I					6
500	TOTAL RECLASSIFICATIONS				48,605		500
	CODE LETTER - I						
1	DEFERRED COMPENSATION	J	EMPLOYEE BENEFITS DEPARTMENT	4	27,171		1
500	TOTAL RECLASSIFICATIONS				27,171		500
	CODE LETTER - J						
1	HO ALLOCATION	K	EMPLOYEE BENEFITS DEPARTMENT	4		367	1
2	HO ALLOCATION	K	PURCH, RCVING, STORING	5.02		497	2
3	HO ALLOCATION	K	OTHER ADMIN AND GENERAL	5.05		2,096	3
4	HO ALLOCATION	K	CENTRAL SERVICES & SUPPLY	14		1,138	4
5	HO ALLOCATION	K	MEDICAL RECORDS & LIBRARY	16		19,144	5
500	TOTAL RECLASSIFICATIONS					23,242	500
	CODE LETTER - K						
1	IMPLANTS	L	IMPL. DEV. CHARGED TO PATIENT	72		5,840,649	1
2	IMPLANTS	L	INTENSIVE CARE UNIT	31		454	2
3							3
4	IMPLANTS	L					4
5	IMPLANTS	L					5
6	IMPLANTS	L					6
7	IMPLANTS	L					7
8	IMPLANTS	L					8
9	IMPLANTS	L					9
10	IMPLANTS	L					10
11	IMPLANTS	L					11
12	IMPLANTS	L					12
13	IMPLANTS	L					13
500	TOTAL RECLASSIFICATIONS					5,841,103	500
	CODE LETTER - L						
1	BILLABLE SUPPLIES	M	MEDICAL SUPPLIES CHARGED TO P	71		4,446,671	1
2	BILLABLE SUPPLIES	M					2
3	BILLABLE SUPPLIES	M					3
4	BILLABLE SUPPLIES	M					4
5	BILLABLE SUPPLIES	M					5
6	BILLABLE SUPPLIES	M					6
7	BILLABLE SUPPLIES	M					7
8	BILLABLE SUPPLIES	M					8
9	BILLABLE SUPPLIES	M					9
10	BILLABLE SUPPLIES	M					10
11	BILLABLE SUPPLIES	M					11
12	BILLABLE SUPPLIES	M					12
13	BILLABLE SUPPLIES	M					13
14	BILLABLE SUPPLIES	M					14
15	BILLABLE SUPPLIES	M					15
16	BILLABLE SUPPLIES	M					16
17	BILLABLE SUPPLIES	M					17
18	BILLABLE SUPPLIES	M					18
19	BILLABLE SUPPLIES	M					19

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
20	BILLABLE SUPPLIES	M					20
21	BILLABLE SUPPLIES	M					21
22	BILLABLE SUPPLIES	M					22
23	BILLABLE SUPPLIES	M					23
24	BILLABLE SUPPLIES	M					24
25	BILLABLE SUPPLIES	M					25
26	BILLABLE SUPPLIES	M					26
27	BILLABLE SUPPLIES	M					27
28	BILLABLE SUPPLIES	M					28
29	BILLABLE SUPPLIES	M					29
30	BILLABLE SUPPLIES	M					30
31	BILLABLE SUPPLIES	M					31
32	BILLABLE SUPPLIES	M					32
33	BILLABLE SUPPLIES	M					33
34	BILLABLE SUPPLIES	M					34
35	BILLABLE SUPPLIES	M					35
36	BILLABLE SUPPLIES	M					36
37	BILLABLE SUPPLIES	M					37
38	BILLABLE SUPPLIES	M					38
39	BILLABLE SUPPLIES	M					39
40							40
41	BILLABLE SUPPLIES	M					41
42	BILLABLE SUPPLIES	M					42
500	TOTAL RECLASSIFICATIONS					4,446,671	500
	CODE LETTER - M						
1	RECLASS OP PROCEDURE COSTS	N	OUTPATIENT PROCEDURES	90.01	417,630	34,555	1
500	TOTAL RECLASSIFICATIONS				417,630	34,555	500
	CODE LETTER - N						
	GRAND TOTAL (INCREASES)				1,171,239	15,810,042	

(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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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	CAFETERIA	A	DIETARY	10	677,833	745,292		1
500	TOTAL RECLASSIFICATIONS				677,833	745,292		500
	CODE LETTER - A							
1	EQUIP DEPR	B	CAP REL COSTS-BLDG & FIXT	1		1,831,277	9	1
2	EQUIP DEPR	B	LABORATORY	60		147,244	9	2
3	EQUIP DEPR	B	OTHER ADMIN AND GENERAL	5.05		42,104	9	3
500	TOTAL RECLASSIFICATIONS					2,020,625		500
	CODE LETTER - B							
1	DIRECTLY ASSOGNED DEPR	D	CAP REL COSTS-BLDG & FIXT	1		17,414	9	1
2	DIRECTLY ASSOGNED DEPR	D					9	2
3	DIRECTLY ASSOGNED DEPR	D					9	3
500	TOTAL RECLASSIFICATIONS					17,414		500
	CODE LETTER - D							
1	INTEREST EXPENSE	H	INTEREST EXPENSE	113		2,681,140	11	1
500	TOTAL RECLASSIFICATIONS					2,681,140		500
	CODE LETTER - H							
1	EMS TRAINING COSTS	I	ADULTS & PEDIATRICS	30	3,722			1
2	EMS TRAINING COSTS	I	INTENSIVE CARE UNIT	31	2,588			2
3	EMS TRAINING COSTS	I	ANESTHESIOLOGY	53	3,528			3
4	EMS TRAINING COSTS	I	CARDIAC CATHETERIZATION	59	2,892			4
5	EMS TRAINING COSTS	I	RESPIRATORY THERAPY	65	2,146			5
6	EMS TRAINING COSTS	I	EMERGENCY	91	33,729			6
500	TOTAL RECLASSIFICATIONS				48,605			500
	CODE LETTER - I							
1	DEFERRED COMPENSATION	J	EMPLOYEE BENEFITS DEPARTMENT	4		27,171		1
500	TOTAL RECLASSIFICATIONS					27,171		500
	CODE LETTER - J							
1	HO ALLOCATION	K	EMPLOYEE BENEFITS DEPARTMENT	4	367			1
2	HO ALLOCATION	K	PURCH, RCVING, STORING	5.02	497			2
3	HO ALLOCATION	K	OTHER ADMIN AND GENERAL	5.05	2,096			3
4	HO ALLOCATION	K	CENTRAL SERVICES & SUPPLY	14	1,138			4
5	HO ALLOCATION	K	MEDICAL RECORDS & LIBRARY	16	19,144			5
500	TOTAL RECLASSIFICATIONS				23,242			500
	CODE LETTER - K							
1	IMPLANTS	L	ANESTHESIOLOGY	53		973		1
2	IMPLANTS	L	CENTRAL SERVICES & SUPPLY	14		356,520		2
3			PARAMED ED PRGM-(SPECIFY)	23		4		3
4	IMPLANTS	L	OPERATING ROOM	50		2,929,818		4
5	IMPLANTS	L	RADIOLOGY-DIAGNOSTIC	54		51,557		5
6	IMPLANTS	L	CARDIAC CATHETERIZATION	59		2,471,297		6
7	IMPLANTS	L	EMERGENCY	91		10,899		7
8	IMPLANTS	L	ADULTS & PEDIATRICS	30		28		8
9	IMPLANTS	L	SUBPROVIDER - IRF	41		93		9
10	IMPLANTS	L	VASCULAR LAB	54.01		571		10
11	IMPLANTS	L	CT SCAN	57		13,697		11
12	IMPLANTS	L	OCCUPATIONAL HEALTH	76.03		868		12
13	IMPLANTS	L	HYPERBARIC OXYGEN THERAPY	76.98		4,778		13
500	TOTAL RECLASSIFICATIONS					5,841,103		500
	CODE LETTER - L							
1	BILLABLE SUPPLIES	M	EMPLOYEE BENEFITS DEPARTMENT	4		720		1
2	BILLABLE SUPPLIES	M	PURCH, RCVING, STORING	5.02		9,778		2
3	BILLABLE SUPPLIES	M	ADMITTING	5.03		11,145		3
4	BILLABLE SUPPLIES	M	CASHIERING	5.04		4,539		4
5	BILLABLE SUPPLIES	M	OTHER ADMIN AND GENERAL	5.05		5,362		5
6	BILLABLE SUPPLIES	M	MAINTENANCE & REPAIRS	6		27		6
7	BILLABLE SUPPLIES	M	OPERATION OF PLANT	7		14,532		7
8	BILLABLE SUPPLIES	M	HOUSEKEEPING	9		17,378		8
9	BILLABLE SUPPLIES	M	DIETARY	10		10,438		9
10	BILLABLE SUPPLIES	M	NURSING ADMINISTRATION	13		371		10
11	BILLABLE SUPPLIES	M	CENTRAL SERVICES & SUPPLY	14		1,251,769		11
12	BILLABLE SUPPLIES	M	PHARMACY	15		111,783		12
13	BILLABLE SUPPLIES	M	MEDICAL RECORDS & LIBRARY	16		4		13
14	BILLABLE SUPPLIES	M	PARAMED ED PRGM-(SPECIFY)	23		963		14
15	BILLABLE SUPPLIES	M	ADULTS & PEDIATRICS	30		206,599		15
16	BILLABLE SUPPLIES	M	INTENSIVE CARE UNIT	31		57,374		16
17	BILLABLE SUPPLIES	M	SUBPROVIDER - IRF	41		83,879		17
18	BILLABLE SUPPLIES	M	OPERATING ROOM	50		1,228,479		18

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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	
19	BILLABLE SUPPLIES	M	RECOVERY ROOM	51		38,722		19
20	BILLABLE SUPPLIES	M	ANESTHESIOLOGY	53		23,813		20
21	BILLABLE SUPPLIES	M	RADIOLOGY-DIAGNOSTIC	54		283,556		21
22	BILLABLE SUPPLIES	M	VASCULAR LAB	54.01		10,265		22
23	BILLABLE SUPPLIES	M	RADIOLOGY-THERAPEUTIC	55		129,961		23
24	BILLABLE SUPPLIES	M	CT SCAN	57		149,209		24
25	BILLABLE SUPPLIES	M	MRI	58		39,748		25
26	BILLABLE SUPPLIES	M	CARDIAC CATHETERIZATION	59		96,583		26
27	BILLABLE SUPPLIES	M	LABORATORY	60		4,894		27
28	BILLABLE SUPPLIES	M	WHOLE BLOOD & PACKED RED BLOO	62		42		28
29	BILLABLE SUPPLIES	M	RESPIRATORY THERAPY	65		65,578		29
30	BILLABLE SUPPLIES	M	PHYSICAL THERAPY	66		7,358		30
31	BILLABLE SUPPLIES	M	OCCUPATIONAL THERAPY	67		1,361		31
32	BILLABLE SUPPLIES	M	SPEECH PATHOLOGY	68		829		32
33	BILLABLE SUPPLIES	M	ELECTROCARDIOLOGY	69		10,289		33
34	BILLABLE SUPPLIES	M	RENAL DIALYSIS	74		11		34
35	BILLABLE SUPPLIES	M	OCCUPATIONAL HEALTH	76.03		8,817		35
36	BILLABLE SUPPLIES	M	HYPERBARIC OXYGEN THERAPY	76.98		357,815		36
37	BILLABLE SUPPLIES	M	EMERGENCY	91		184,479		37
38	BILLABLE SUPPLIES	M	C'VILLE OUT	91.01		1,832		38
39	BILLABLE SUPPLIES	M	NUTRITION COUNSELING	91.03		11		39
40			GIFT, FLOWER, COFFEE SHOP & C	190		14,368		40
41	BILLABLE SUPPLIES	M	HUNTLEY OP	91.04		38		41
42	BILLABLE SUPPLIES	M	COMMUNITY WELLNESS	194.02		1,952		42
500	TOTAL RECLASSIFICATIONS					4,446,671		500
	CODE LETTER - M							
1	RECLASS OP PROCEDURE COSTS	N	ADULTS & PEDIATRICS	30	417,630	34,555		1
500	TOTAL RECLASSIFICATIONS				417,630	34,555		500
	CODE LETTER - N							
	GRAND TOTAL (DECREASES)				1,167,310	15,813,971		

(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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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	2,549,055					2,549,055		1
2	LAND IMPROVEMENTS	5,939,365	211,149		211,149	3,084	6,147,430	1,416,425	2
3	BUILDINGS AND FIXTURES	152,038,028	45,815		45,815	1,227,455	150,856,388	17,533,810	3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	1,450,447				4,829	1,445,618	1,421,051	5
6	MOVABLE EQUIPMENT	65,652,624	1,282,697		1,282,697	1,375,137	65,560,184	34,997,699	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	227,629,519	1,539,661		1,539,661	2,610,505	226,558,675	55,368,985	8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	227,629,519	1,539,661		1,539,661	2,610,505	226,558,675	55,368,985	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	6,266,175						6,266,175	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)	6,266,175						6,266,175	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	157,003,818		157,003,818	0.705432					1
2	CAP REL COSTS-MVBLE EQU	65,560,184		65,560,184	0.294568					2
3	TOTAL (sum of lines 1-2)	222,564,002		222,564,002	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	7,387,786		1,866,270				9,254,056	1
2	CAP REL COSTS-MVBLE EQUIP	4,025,421						4,025,421	2
3	TOTAL (sum of lines 1-2)	11,413,207		1,866,270				13,279,477	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.)

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-2,679	PURCH, RCVING, STORING	5.02		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)	A	-21,956	COMMUNICATIONS	5.01		7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,478,663				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-4,369,149				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-544,716	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-10,855	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-4,913	CAFETERIA	11		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	INTEREST INCOME	B	-814,870	CAP REL COSTS-BLDG & FIXT	1	11	33
34							34
34.01	MISC REVENUE	B	-1,481	EMPLOYEE BENEFITS DEPARTMENT	4		34.01
34.02	MISC REVENUE	B	-44,277	OTHER ADMIN AND GENERAL	5.05		34.02
34.03	MISC REVENUE	B	-3,085	NURSING ADMINISTRATION	13		34.03
34.05	MISC REVENUE	B	7	RADIOLOGY-THERAPEUTIC	55		34.05
34.06	MISC REVENUE	B	-216	CASHIERING	5.04		34.06
34.07	MISC REVENUE	B	-699	CAFETERIA	11		34.07
34.08	MISC REVENUE	B	-2,200	PHARMACY	15		34.08
34.10	MISC REVENUE	B	-5,823	NUTRITION COUNSELING	91.03		34.10
35	SISTERS MEALS	A	-26,217	CAFETERIA	11		35
35.10	PHP TRANSPORTATION/FOOD	B	-4,784	PSYCH	76.02		35.10
36	EMS	B	-90,020	PARAMED ED PRGM-(SPECIFY)	23		36
37	MISC REVENUE	B	-19,634	EMERGENCY	91		37
38	EMPLOYEE ASSISTANCE PROGRAM	B	-132,067	EMPLOYEE BENEFITS DEPARTMENT	4		38
39	PSYCH EDUCATION	B	-33,581	ADULTS & PEDIATRICS	30		39
40	RENT	B	-7,220	HUNTLEY OP	91.04		40
41	RENT	B	-83,612	C'VILLE OUT	91.01		41
42	MISC REVENUE	B	-8,104	RADIOLOGY-DIAGNOSTIC	54		42
43	MISC REVENUE	B	-33,350	OTHER ADMIN AND GENERAL	5.05		43
44	LOBBYING EXPENSE	A	-35,288	OTHER ADMIN AND GENERAL	5.05		44
45	OFFSET BILL TO OTHER MINISTRIES	A	-9,597	OTHER ADMIN AND GENERAL	5.05		45
46	FAS 87 REV NEGATIVE EXP	A	18,585	EMPLOYEE BENEFITS DEPARTMENT	4		46
47	ADD BACK DEPRECIATION ON IMPAIR	A	2,965,205	CAP REL COSTS-BLDG & FIXT	1	9	47
48	ADD BACK DEPRECIATION ON IMPAIR	A	2,004,796	CAP REL COSTS-MVBLE EQUIP	2	9	48
49	PENSION 3 YEAR AVE AND 10 YR PREFU	A	1,364,945	EMPLOYEE BENEFITS DEPARTMENT	4		49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,435,518				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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	

(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.

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	1	CAP REL COSTS-BLDG & FIXT	CAPITAL	2,221,411	2,216,314	5,097	9	1
2	4	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	2,445,675	686,407	1,759,268		2
3	5.02	PURCH, RCVING, STORING	PURCHASING	552	552			3
3.01	5.05	OTHER ADMIN AND GENERAL	A&G	10,467,998	14,326,608	-3,858,610		3.01
3.02	10	DIETARY	DIETARY	499,190	499,190			3.02
3.03	14	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLIES	1,444	1,444			3.03
3.04	16	MEDICAL RECORDS & LIBRARY	HIM	20,771	20,771			3.04
3.05	60	LABORATORY	ALVERNO	4,689,325	4,584,161	105,164		3.05
3.06	113	INTEREST EXPENSE	INTEREST	2,675,427	5,055,495	-2,380,068		3.06
4			ADMINISTRATIVE & GENERAL					4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			23,021,793	27,390,942	-4,369,149		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	PRESENCE HEALTH PRV		PRESENCE HEALTH PRV		HOME OFFICE	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:

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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	5.05	OTHER ADMIN AND GENE OTHER ADMIN AND	743,327	660,514	82,813	177,200	658	56,057	2,803	1
2	13	NURSING ADMINISTRATI NURSING ADMINIS								2
3	16	MEDICAL RECORDS & LI MEDICAL RECORDS								3
4	30	ADULTS & PEDIATRICS ADULTS & PEDIAT	103,104	49,104	54,000	154,100	360	26,671	1,334	4
5	31	INTENSIVE CARE UNIT INTENSIVE CARE	462,738	450,000	12,738	177,200	65	5,538	277	5
6	41	SUBPROVIDER - IRF SUBPROVIDER - I	86,659	3,619	83,040	177,700	1,038	88,679	4,434	6
7	53	ANESTHESIOLOGY ANESTHESIOLOGY	600,000	600,000						7
8	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN	67,020	6,257	60,763	225,300	489	52,967	2,648	8
9	55	RADIOLOGY-THERAPEUTI RADIOLOGY-THERA	197,543	146,187	51,356	177,200	278	23,683	1,184	9
10	58	MRI MAGNETIC RESONA								10
11	59	CARDIAC CATHETERIZAT CARDIAC CATHETE	888		888	177,200	6	511	26	11
12	60	LABORATORY LABORATORY	45,999		45,999	215,700	253	26,237	1,312	12
13	69	ELECTROCARDIOLOGY ELECTROCARDIOLO	5,713	2,625	3,088	177,200	22	1,874	94	13
14	76.03	OCCUPATIONAL HEALTH OCCUPATIONAL HE	288,371	288,371						14
15	76.98	HYPERBARIC OXYGEN TH HYPERBARIC OXYG	2,713		2,713	177,200	21	1,789	89	15
16	91	EMERGENCY EMERGENCY	1,173,335	1,140,935	32,400	177,200	240	20,446	1,022	16
17	57	CT SCAN CT SCAN	66	66						17
200		TOTAL	3,777,476	3,347,678	429,798		3,430	304,452	15,223	200

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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	5.05	OTHER ADMIN AND GENE OTHER ADMIN AND					56,057	26,756	687,270	1
2	13	NURSING ADMINISTRATI NURSING ADMINIS								2
3	16	MEDICAL RECORDS & LI MEDICAL RECORDS								3
4	30	ADULTS & PEDIATRICS ADULTS & PEDIAT					26,671	27,329	76,433	4
5	31	INTENSIVE CARE UNIT INTENSIVE CARE					5,538	7,200	457,200	5
6	41	SUBPROVIDER - IRF SUBPROVIDER - I					88,679		3,619	6
7	53	ANESTHESIOLOGY ANESTHESIOLOGY							600,000	7
8	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN					52,967	7,796	14,053	8
9	55	RADIOLOGY-THERAPEUTI RADIOLOGY-THERA					23,683	27,673	173,860	9
10	58	MRI MAGNETIC RESONA								10
11	59	CARDIAC CATHETERIZAT CARDIAC CATHETE					511	377	377	11
12	60	LABORATORY LABORATORY					26,237	19,762	19,762	12
13	69	ELECTROCARDIOLOGY ELECTROCARDIOLO					1,874	1,214	3,839	13
14	76.03	OCCUPATIONAL HEALTH OCCUPATIONAL HE							288,371	14
15	76.98	HYPERBARIC OXYGEN TH HYPERBARIC OXYG					1,789	924	924	15
16	91	EMERGENCY EMERGENCY					20,446	11,954	1,152,889	16
17	57	CT SCAN CT SCAN							66	17
200		TOTAL					304,452	130,985	3,478,663	200

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	PURCH, RCVING, STORING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	9,254,056	9,254,056					1
2	CAP REL COSTS-MVBLE EQUIP	4,025,421		4,025,421				2
4	EMPLOYEE BENEFITS DEPARTMENT	14,615,519	54,637	6,258	14,676,414			4
5.01	COMMUNICATIONS	331,460	41,817	113,277	47,237	533,791		5.01
5.02	PURCH, RCVING, STORING	187,218	336,743	6,692	154	8,340	539,147	5.02
5.03	ADMITTING	972,586	109,159	2,114	291,341	14,828	629	5.03
5.04	CASHIERING	1,030,732		4,867	40,326	19,461	870	5.04
5.05	OTHER ADMIN AND GENERAL	25,346,795	929,789	374,929	778,761	83,408	885	5.05
6	MAINTENANCE & REPAIRS	2,885,188	776,652	71,387	160,761	927	6,939	6
7	OPERATION OF PLANT	3,194,650	230,450	27,764	244,971	18,534	3,280	7
8	LAUNDRY & LINEN SERVICE	397,637	57,240			927	2,425	8
9	HOUSEKEEPING	1,152,891	50,920	9,720	317,913	1,853	4,750	9
10	DIETARY	885,641	456,888	134,407	132,622	12,047	39,473	10
11	CAFETERIA	846,580			210,626	1,853		11
13	NURSING ADMINISTRATION	2,997,469	38,313	155,511	781,981	19,461	1,979	13
14	CENTRAL SERVICES & SUPPLY	602,831	148,323	131,136	94,921	4,634	1,583	14
15	PHARMACY	9,663,290	129,216	5,766	607,431	6,487	795	15
16	MEDICAL RECORDS & LIBRARY	3,077,208	87,268	34,423	420,975	18,534	1,281	16
23	PARAMED ED PRGM-(SPECIFY)	237,672	40,932	2,653	103,994	4,634	599	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	8,587,565	2,386,325	200,220	2,554,235	78,771	7,085	30
31	INTENSIVE CARE UNIT	2,171,185	251,407	112,872	627,915	6,487	821	31
41	SUBPROVIDER - IRF	5,118,591	480,760	86,034	1,213,020	12,047	4,304	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,230,951	294,321	808,525	674,437	28,728	5,339	50
51	RECOVERY ROOM	2,035,985	135,355	8,813	614,803	5,560	604	51
53	ANESTHESIOLOGY	126,884	10,233	11,920	31,637	2,780	67	53
54	RADIOLOGY-DIAGNOSTIC	2,479,001	344,766	403,715	666,468	32,435	1,031	54
54.01	VASCULAR LAB	399,574	13,426	81,674	120,275	927	436	54.01
55	RADIOLOGY-THERAPEUTIC	1,904,548	425,697	578,505	410,077	28,728	4,746	55
57	CT SCAN	481,954		2,131	141,956		290	57
58	MRI	205,324	25,869	432	60,882		17	58
59	CARDIAC CATHETERIZATION	1,108,596	101,512	172,563	315,172			59
60	LABORATORY	5,137,103	238,014	31,650	25,702	18,534	843	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	647,348	2,178			927	25,849	62
65	RESPIRATORY THERAPY	1,030,905	10,233	67,952	288,185	6,487	3,433	65
66	PHYSICAL THERAPY	2,217,214	104,427	15,741	677,826	8,340	290	66
67	OCCUPATIONAL THERAPY	992,263	176,664	239	260,731	927	77	67
68	SPEECH PATHOLOGY	431,916	1,474	275	133,422	927	41	68
69	ELECTROCARDIOLOGY	796,068	139,563	183,185	229,670	6,487	175	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,446,671					177,560	71
72	IMPL. DEV. CHARGED TO PATIENTS	5,840,649					233,220	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	376,607	29,308					74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH	359,699	92,098		103,710	15,754		76.02
76.03	OCCUPATIONAL HEALTH	474,261	45,681	2,331	109,252		330	76.03
76.97	CARDIAC REHABILITATION	92,009		21,452	27,191		151	76.97
76.98	HYPERBARIC OXYGEN THERAPY	356,601	29,635	1,409			530	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES	452,185			129,772			90.01
91	EMERGENCY	3,342,952	327,460	108,182	741,035	29,655	5,871	91
91.01	C'VILLE OUT	180,600		7,158	31,100	927	106	91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING	370,055	41,817	209	114,450		46	91.03
91.04	HUNTLEY OP	95,153		9,493	9,434		5	91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	137,195,261	9,196,570	3,997,584	14,546,371	501,356	538,755	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,146	31,289		5,179	1,853	43	190
194	OTHER NONREIMBURSABLE COST CENTER	277,918		27,111	23,071			194
194.01	MOB	12,061			3,748	26,875		194.01
194.02	COMMUNITY WELLNESS	107,100			32,895		28	194.02
194.03	FUND DEVELOPMENT	276,236	26,197	726	65,150	3,707	321	194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	137,938,722	9,254,056	4,025,421	14,676,414	533,791	539,147	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	ADMITTING	CASHIERING	SUBTOTAL (cols.0-4)	OTHER ADMIN AND GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
		5.03	5.04	4A	5.05	6	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING	1,390,657						5.03
5.04	CASHIERING		1,096,256					5.04
5.05	OTHER ADMIN AND GENERAL			27,514,567	27,514,567			5.05
6	MAINTENANCE & REPAIRS			3,901,854	972,233	4,874,087		6
7	OPERATION OF PLANT			3,719,649	926,832	160,341	4,806,822	7
8	LAUNDRY & LINEN SERVICE			458,229	114,178	39,826	40,613	8
9	HOUSEKEEPING			1,538,047	383,238	35,429	36,128	9
10	DIETARY			1,661,078	413,894	317,891	324,168	10
11	CAFETERIA			1,059,059	263,888			11
13	NURSING ADMINISTRATION			3,994,714	995,371	26,657	27,183	13
14	CENTRAL SERVICES & SUPPLY			983,428	245,043	103,199	105,237	14
15	PHARMACY			10,412,985	2,594,624	89,905	91,680	15
16	MEDICAL RECORDS & LIBRARY			3,639,689	906,909	60,719	61,918	16
23	PARAMED ED PRGM-(SPECIFY)			390,484	97,298	28,480	29,042	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	158,337	124,792	14,097,330	3,512,617	1,660,348	1,693,132	30
31	INTENSIVE CARE UNIT	37,369	29,452	3,237,508	806,696	174,923	178,377	31
41	SUBPROVIDER - IRF	69,416	54,709	7,038,881	1,753,892	334,501	341,106	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	165,639	130,770	5,338,710	1,330,257	204,781	208,825	50
51	RECOVERY ROOM	63,694	50,200	2,915,014	726,340	94,177	96,037	51
53	ANESTHESIOLOGY	27,253	21,479	232,253	57,871	7,120	7,261	53
54	RADIOLOGY-DIAGNOSTIC	54,249	42,756	4,024,421	1,002,773	239,880	244,616	54
54.01	VASCULAR LAB	20,582	16,221	653,115	162,738	9,341	9,526	54.01
55	RADIOLOGY-THERAPEUTIC	50,517	39,815	3,442,633	857,808	296,190	302,038	55
57	CT SCAN	99,381	78,326	804,038	200,344			57
58	MRI	24,804	19,549	336,877	83,940	17,999	18,355	58
59	CARDIAC CATHETERIZATION	51,554	40,632	1,790,029	446,025	70,630	72,024	59
60	LABORATORY	124,970	98,494	5,675,310	1,414,128	165,604	168,874	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,179	2,506	681,987	169,932	1,515	1,545	62
65	RESPIRATORY THERAPY	24,442	19,264	1,450,901	361,524	7,120	7,261	65
66	PHYSICAL THERAPY	26,680	21,027	3,071,545	765,343	72,658	74,092	66
67	OCCUPATIONAL THERAPY	13,998	11,032	1,455,931	362,777	122,919	125,346	67
68	SPEECH PATHOLOGY	6,750	5,320	580,125	144,551	1,025	1,046	68
69	ELECTROCARDIOLOGY	29,945	23,601	1,408,694	351,007	97,105	99,022	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,730	44,711	4,725,672	1,177,505			71
72	IMPL. DEV. CHARGED TO PATIENTS	44,798	35,307	6,153,974	1,533,398			72
73	DRUGS CHARGED TO PATIENTS	95,447	75,226	170,673	42,527			73
74	RENAL DIALYSIS	5,503	4,337	415,755	103,595	20,392	20,794	74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH	13,787	10,866	595,914	148,485	64,080	65,345	76.02
76.03	OCCUPATIONAL HEALTH	1,746	1,376	634,977	158,218	31,783	32,411	76.03
76.97	CARDIAC REHABILITATION	969	763	142,535	35,516			76.97
76.98	HYPERBARIC OXYGEN THERAPY	8,825	6,956	403,956	100,655	20,619	21,027	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES	8,047	6,342	596,346	148,593			90.01
91	EMERGENCY	100,694	79,361	4,735,210	1,179,882	227,838	232,337	91
91.01	C'VILLE OUT	758	598	221,247	55,129			91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING	468	369	527,414	131,417	29,095	29,669	91.03
91.04	HUNTLEY OP	126	99	114,310	28,483			91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,390,657	1,096,256	136,947,068	27,267,474	4,834,090	4,766,035	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			108,510	27,038	21,770	22,200	190
194	OTHER NONREIMBURSABLE COST CENTER			328,100	81,753			194
194.01	MOB			42,684	10,636			194.01
194.02	COMMUNITY WELLNESS			140,023	34,890			194.02
194.03	FUND DEVELOPMENT			372,337	92,776	18,227	18,587	194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,390,657	1,096,256	137,938,722	27,514,567	4,874,087	4,806,822	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		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
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING							5.04
5.05	OTHER ADMIN AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	652,846						8
9	HOUSEKEEPING		1,992,842					9
10	DIETARY		54,255	2,771,286				10
11	CAFETERIA		22,757		1,345,704			11
13	NURSING ADMINISTRATION		8,705		62,996	5,115,626		13
14	CENTRAL SERVICES & SUPPLY	3,122	13,835		17,359	92,704	1,563,927	14
15	PHARMACY		6,610		47,643	254,435		15
16	MEDICAL RECORDS & LIBRARY		11,306		51,006	74,267		16
23	PARAMED ED PRGM-(SPECIFY)				18,473	98,657		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	269,096	813,428	1,238,947	309,081	1,650,653	53	30
31	INTENSIVE CARE UNIT	32,839	89,221	57,062	58,077	310,161	20	31
41	SUBPROVIDER - IRF	47,313	104,898	696,150	152,588	814,899		41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	58,946	259,210		67,771	361,929	11,362	50
51	RECOVERY ROOM	49,221	33,846	4,459	61,452	328,183		51
53	ANESTHESIOLOGY		12,209		4,108	21,939	6	53
54	RADIOLOGY-DIAGNOSTIC	30,956	158,647		74,773	99,831		54
54.01	VASCULAR LAB	8,364	4,949		10,250	13,686		54.01
55	RADIOLOGY-THERAPEUTIC	2,340	57,253	26,547	39,416	52,626	36	55
57	CT SCAN	5,326			14,113	18,846	667	57
58	MRI	3,179			5,329	7,114		58
59	CARDIAC CATHETERIZATION	7,334			26,878	35,888	125	59
60	LABORATORY		38,686		2,178	2,906		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		1,662				91,173	62
65	RESPIRATORY THERAPY		9,753		32,173	42,955	11,409	65
66	PHYSICAL THERAPY	5,787	14,882		69,365	92,611		66
67	OCCUPATIONAL THERAPY		16,291		25,152	33,582		67
68	SPEECH PATHOLOGY				11,774	15,723		68
69	ELECTROCARDIOLOGY	4,457	5,238		25,921	34,609		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						625,411	71
72	IMPL. DEV. CHARGED TO PATIENTS						821,475	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH		7,260	746,129	11,657	62,256		76.02
76.03	OCCUPATIONAL HEALTH	3,077			14,341			76.03
76.97	CARDIAC REHABILITATION				2,905	3,881	165	76.97
76.98	HYPERBARIC OXYGEN THERAPY	13,720					1,560	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES				15,712	83,909		90.01
91	EMERGENCY	107,026	214,925	1,992	83,061	443,585	446	91
91.01	C'VILLE OUT							91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING				11,945	63,791		91.03
91.04	HUNTLEY OP							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	652,103	1,959,826	2,771,286	1,327,497	5,115,626	1,563,908	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		4,696		1,563		19	190
194	OTHER NONREIMBURSABLE COST CENTER				5,825			194
194.01	MOB		28,320		734			194.01
194.02	COMMUNITY WELLNESS	743			3,705			194.02
194.03	FUND DEVELOPMENT				6,380			194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	652,846	1,992,842	2,771,286	1,345,704	5,115,626	1,563,927	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING							5.04
5.05	OTHER ADMIN AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	13,497,882						15
16	MEDICAL RECORDS & LIBRARY		4,805,814					16
23	PARAMED ED PRGM-(SPECIFY)	1,049		663,483				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	120,777	2,022,649	55,872	27,443,983		27,443,983	30
31	INTENSIVE CARE UNIT	49,884	231,577	29,682	5,256,027		5,256,027	31
41	SUBPROVIDER - IRF	15,599	620,456		11,920,283		11,920,283	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	161,491	767,413		8,770,695		8,770,695	50
51	RECOVERY ROOM	42,903			4,351,632		4,351,632	51
53	ANESTHESIOLOGY	7,329		59,364	409,460		409,460	53
54	RADIOLOGY-DIAGNOSTIC	2,217			5,878,114		5,878,114	54
54.01	VASCULAR LAB	347			872,316		872,316	54.01
55	RADIOLOGY-THERAPEUTIC	39,930			5,116,817		5,116,817	55
57	CT SCAN	12,812			1,056,146		1,056,146	57
58	MRI	1,822			474,615		474,615	58
59	CARDIAC CATHETERIZATION	9,733		29,682	2,488,348		2,488,348	59
60	LABORATORY	373			7,468,059		7,468,059	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS				947,814		947,814	62
65	RESPIRATORY THERAPY	23		29,682	1,952,801		1,952,801	65
66	PHYSICAL THERAPY				4,166,283		4,166,283	66
67	OCCUPATIONAL THERAPY				2,141,998		2,141,998	67
68	SPEECH PATHOLOGY				754,244		754,244	68
69	ELECTROCARDIOLOGY	4,445			2,030,498		2,030,498	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				6,528,588		6,528,588	71
72	IMPL. DEV. CHARGED TO PATIENTS				8,508,847		8,508,847	72
73	DRUGS CHARGED TO PATIENTS	12,849,623			13,062,823		13,062,823	73
74	RENAL DIALYSIS				560,536		560,536	74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH				1,701,126		1,701,126	76.02
76.03	OCCUPATIONAL HEALTH	177			874,984		874,984	76.03
76.97	CARDIAC REHABILITATION				185,002		185,002	76.97
76.98	HYPERBARIC OXYGEN THERAPY	335			561,872		561,872	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES				844,560		844,560	90.01
91	EMERGENCY	177,013	1,163,719	459,201	9,026,235		9,026,235	91
91.01	C'VILLE OUT				276,376		276,376	91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING				793,331		793,331	91.03
91.04	HUNTLEY OP				142,793		142,793	91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	13,497,882	4,805,814	663,483	136,567,206		136,567,206	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				185,796		185,796	190
194	OTHER NONREIMBURSABLE COST CENTER				415,678		415,678	194
194.01	MOB				82,374		82,374	194.01
194.02	COMMUNITY WELLNESS				179,361		179,361	194.02
194.03	FUND DEVELOPMENT				508,307		508,307	194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	13,497,882	4,805,814	663,483	137,938,722		137,938,722	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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	COMMUNICATIONS	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT	70	54,637	6,258	60,965	60,965		4
5.01	COMMUNICATIONS		41,817	113,277	155,094	196	155,290	5.01
5.02	PURCH, RCVING, STORING	387	336,743	6,692	343,822	1	2,426	5.02
5.03	ADMITTING		109,159	2,114	111,273	1,210	4,314	5.03
5.04	CASHIERING			4,867	4,867	168	5,662	5.04
5.05	OTHER ADMIN AND GENERAL	338,560	929,789	374,929	1,643,278	3,235	24,262	5.05
6	MAINTENANCE & REPAIRS		776,652	71,387	848,039	668	270	6
7	OPERATION OF PLANT	1,785	230,450	27,764	259,999	1,018	5,392	7
8	LAUNDRY & LINEN SERVICE		57,240		57,240		270	8
9	HOUSEKEEPING		50,920	9,720	60,640	1,321	539	9
10	DIETARY		456,888	134,407	591,295	551	3,505	10
11	CAFETERIA					875	539	11
13	NURSING ADMINISTRATION	20,795	38,313	155,511	214,619	3,249	5,662	13
14	CENTRAL SERVICES & SUPPLY	228,986	148,323	131,136	508,445	394	1,348	14
15	PHARMACY	287,232	129,216	5,766	422,214	2,524	1,887	15
16	MEDICAL RECORDS & LIBRARY		87,268	34,423	121,691	1,749	5,392	16
23	PARAMED ED PRGM-(SPECIFY)		40,932	2,653	43,585	432	1,348	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,155	2,386,325	200,220	2,587,700	10,601	22,916	30
31	INTENSIVE CARE UNIT		251,407	112,872	364,279	2,609	1,887	31
41	SUBPROVIDER - IRF	3,120	480,760	86,034	569,914	5,040	3,505	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	280,506	294,321	808,525	1,383,352	2,802	8,358	50
51	RECOVERY ROOM		135,355	8,813	144,168	2,554	1,618	51
53	ANESTHESIOLOGY		10,233	11,920	22,153	131	809	53
54	RADIOLOGY-DIAGNOSTIC	38,182	344,766	403,715	786,663	2,769	9,436	54
54.01	VASCULAR LAB		13,426	81,674	95,100	500	270	54.01
55	RADIOLOGY-THERAPEUTIC		425,697	578,505	1,004,202	1,704	8,358	55
57	CT SCAN	7,264		2,131	9,395	590		57
58	MRI		25,869	432	26,301	253		58
59	CARDIAC CATHETERIZATION	51,443	101,512	172,563	325,518	1,309		59
60	LABORATORY		238,014	31,650	269,664	107	5,392	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		2,178		2,178		270	62
65	RESPIRATORY THERAPY	10,400	10,233	67,952	88,585	1,197	1,887	65
66	PHYSICAL THERAPY		104,427	15,741	120,168	2,816	2,426	66
67	OCCUPATIONAL THERAPY		176,664	239	176,903	1,083	270	67
68	SPEECH PATHOLOGY		1,474	275	1,749	554	270	68
69	ELECTROCARDIOLOGY		139,563	183,185	322,748	954	1,887	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		29,308		29,308			74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH		92,098		92,098	431	4,583	76.02
76.03	OCCUPATIONAL HEALTH		45,681	2,331	48,012	454		76.03
76.97	CARDIAC REHABILITATION			21,452	21,452	113		76.97
76.98	HYPERBARIC OXYGEN THERAPY		29,635	1,409	31,044			76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES					539		90.01
91	EMERGENCY	14,760	327,460	108,182	450,402	3,079	8,627	91
91.01	C'VILLE OUT			7,158	7,158	129	270	91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING		41,817	209	42,026	475		91.03
91.04	HUNTLEY OP	30,316		9,493	39,809	39		91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,314,961	9,196,570	3,997,584	14,509,115	60,423	145,855	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		31,289		31,289	22	539	190
194	OTHER NONREIMBURSABLE COST CENTER	88,595		27,111	115,706	96		194
194.01	MOB					16	7,818	194.01
194.02	COMMUNITY WELLNESS					137		194.02
194.03	FUND DEVELOPMENT		26,197	726	26,923	271	1,078	194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,403,556	9,254,056	4,025,421	14,683,033	60,965	155,290	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PURCH, RCVING, STORING	ADMITTING	CASHIERING	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	6	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING	346,249						5.02
5.03	ADMITTING	404	117,201					5.03
5.04	CASHIERING	559		11,256				5.04
5.05	OTHER ADMIN AND GENERAL	569			1,671,344			5.05
6	MAINTENANCE & REPAIRS	4,457			59,058	912,492		6
7	OPERATION OF PLANT	2,106			56,301	30,018	354,834	7
8	LAUNDRY & LINEN SERVICE	1,557			6,936	7,456	2,998	8
9	HOUSEKEEPING	3,051			23,280	6,633	2,667	9
10	DIETARY	25,350			25,142	59,513	23,930	10
11	CAFETERIA				16,030			11
13	NURSING ADMINISTRATION	1,271			60,464	4,991	2,007	13
14	CENTRAL SERVICES & SUPPLY	1,017			14,885	19,320	7,768	14
15	PHARMACY	511			157,611	16,831	6,768	15
16	MEDICAL RECORDS & LIBRARY	823			55,090	11,367	4,571	16
23	PARAMED ED PRGM-(SPECIFY)	385			5,910	5,332	2,144	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	4,550	13,327	1,287	213,340	310,837	124,984	30
31	INTENSIVE CARE UNIT	527	3,145	304	49,003	32,748	13,168	31
41	SUBPROVIDER - IRF	2,764	5,843	564	106,541	62,623	25,180	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,429	14,092	1,296	80,807	38,338	15,415	50
51	RECOVERY ROOM	388	5,361	518	44,122	17,631	7,089	51
53	ANESTHESIOLOGY	43	2,294	222	3,515	1,333	536	53
54	RADIOLOGY-DIAGNOSTIC	662	4,566	441	60,914	44,909	18,057	54
54.01	VASCULAR LAB	280	1,732	167	9,886	1,749	703	54.01
55	RADIOLOGY-THERAPEUTIC	3,048	4,252	411	52,108	55,451	22,296	55
57	CT SCAN	186	8,365	808	12,170			57
58	MRI	11	2,088	202	5,099	3,370	1,355	58
59	CARDIAC CATHETERIZATION		4,339	419	27,094	13,223	5,317	59
60	LABORATORY	541	10,519	1,016	85,901	31,003	12,466	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	16,601	268	26	10,323	284	114	62
65	RESPIRATORY THERAPY	2,205	2,057	199	21,961	1,333	536	65
66	PHYSICAL THERAPY	186	2,246	217	46,491	13,602	5,469	66
67	OCCUPATIONAL THERAPY	49	1,178	114	22,037	23,012	9,253	67
68	SPEECH PATHOLOGY	26	568	55	8,781	192	77	68
69	ELECTROCARDIOLOGY	112	2,520	243	21,322	18,179	7,310	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,030	4,775	461	71,528			71
72	IMPL. DEV. CHARGED TO PATIENTS	149,780	3,771	364	93,147			72
73	DRUGS CHARGED TO PATIENTS		8,034	776	2,583			73
74	RENAL DIALYSIS		463	45	6,293	3,818	1,535	74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH		1,160	112	9,020	11,997	4,824	76.02
76.03	OCCUPATIONAL HEALTH	212	147	14	9,611	5,950	2,393	76.03
76.97	CARDIAC REHABILITATION	97	82	8	2,157			76.97
76.98	HYPERBARIC OXYGEN THERAPY	340	743	72	6,114	3,860	1,552	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES		677	65	9,026			90.01
91	EMERGENCY	3,770	8,475	819	71,672	42,654	17,151	91
91.01	C'VILLE OUT	68	64	6	3,349			91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING	30	39	4	7,983	5,447	2,190	91.03
91.04	HUNTLEY OP	3	11	1	1,730			91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	345,998	117,201	11,256	1,656,335	905,004	351,823	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27			1,642	4,076	1,639	190
194	OTHER NONREIMBURSABLE COST CENTER				4,966			194
194.01	MOB				646			194.01
194.02	COMMUNITY WELLNESS	18			2,119			194.02
194.03	FUND DEVELOPMENT	206			5,636	3,412	1,372	194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	346,249	117,201	11,256	1,671,344	912,492	354,834	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		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
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING							5.04
5.05	OTHER ADMIN AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	76,457						8
9	HOUSEKEEPING		98,131					9
10	DIETARY		2,672	731,958				10
11	CAFETERIA		1,121		18,565			11
13	NURSING ADMINISTRATION		429		869	293,561		13
14	CENTRAL SERVICES & SUPPLY	366	681		239	5,320	559,783	14
15	PHARMACY		326		657	14,601		15
16	MEDICAL RECORDS & LIBRARY		557		704	4,262		16
23	PARAMED ED PRGM-(SPECIFY)				255	5,661		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	31,515	40,053	327,233	4,262	94,724	19	30
31	INTENSIVE CARE UNIT	3,846	4,393	15,071	801	17,799	7	31
41	SUBPROVIDER - IRF	5,541	5,165	183,869	2,105	46,763		41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,903	12,764		935	20,769	4,067	50
51	RECOVERY ROOM	5,764	1,667	1,178	848	18,833		51
53	ANESTHESIOLOGY		601		57	1,259	2	53
54	RADIOLOGY-DIAGNOSTIC	3,625	7,812		1,032	5,729		54
54.01	VASCULAR LAB	980	244		141	785		54.01
55	RADIOLOGY-THERAPEUTIC	274	2,819	7,012	544	3,020	13	55
57	CT SCAN	624			195	1,081	239	57
58	MRI	372			74	408		58
59	CARDIAC CATHETERIZATION	859			371	2,059	45	59
60	LABORATORY		1,905		30	167		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		82				32,634	62
65	RESPIRATORY THERAPY		480		444	2,465	4,084	65
66	PHYSICAL THERAPY	678	733		957	5,314		66
67	OCCUPATIONAL THERAPY		802		347	1,927		67
68	SPEECH PATHOLOGY				162	902		68
69	ELECTROCARDIOLOGY	522	258		358	1,986		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						223,859	71
72	IMPL. DEV. CHARGED TO PATIENTS						294,030	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH		358	197,069	161	3,573		76.02
76.03	OCCUPATIONAL HEALTH	360			198			76.03
76.97	CARDIAC REHABILITATION				40	223	59	76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,607					558	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES				217	4,815		90.01
91	EMERGENCY	12,534	10,583	526	1,146	25,455	160	91
91.01	C'VILLE OUT							91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING				165	3,661		91.03
91.04	HUNTLEY OP							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	76,370	96,505	731,958	18,314	293,561	559,776	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		231		22		7	190
194	OTHER NONREIMBURSABLE COST CENTER				80			194
194.01	MOB		1,395		10			194.01
194.02	COMMUNITY WELLNESS	87			51			194.02
194.03	FUND DEVELOPMENT				88			194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	76,457	98,131	731,958	18,565	293,561	559,783	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	23	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING							5.04
5.05	OTHER ADMIN AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	623,930						15
16	MEDICAL RECORDS & LIBRARY		206,206					16
23	PARAMED ED PRGM-(SPECIFY)	48		65,100				23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,583	86,788		3,879,719		3,879,719	30
31	INTENSIVE CARE UNIT	2,306	9,936		521,829		521,829	31
41	SUBPROVIDER - IRF	721	26,622		1,052,760		1,052,760	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	7,465	32,928		1,633,720		1,633,720	50
51	RECOVERY ROOM	1,983			253,722		253,722	51
53	ANESTHESIOLOGY	339			33,294		33,294	53
54	RADIOLOGY-DIAGNOSTIC	102			946,717		946,717	54
54.01	VASCULAR LAB	16			112,553		112,553	54.01
55	RADIOLOGY-THERAPEUTIC	1,846			1,167,358		1,167,358	55
57	CT SCAN	592			34,245		34,245	57
58	MRI	84			39,617		39,617	58
59	CARDIAC CATHETERIZATION	450			381,003		381,003	59
60	LABORATORY	17			418,728		418,728	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS				62,780		62,780	62
65	RESPIRATORY THERAPY	1			127,434		127,434	65
66	PHYSICAL THERAPY				201,303		201,303	66
67	OCCUPATIONAL THERAPY				236,975		236,975	67
68	SPEECH PATHOLOGY				13,336		13,336	68
69	ELECTROCARDIOLOGY	205			378,604		378,604	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				414,653		414,653	71
72	IMPL. DEV. CHARGED TO PATIENTS				541,092		541,092	72
73	DRUGS CHARGED TO PATIENTS	593,967			605,360		605,360	73
74	RENAL DIALYSIS				41,462		41,462	74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH				325,386		325,386	76.02
76.03	OCCUPATIONAL HEALTH	8			67,359		67,359	76.03
76.97	CARDIAC REHABILITATION				24,231		24,231	76.97
76.98	HYPERBARIC OXYGEN THERAPY	15			45,905		45,905	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES				15,339		15,339	90.01
91	EMERGENCY	8,182	49,932		715,167		715,167	91
91.01	C'VILLE OUT				11,044		11,044	91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING				62,020		62,020	91.03
91.04	HUNTLEY OP				41,593		41,593	91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	623,930	206,206		14,406,308		14,406,308	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				39,494		39,494	190
194	OTHER NONREIMBURSABLE COST CENTER				120,848		120,848	194
194.01	MOB				9,885		9,885	194.01
194.02	COMMUNITY WELLNESS				2,412		2,412	194.02
194.03	FUND DEVELOPMENT				38,986		38,986	194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS			65,100	65,100		65,100	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	623,930	206,206	65,100	14,683,033		14,683,033	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	COMMUNICATIONS NUMBER PHONES	PURCH, RCVING, STORING PURCH REQUIS $	ADMITTING GROSS CHARGES	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	565,203						1
2	CAP REL COSTS-MVBLE EQUIP		4,474,404					2
4	EMPLOYEE BENEFITS DEPARTMENT	3,337	6,956	47,231,310				4
5.01	COMMUNICATIONS	2,554	125,912	152,016	576			5.01
5.02	PURCH, RCVING, STORING	20,567	7,438	497	9	13,502,118		5.02
5.03	ADMITTING	6,667	2,350	937,587	16	15,763	665,101,272	5.03
5.04	CASHIERING		5,410	129,776	21	21,792		5.04
5.05	OTHER ADMIN AND GENERAL	56,788	416,747	2,506,191	90	22,172		5.05
6	MAINTENANCE & REPAIRS	47,435	79,349	517,357	1	173,785		6
7	OPERATION OF PLANT	14,075	30,861	788,360	20	82,136		7
8	LAUNDRY & LINEN SERVICE	3,496			1	60,728		8
9	HOUSEKEEPING	3,110	10,804	1,023,099	2	118,956		9
10	DIETARY	27,905	149,398	426,802	13	988,531		10
11	CAFETERIA			677,833	2			11
13	NURSING ADMINISTRATION	2,340	172,856	2,516,554	21	49,566		13
14	CENTRAL SERVICES & SUPPLY	9,059	145,762	305,473	5	39,640		14
15	PHARMACY	7,892	6,409	1,954,821	7	19,918		15
16	MEDICAL RECORDS & LIBRARY	5,330	38,262	1,354,773	20	32,091		16
23	PARAMED ED PRGM-(SPECIFY)	2,500	2,949	334,672	5	15,008		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	145,748	222,552	8,219,998	85	177,428	75,723,044	30
31	INTENSIVE CARE UNIT	15,355	125,461	2,020,742	7	20,561	17,871,331	31
41	SUBPROVIDER - IRF	29,363	95,630	3,903,712	13	107,797	33,197,416	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	17,976	898,707	2,170,458	31	133,711	79,249,387	50
51	RECOVERY ROOM	8,267	9,796	1,978,543	6	15,127	30,461,056	51
53	ANESTHESIOLOGY	625	13,249	101,812	3	1,689	13,033,298	53
54	RADIOLOGY-DIAGNOSTIC	21,057	448,744	2,144,811	35	25,812	25,943,932	54
54.01	VASCULAR LAB	820	90,784	387,065	1	10,921	9,842,959	54.01
55	RADIOLOGY-THERAPEUTIC	26,000	643,030	1,319,701	31	118,856	24,159,450	55
57	CT SCAN		2,369	456,839		7,266	47,527,853	57
58	MRI	1,580	480	195,930		435	11,862,458	58
59	CARDIAC CATHETERIZATION	6,200	191,810	1,014,278			24,655,082	59
60	LABORATORY	14,537	35,180	82,713	20	21,109	59,765,701	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	133			1	647,353	1,520,482	62
65	RESPIRATORY THERAPY	625	75,531	927,429	7	85,977	11,689,129	65
66	PHYSICAL THERAPY	6,378	17,497	2,181,362	9	7,261	12,759,354	66
67	OCCUPATIONAL THERAPY	10,790	266	839,079	1	1,921	6,694,397	67
68	SPEECH PATHOLOGY	90	306	429,377	1	1,028	3,227,976	68
69	ELECTROCARDIOLOGY	8,524	203,617	739,120	7	4,381	14,320,700	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					4,446,671	27,130,438	71
72	IMPL. DEV. CHARGED TO PATIENTS					5,840,649	21,424,078	72
73	DRUGS CHARGED TO PATIENTS						45,646,572	73
74	RENAL DIALYSIS	1,790					2,631,585	74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH	5,625		333,757	17		6,593,683	76.02
76.03	OCCUPATIONAL HEALTH	2,790	2,591	351,593		8,263	834,950	76.03
76.97	CARDIAC REHABILITATION		23,845	87,506		3,772	463,253	76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,810	1,566			13,271	4,220,696	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES			417,630			3,848,513	90.01
91	EMERGENCY	20,000	120,248	2,384,780	32	147,022	48,156,008	91
91.01	C'VILLE OUT		7,956	100,085	1	2,664	362,699	91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING	2,554	232	368,319		1,162	223,619	91.03
91.04	HUNTLEY OP		10,552	30,359		129	60,173	91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	561,692	4,443,462	46,812,809	541	13,492,322	665,101,272	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,911		16,667	2	1,072		190
194	OTHER NONREIMBURSABLE COST CENTER		30,135	74,247				194
194.01	MOB			12,061	29			194.01
194.02	COMMUNITY WELLNESS			105,861		694		194.02
194.03	FUND DEVELOPMENT	1,600	807	209,665	4	8,030		194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	9,254,056	4,025,421	14,676,414	533,791	539,147	1,390,657	202
203	UNIT COST MULT-WS B PT I	16.372977	0.899655	0.310735	926.720486	0.039931	0.002091	203
204	COST TO BE ALLOC PER B PT II			60,965	155,290	346,249	117,201	204
205	UNIT COST MULT-WS B PT II			0.001291	269.600694	0.025644	0.000176	205

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CASHIERING GROSS CHARGES	RECON-CILIATION	OTHER ADMIN AND GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5.04	5A.05	5.05	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING	665,101,272						5.04
5.05	OTHER ADMIN AND GENERAL		-27,514,567	110,424,155				5.05
6	MAINTENANCE & REPAIRS			3,901,854	427,855			6
7	OPERATION OF PLANT			3,719,649	14,075	413,780		7
8	LAUNDRY & LINEN SERVICE			458,229	3,496	3,496	836,346	8
9	HOUSEKEEPING			1,538,047	3,110	3,110		9
10	DIETARY			1,661,078	27,905	27,905		10
11	CAFETERIA			1,059,059				11
13	NURSING ADMINISTRATION			3,994,714	2,340	2,340		13
14	CENTRAL SERVICES & SUPPLY			983,428	9,059	9,059	3,999	14
15	PHARMACY			10,412,985	7,892	7,892		15
16	MEDICAL RECORDS & LIBRARY			3,639,689	5,330	5,330		16
23	PARAMED ED PRGM-(SPECIFY)			390,484	2,500	2,500		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	75,723,044		14,097,330	145,748	145,748	344,733	30
31	INTENSIVE CARE UNIT	17,871,331		3,237,508	15,355	15,355	42,069	31
41	SUBPROVIDER - IRF	33,197,416		7,038,881	29,363	29,363	60,612	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	79,249,387		5,338,710	17,976	17,976	75,515	50
51	RECOVERY ROOM	30,461,056		2,915,014	8,267	8,267	63,056	51
53	ANESTHESIOLOGY	13,033,298		232,253	625	625		53
54	RADIOLOGY-DIAGNOSTIC	25,943,932		4,024,421	21,057	21,057	39,657	54
54.01	VASCULAR LAB	9,842,959		653,115	820	820	10,715	54.01
55	RADIOLOGY-THERAPEUTIC	24,159,450		3,442,633	26,000	26,000	2,998	55
57	CT SCAN	47,527,853		804,038			6,823	57
58	MRI	11,862,458		336,877	1,580	1,580	4,072	58
59	CARDIAC CATHETERIZATION	24,655,082		1,790,029	6,200	6,200	9,395	59
60	LABORATORY	59,765,701		5,675,310	14,537	14,537		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,520,482		681,987	133	133		62
65	RESPIRATORY THERAPY	11,689,129		1,450,901	625	625		65
66	PHYSICAL THERAPY	12,759,354		3,071,545	6,378	6,378	7,413	66
67	OCCUPATIONAL THERAPY	6,694,397		1,455,931	10,790	10,790		67
68	SPEECH PATHOLOGY	3,227,976		580,125	90	90		68
69	ELECTROCARDIOLOGY	14,320,700		1,408,694	8,524	8,524	5,710	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,130,438		4,725,672				71
72	IMPL. DEV. CHARGED TO PATIENTS	21,424,078		6,153,974				72
73	DRUGS CHARGED TO PATIENTS	45,646,572		170,673				73
74	RENAL DIALYSIS	2,631,585		415,755	1,790	1,790		74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH	6,593,683		595,914	5,625	5,625		76.02
76.03	OCCUPATIONAL HEALTH	834,950		634,977	2,790	2,790	3,942	76.03
76.97	CARDIAC REHABILITATION	463,253		142,535				76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,220,696		403,956	1,810	1,810	17,577	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES	3,848,513		596,346				90.01
91	EMERGENCY	48,156,008		4,735,210	20,000	20,000	137,108	91
91.01	C'VILLE OUT	362,699		221,247				91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING	223,619		527,414	2,554	2,554		91.03
91.04	HUNTLEY OP	60,173		114,310				91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	665,101,272	-27,514,567	109,432,501	424,344	410,269	835,394	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			108,510	1,911	1,911		190
194	OTHER NONREIMBURSABLE COST CENTER			328,100				194
194.01	MOB			42,684				194.01
194.02	COMMUNITY WELLNESS			140,023			952	194.02
194.03	FUND DEVELOPMENT			372,337	1,600	1,600		194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,096,256		27,514,567	4,874,087	4,806,822	652,846	202
203	UNIT COST MULT-WS B PT I	0.001648		0.249172	11.391913	11.616854	0.780593	203
204	COST TO BE ALLOC PER B PT II	11,256		1,671,344	912,492	354,834	76,457	204
205	UNIT COST MULT-WS B PT II	0.000017		0.015136	2.132713	0.857543	0.091418	205

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA HOURS	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		9	10	11	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING							5.04
5.05	OTHER ADMIN AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	55,170						9
10	DIETARY	1,502	175,274					10
11	CAFETERIA	630		1,231,378				11
13	NURSING ADMINISTRATION	241		57,644	876,513			13
14	CENTRAL SERVICES & SUPPLY	383		15,884	15,884	11,119,480		14
15	PHARMACY	183		43,595	43,595		7,786,649	15
16	MEDICAL RECORDS & LIBRARY	313		46,673	12,725			16
23	PARAMED ED PRGM-(SPECIFY)			16,904	16,904		605	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	22,519	78,359	282,823	282,823	374	69,674	30
31	INTENSIVE CARE UNIT	2,470	3,609	53,143	53,143	143	28,777	31
41	SUBPROVIDER - IRF	2,904	44,029	139,625	139,625		8,999	41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	7,176		62,013	62,013	80,781	93,161	50
51	RECOVERY ROOM	937	282	56,231	56,231		24,750	51
53	ANESTHESIOLOGY	338		3,759	3,759	43	4,228	53
54	RADIOLOGY-DIAGNOSTIC	4,392		68,421	17,105		1,279	54
54.01	VASCULAR LAB	137		9,379	2,345		200	54.01
55	RADIOLOGY-THERAPEUTIC	1,585	1,679	36,067	9,017	259	23,035	55
57	CT SCAN			12,914	3,229	4,744	7,391	57
58	MRI			4,876	1,219		1,051	58
59	CARDIAC CATHETERIZATION			24,595	6,149	887	5,615	59
60	LABORATORY	1,071		1,993	498		215	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	46				648,237		62
65	RESPIRATORY THERAPY	270		29,440	7,360	81,119	13	65
66	PHYSICAL THERAPY	412		63,472	15,868			66
67	OCCUPATIONAL THERAPY	451		23,015	5,754			67
68	SPEECH PATHOLOGY			10,774	2,694			68
69	ELECTROCARDIOLOGY	145		23,719	5,930		2,564	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					4,446,671		71
72	IMPL. DEV. CHARGED TO PATIENTS					5,840,649		72
73	DRUGS CHARGED TO PATIENTS						7,412,682	73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH	201	47,190	10,667	10,667			76.02
76.03	OCCUPATIONAL HEALTH			13,123			102	76.03
76.97	CARDIAC REHABILITATION			2,658	665	1,176		76.97
76.98	HYPERBARIC OXYGEN THERAPY					11,089	193	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES			14,377	14,377			90.01
91	EMERGENCY	5,950	126	76,004	76,004	3,171	102,115	91
91.01	C'VILLE OUT							91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING			10,930	10,930			91.03
91.04	HUNTLEY OP							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	54,256	175,274	1,214,718	876,513	11,119,343	7,786,649	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	130		1,430		137		190
194	OTHER NONREIMBURSABLE COST CENTER			5,330				194
194.01	MOB	784		672				194.01
194.02	COMMUNITY WELLNESS			3,390				194.02
194.03	FUND DEVELOPMENT			5,838				194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,992,842	2,771,286	1,345,704	5,115,626	1,563,927	13,497,882	202
203	UNIT COST MULT-WS B PT I	36.121842	15.811164	1.092844	5.836338	0.140647	1.733465	203
204	COST TO BE ALLOC PER B PT II	98,131	731,958	18,565	293,561	559,783	623,930	204
205	UNIT COST MULT-WS B PT II	1.778702	4.176079	0.015077	0.334919	0.050343	0.080128	205

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	PARAMED EDUCATION ASSIGNED TIME					
		16	23					

	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING							5.04
5.05	OTHER ADMIN AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	18,117						16
23	PARAMED ED PRGM-(SPECIFY)		1,520					23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	7,625	128					30
31	INTENSIVE CARE UNIT	873	68					31
41	SUBPROVIDER - IRF	2,339						41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,893						50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY		136					53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	VASCULAR LAB							54.01
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION		68					59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
65	RESPIRATORY THERAPY		68					65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH							76.02
76.03	OCCUPATIONAL HEALTH							76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES							90.01
91	EMERGENCY	4,387	1,052					91
91.01	C'VILLE OUT							91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING							91.03
91.04	HUNTLEY OP							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	18,117	1,520					118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
194	OTHER NONREIMBURSABLE COST CENTER							194
194.01	MOB							194.01
194.02	COMMUNITY WELLNESS							194.02
194.03	FUND DEVELOPMENT							194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	4,805,814	663,483					202
203	UNIT COST MULT-WS B PT I	265.265441	436.501974					203

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	PARAMED EDUCATION ASSIGNED TIME					
		16	23					
204	COST TO BE ALLOC PER B PT II	206,206	65,100					204
205	UNIT COST MULT-WS B PT II	11.381906	42.828947					205

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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	27,443,983		27,443,983	27,329	27,471,312	30
31	INTENSIVE CARE UNIT	5,256,027		5,256,027	7,200	5,263,227	31
41	SUBPROVIDER - IRF	11,920,283		11,920,283		11,920,283	41
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,770,695		8,770,695		8,770,695	50
51	RECOVERY ROOM	4,351,632		4,351,632		4,351,632	51
53	ANESTHESIOLOGY	409,460		409,460		409,460	53
54	RADIOLOGY-DIAGNOSTIC	5,878,114		5,878,114	7,796	5,885,910	54
54.01	VASCULAR LAB	872,316		872,316		872,316	54.01
55	RADIOLOGY-THERAPEUTIC	5,116,817		5,116,817	27,673	5,144,490	55
57	CT SCAN	1,056,146		1,056,146		1,056,146	57
58	MRI	474,615		474,615		474,615	58
59	CARDIAC CATHETERIZATION	2,488,348		2,488,348	377	2,488,725	59
60	LABORATORY	7,468,059		7,468,059	19,762	7,487,821	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	947,814		947,814		947,814	62
65	RESPIRATORY THERAPY	1,952,801		1,952,801		1,952,801	65
66	PHYSICAL THERAPY	4,166,283		4,166,283		4,166,283	66
67	OCCUPATIONAL THERAPY	2,141,998		2,141,998		2,141,998	67
68	SPEECH PATHOLOGY	754,244		754,244		754,244	68
69	ELECTROCARDIOLOGY	2,030,498		2,030,498	1,214	2,031,712	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,528,588		6,528,588		6,528,588	71
72	IMPL. DEV. CHARGED TO PATIENTS	8,508,847		8,508,847		8,508,847	72
73	DRUGS CHARGED TO PATIENTS	13,062,823		13,062,823		13,062,823	73
74	RENAL DIALYSIS	560,536		560,536		560,536	74
76	OTHER ANCILLARY SERVICES COST CENTE						76
76.02	PSYCH	1,701,126		1,701,126		1,701,126	76.02
76.03	OCCUPATIONAL HEALTH	874,984		874,984		874,984	76.03
76.97	CARDIAC REHABILITATION	185,002		185,002		185,002	76.97
76.98	HYPERBARIC OXYGEN THERAPY	561,872		561,872	924	562,796	76.98
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PROCEDURES	844,560		844,560		844,560	90.01
91	EMERGENCY	9,026,235		9,026,235	11,954	9,038,189	91
91.01	C'VILLE OUT	276,376		276,376		276,376	91.01
91.02	LAKE HILL OUT						91.02
91.03	NUTRITION COUNSELING	793,331		793,331		793,331	91.03
91.04	HUNTLEY OP	142,793		142,793		142,793	91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,837,707		2,837,707		2,837,707	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	139,404,913		139,404,913	104,229	139,509,142	200
201	LESS OBSERVATION BEDS	2,837,707		2,837,707		2,837,707	201
202	TOTAL (SEE INSTRUCTIONS)	136,567,206		136,567,206		136,671,435	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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	65,616,872		65,616,872				30
31	INTENSIVE CARE UNIT	17,824,295		17,824,295				31
41	SUBPROVIDER - IRF	33,197,416		33,197,416				41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	39,891,626	39,357,761	79,249,387	0.110672	0.110672	0.110672	50
51	RECOVERY ROOM	13,274,178	17,186,878	30,461,056	0.142859	0.142859	0.142859	51
53	ANESTHESIOLOGY	6,862,619	6,170,680	13,033,299	0.031416	0.031416	0.031416	53
54	RADIOLOGY-DIAGNOSTIC	6,074,005	19,869,927	25,943,932	0.226570	0.226570	0.226870	54
54.01	VASCULAR LAB	2,490,277	7,352,682	9,842,959	0.088623	0.088623	0.088623	54.01
55	RADIOLOGY-THERAPEUTIC	809,719	23,349,731	24,159,450	0.211794	0.211794	0.212939	55
57	CT SCAN	11,751,641	35,776,212	47,527,853	0.022222	0.022222	0.022222	57
58	MRI	3,172,480	8,689,979	11,862,459	0.040010	0.040010	0.040010	58
59	CARDIAC CATHETERIZATION	13,338,879	11,316,203	24,655,082	0.100926	0.100926	0.100942	59
60	LABORATORY	31,292,451	28,473,250	59,765,701	0.124956	0.124956	0.125286	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,026,675	493,807	1,520,482	0.623364	0.623364	0.623364	62
65	RESPIRATORY THERAPY	10,794,984	894,145	11,689,129	0.167061	0.167061	0.167061	65
66	PHYSICAL THERAPY	8,988,103	3,771,251	12,759,354	0.326528	0.326528	0.326528	66
67	OCCUPATIONAL THERAPY	6,613,617	80,780	6,694,397	0.319969	0.319969	0.319969	67
68	SPEECH PATHOLOGY	3,213,290	14,686	3,227,976	0.233658	0.233658	0.233658	68
69	ELECTROCARDIOLOGY	6,094,450	8,226,250	14,320,700	0.141788	0.141788	0.141872	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,792,918	9,337,520	27,130,438	0.240637	0.240637	0.240637	71
72	IMPL. DEV. CHARGED TO PATIENTS	15,381,319	6,042,759	21,424,078	0.397163	0.397163	0.397163	72
73	DRUGS CHARGED TO PATIENTS	23,124,676	22,521,897	45,646,573	0.286173	0.286173	0.286173	73
74	RENAL DIALYSIS	2,598,694	32,891	2,631,585	0.213003	0.213003	0.213003	74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH	4,260,406	2,333,277	6,593,683	0.257993	0.257993	0.257993	76.02
76.03	OCCUPATIONAL HEALTH		834,950	834,950	1.047948	1.047948	1.047948	76.03
76.97	CARDIAC REHABILITATION		463,253	463,253	0.399354	0.399354	0.399354	76.97
76.98	HYPERBARIC OXYGEN THERAPY	29,870	4,190,825	4,220,695	0.133123	0.133123	0.133342	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES		3,848,513	3,848,513	0.219451	0.219451	0.219451	90.01
91	EMERGENCY	12,092,998	36,063,010	48,156,008	0.187437	0.187437	0.187686	91
91.01	C'VILLE OUT		362,699	362,699	0.761998	0.761998	0.761998	91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING	624	222,995	223,619	3.547690	3.547690	3.547690	91.03
91.04	HUNTLEY OP		60,173	60,173	2.373041	2.373041	2.373041	91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,137,005	7,015,906	10,152,911	0.279497	0.279497	0.279497	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	360,746,087	304,354,890	665,100,977				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	360,746,087	304,354,890	665,100,977				202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	3,879,719		3,879,719	27,203	142.62	12,180	1,737,112	30
31	INTENSIVE CARE UNIT	521,829		521,829	2,607	200.16	1,381	276,421	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	1,052,760		1,052,760	13,712	76.78	11,819	907,463	41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	5,454,308		5,454,308	43,522		25,380	2,920,996	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0217** **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	1,633,720	79,249,387	0.020615	18,726,826	386,054	50
51	RECOVERY ROOM	253,722	30,461,056	0.008329	6,649,888	55,387	51
53	ANESTHESIOLOGY	33,294	13,033,299	0.002555	3,139,123	8,020	53
54	RADIOLOGY-DIAGNOSTIC	946,717	25,943,932	0.036491	3,447,835	125,815	54
54.01	VASCULAR LAB	112,553	9,842,959	0.011435	1,346,421	15,396	54.01
55	RADIOLOGY-THERAPEUTIC	1,167,358	24,159,450	0.048319	674,762	32,604	55
57	CT SCAN	34,245	47,527,853	0.000721	6,154,399	4,437	57
58	MRI	39,617	11,862,459	0.003340	1,695,911	5,664	58
59	CARDIAC CATHETERIZATION	381,003	24,655,082	0.015453	7,185,183	111,033	59
60	LABORATORY	418,728	59,765,701	0.007006	15,961,452	111,826	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	62,780	1,520,482	0.041290	492,535	20,337	62
65	RESPIRATORY THERAPY	127,434	11,689,129	0.010902	5,305,689	57,843	65
66	PHYSICAL THERAPY	201,303	12,759,354	0.015777	1,496,377	23,608	66
67	OCCUPATIONAL THERAPY	236,975	6,694,397	0.035399	535,834	18,968	67
68	SPEECH PATHOLOGY	13,336	3,227,976	0.004131	392,193	1,620	68
69	ELECTROCARDIOLOGY	378,604	14,320,700	0.026438	3,569,293	94,365	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	414,653	27,130,438	0.015284	8,293,104	126,752	71
72	IMPL. DEV. CHARGED TO PATIENTS	541,092	21,424,078	0.025256	7,841,338	198,041	72
73	DRUGS CHARGED TO PATIENTS	605,360	45,646,573	0.013262	9,754,722	129,367	73
74	RENAL DIALYSIS	41,462	2,631,585	0.015756	1,356,746	21,377	74
76	OTHER ANCILLARY SERVICES COST CENTE						76
76.02	PSYCH	325,386	6,593,683	0.049348	821,194	40,524	76.02
76.03	OCCUPATIONAL HEALTH	67,359	834,950	0.080674			76.03
76.97	CARDIAC REHABILITATION	24,231	463,253	0.052306			76.97
76.98	HYPERBARIC OXYGEN THERAPY	45,905	4,220,695	0.010876	12,606	137	76.98
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PROCEDURES	15,339	3,848,513	0.003986			90.01
91	EMERGENCY	715,167	48,156,008	0.014851	5,868,321	87,150	91
91.01	C'VILLE OUT	11,044	362,699	0.030449			91.01
91.02	LAKE HILL OUT						91.02
91.03	NUTRITION COUNSELING	62,020	223,619	0.277347	624	173	91.03
91.04	HUNTLEY OP	41,593	60,173	0.691224			91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	400,764	10,152,911	0.039473	1,915,182	75,598	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	9,352,764	548,462,394		112,637,558	1,752,096	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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)		55,872			55,872	30
31	INTENSIVE CARE UNIT		29,682			29,682	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)		85,554			85,554	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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)	27,203	2.05	12,180	24,969	30
31	INTENSIVE CARE UNIT	2,607	11.39	1,381	15,730	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	13,712		11,819		41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	43,522		25,380	40,699	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0217** **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
53	ANESTHESIOLOGY			59,364		59,364	59,364	53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	VASCULAR LAB							54.01
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION			29,682		29,682	29,682	59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
65	RESPIRATORY THERAPY			29,682		29,682	29,682	65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH							76.02
76.03	OCCUPATIONAL HEALTH							76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES							90.01
91	EMERGENCY			459,201		459,201	459,201	91
91.01	C'VILLE OUT							91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING							91.03
91.04	HUNTLEY OP							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)			5,772		5,772	5,772	92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			583,701		583,701	583,701	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0217** | **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	79,249,387			18,726,826		15,801,795		50
51	RECOVERY ROOM	30,461,056			6,649,888		6,506,272		51
53	ANESTHESIOLOGY	13,033,299	0.004555	0.004555	3,139,123	14,299	1,931,844	8,800	53
54	RADIOLOGY-DIAGNOSTIC	25,943,932			3,447,835		5,713,605		54
54.01	VASCULAR LAB	9,842,959			1,346,421		1,950,967		54.01
55	RADIOLOGY-THERAPEUTIC	24,159,450			674,762		10,430,187		55
57	CT SCAN	47,527,853			6,154,399		10,619,931		57
58	MRI	11,862,459			1,695,911		4,464,221		58
59	CARDIAC CATHETERIZATION	24,655,082	0.001204	0.001204	7,185,183	8,651	5,638,084	6,788	59
60	LABORATORY	59,765,701			15,961,452		1,228,853		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,520,482			492,535		137,687		62
65	RESPIRATORY THERAPY	11,689,129	0.002539	0.002539	5,305,689	13,471	555,461	1,410	65
66	PHYSICAL THERAPY	12,759,354			1,496,377				66
67	OCCUPATIONAL THERAPY	6,694,397			535,834				67
68	SPEECH PATHOLOGY	3,227,976			392,193				68
69	ELECTROCARDIOLOGY	14,320,700			3,569,293		3,169,971		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,130,438			8,293,104		4,024,620		71
72	IMPL. DEV. CHARGED TO PATIENTS	21,424,078			7,841,338		2,847,882		72
73	DRUGS CHARGED TO PATIENTS	45,646,573			9,754,722		9,250,570		73
74	RENAL DIALYSIS	2,631,585			1,356,746		26,334		74
76	OTHER ANCILLARY SERVICES COST CENTE								76
76.02	PSYCH	6,593,683			821,194		44,328		76.02
76.03	OCCUPATIONAL HEALTH	834,950							76.03
76.97	CARDIAC REHABILITATION	463,253							76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,220,695			12,606		2,132,671		76.98
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PROCEDURES	3,848,513					1,322,728		90.01
91	EMERGENCY	48,156,008	0.009536	0.009536	5,868,321	55,960	6,818,601	65,022	91
91.01	C'VILLE OUT	362,699							91.01
91.02	LAKE HILL OUT								91.02
91.03	NUTRITION COUNSELING	223,619			624		61,612		91.03
91.04	HUNTLEY OP	60,173					1,689		91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	10,152,911	0.000569	0.000569	1,915,182	1,090	2,659,561	1,513	92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	548,462,394			112,637,558	93,471	97,339,474	83,533	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0217** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[XX] TITLE XVIII, PART B [ ] IPF [ ] 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	0.110672	15,801,795			1,748,816			50
51	RECOVERY ROOM	0.142859	6,506,272			929,480			51
53	ANESTHESIOLOGY	0.031416	1,931,844			60,691			53
54	RADIOLOGY-DIAGNOSTIC	0.226570	5,713,605			1,294,531			54
54.01	VASCULAR LAB	0.088623	1,950,967			172,901			54.01
55	RADIOLOGY-THERAPEUTIC	0.211794	10,430,187			2,209,051			55
57	CT SCAN	0.022222	10,619,931			235,996			57
58	MRI	0.040010	4,464,221			178,613			58
59	CARDIAC CATHETERIZATION	0.100926	5,638,084			569,029			59
60	LABORATORY	0.124956	1,228,853			153,553			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.623364	137,687			85,829			62
65	RESPIRATORY THERAPY	0.167061	555,461			92,796			65
66	PHYSICAL THERAPY	0.326528							66
67	OCCUPATIONAL THERAPY	0.319969							67
68	SPEECH PATHOLOGY	0.233658							68
69	ELECTROCARDIOLOGY	0.141788	3,169,971			449,464			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240637	4,024,620	34,594		968,472	8,325		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.397163	2,847,882			1,131,073			72
73	DRUGS CHARGED TO PATIENTS	0.286173	9,250,570		64,881	2,647,263		18,567	73
74	RENAL DIALYSIS	0.213003	26,334			5,609			74
76	OTHER ANCILLARY SERVICES COST CENTE								76
76.02	PSYCH	0.257993	44,328			11,436			76.02
76.03	OCCUPATIONAL HEALTH	1.047948							76.03
76.97	CARDIAC REHABILITATION	0.399354							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.133123	2,132,671			283,908			76.98
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PROCEDURES	0.219451	1,322,728			290,274			90.01
91	EMERGENCY	0.187437	6,818,601			1,278,058			91
91.01	C'VILLE OUT	0.761998							91.01
91.02	LAKE HILL OUT								91.02
91.03	NUTRITION COUNSELING	3.547690	61,612			218,580			91.03
91.04	HUNTLEY OP	2.373041	1,689			4,008			91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.279497	2,659,561			743,339			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		97,339,474	34,594	64,881	15,762,770	8,325	18,567	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		97,339,474	34,594	64,881	15,762,770	8,325	18,567	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T217** **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	1,633,720	79,249,387	0.020615	48,272	995	50
51	RECOVERY ROOM	253,722	30,461,056	0.008329	20,443	170	51
53	ANESTHESIOLOGY	33,294	13,033,299	0.002555	3,056	8	53
54	RADIOLOGY-DIAGNOSTIC	946,717	25,943,932	0.036491	355,492	12,972	54
54.01	VASCULAR LAB	112,553	9,842,959	0.011435	229,628	2,626	54.01
55	RADIOLOGY-THERAPEUTIC	1,167,358	24,159,450	0.048319	2,450	118	55
57	CT SCAN	34,245	47,527,853	0.000721	392,799	283	57
58	MRI	39,617	11,862,459	0.003340	91,667	306	58
59	CARDIAC CATHETERIZATION	381,003	24,655,082	0.015453	36,930	571	59
60	LABORATORY	418,728	59,765,701	0.007006	2,733,039	19,148	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	62,780	1,520,482	0.041290	92,615	3,824	62
65	RESPIRATORY THERAPY	127,434	11,689,129	0.010902	2,044,772	22,292	65
66	PHYSICAL THERAPY	201,303	12,759,354	0.015777	5,736,979	90,512	66
67	OCCUPATIONAL THERAPY	236,975	6,694,397	0.035399	5,017,831	177,626	67
68	SPEECH PATHOLOGY	13,336	3,227,976	0.004131	2,203,119	9,101	68
69	ELECTROCARDIOLOGY	378,604	14,320,700	0.026438	121,192	3,204	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	414,653	27,130,438	0.015284	1,143,934	17,484	71
72	IMPL. DEV. CHARGED TO PATIENTS	541,092	21,424,078	0.025256	3,233	82	72
73	DRUGS CHARGED TO PATIENTS	605,360	45,646,573	0.013262	4,551,246	60,359	73
74	RENAL DIALYSIS	41,462	2,631,585	0.015756	512,685	8,078	74
76	OTHER ANCILLARY SERVICES COST CENTE						76
76.02	PSYCH	325,386	6,593,683	0.049348			76.02
76.03	OCCUPATIONAL HEALTH	67,359	834,950	0.080674			76.03
76.97	CARDIAC REHABILITATION	24,231	463,253	0.052306			76.97
76.98	HYPERBARIC OXYGEN THERAPY	45,905	4,220,695	0.010876			76.98
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PROCEDURES	15,339	3,848,513	0.003986			90.01
91	EMERGENCY	715,167	48,156,008	0.014851	120,674	1,792	91
91.01	C'VILLE OUT	11,044	362,699	0.030449			91.01
91.02	LAKE HILL OUT						91.02
91.03	NUTRITION COUNSELING	62,020	223,619	0.277347			91.03
91.04	HUNTLEY OP	41,593	60,173	0.691224			91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)		10,152,911				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	8,952,000	548,462,394		25,462,056	431,551	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T217** | **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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY			59,364		59,364	59,364	53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	VASCULAR LAB							54.01
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION			29,682		29,682	29,682	59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
65	RESPIRATORY THERAPY			29,682		29,682	29,682	65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH							76.02
76.03	OCCUPATIONAL HEALTH							76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES							90.01
91	EMERGENCY			459,201		459,201	459,201	91
91.01	C'VILLE OUT							91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING							91.03
91.04	HUNTLEY OP							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			577,929		577,929	577,929	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T217** **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	79,249,387			48,272				50
51	RECOVERY ROOM	30,461,056			20,443				51
53	ANESTHESIOLOGY	13,033,299	0.004555	0.004555	3,056	14			53
54	RADIOLOGY-DIAGNOSTIC	25,943,932			355,492				54
54.01	VASCULAR LAB	9,842,959			229,628				54.01
55	RADIOLOGY-THERAPEUTIC	24,159,450			2,450				55
57	CT SCAN	47,527,853			392,799				57
58	MRI	11,862,459			91,667				58
59	CARDIAC CATHETERIZATION	24,655,082	0.001204	0.001204	36,930	44			59
60	LABORATORY	59,765,701			2,733,039				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,520,482			92,615				62
65	RESPIRATORY THERAPY	11,689,129	0.002539	0.002539	2,044,772	5,192			65
66	PHYSICAL THERAPY	12,759,354			5,736,979				66
67	OCCUPATIONAL THERAPY	6,694,397			5,017,831				67
68	SPEECH PATHOLOGY	3,227,976			2,203,119				68
69	ELECTROCARDIOLOGY	14,320,700			121,192				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,130,438			1,143,934				71
72	IMPL. DEV. CHARGED TO PATIENTS	21,424,078			3,233				72
73	DRUGS CHARGED TO PATIENTS	45,646,573			4,551,246				73
74	RENAL DIALYSIS	2,631,585			512,685				74
76	OTHER ANCILLARY SERVICES COST CENTE								76
76.02	PSYCH	6,593,683							76.02
76.03	OCCUPATIONAL HEALTH	834,950							76.03
76.97	CARDIAC REHABILITATION	463,253							76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,220,695							76.98
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PROCEDURES	3,848,513							90.01
91	EMERGENCY	48,156,008	0.009536	0.009536	120,674	1,151			91
91.01	C'VILLE OUT	362,699							91.01
91.02	LAKE HILL OUT								91.02
91.03	NUTRITION COUNSELING	223,619							91.03
91.04	HUNTLEY OP	60,173							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	10,152,911							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	548,462,394			25,462,056	6,401			200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T217** **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	0.110672							50
51	RECOVERY ROOM	0.142859							51
53	ANESTHESIOLOGY	0.031416							53
54	RADIOLOGY-DIAGNOSTIC	0.226570							54
54.01	VASCULAR LAB	0.088623							54.01
55	RADIOLOGY-THERAPEUTIC	0.211794							55
57	CT SCAN	0.022222							57
58	MRI	0.040010							58
59	CARDIAC CATHETERIZATION	0.100926							59
60	LABORATORY	0.124956							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.623364							62
65	RESPIRATORY THERAPY	0.167061							65
66	PHYSICAL THERAPY	0.326528							66
67	OCCUPATIONAL THERAPY	0.319969							67
68	SPEECH PATHOLOGY	0.233658							68
69	ELECTROCARDIOLOGY	0.141788							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240637							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.397163							72
73	DRUGS CHARGED TO PATIENTS	0.286173			5,534			1,584	73
74	RENAL DIALYSIS	0.213003							74
76	OTHER ANCILLARY SERVICES COST CENTE								76
76.02	PSYCH	0.257993							76.02
76.03	OCCUPATIONAL HEALTH	1.047948							76.03
76.97	CARDIAC REHABILITATION	0.399354							76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.133123							76.98
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PROCEDURES	0.219451							90.01
91	EMERGENCY	0.187437							91
91.01	C'VILLE OUT	0.761998							91.01
91.02	LAKE HILL OUT								91.02
91.03	NUTRITION COUNSELING	3.547690							91.03
91.04	HUNTLEY OP	2.373041							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.279497							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)				5,534			1,584	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)				5,534			1,584	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0217** **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)	27,203	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	27,203	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)	24,393	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)	12,180	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)	27,471,312	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	27,471,312	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)	27,471,312	37

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0217** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,009.86	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					12,300,095	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)					12,300,095	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	5,263,227	2,607	2,018.88	1,381	2,788,073	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)					19,590,393	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					34,678,561	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	2,054,232	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	1,845,567	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	3,899,799	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	30,778,762	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0217** **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)					2,810	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,009.86	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					2,837,707	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	3,879,719	27,471,312	0.141228	2,837,707	400,764	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST	55,872	27,471,312	0.002034	2,837,707	5,772	92
93	ALL OTHER MEDICAL EDUCATION						93

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T217** **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)	13,712	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	13,712	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)	13,712	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,819	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)	11,920,283	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	11,920,283	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)	11,920,283	37

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T217** **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)	869.33	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	10,274,611	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	10,274,611	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	6,589,409	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	16,864,020	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	907,463	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	437,952	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	1,345,415	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	15,518,605	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0217** **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		32,490,771		30
31	INTENSIVE CARE UNIT		9,461,719		31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.110672	18,726,826	2,072,535	50
51	RECOVERY ROOM	0.142859	6,649,888	949,996	51
53	ANESTHESIOLOGY	0.031416	3,139,123	98,619	53
54	RADIOLOGY-DIAGNOSTIC	0.226870	3,447,835	782,210	54
54.01	VASCULAR LAB	0.088623	1,346,421	119,324	54.01
55	RADIOLOGY-THERAPEUTIC	0.212939	674,762	143,683	55
57	CT SCAN	0.022222	6,154,399	136,763	57
58	MRI	0.040010	1,695,911	67,853	58
59	CARDIAC CATHETERIZATION	0.100942	7,185,183	725,287	59
60	LABORATORY	0.125286	15,961,452	1,999,746	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.623364	492,535	307,029	62
65	RESPIRATORY THERAPY	0.167061	5,305,689	886,374	65
66	PHYSICAL THERAPY	0.326528	1,496,377	488,609	66
67	OCCUPATIONAL THERAPY	0.319969	535,834	171,450	67
68	SPEECH PATHOLOGY	0.233658	392,193	91,639	68
69	ELECTROCARDIOLOGY	0.141872	3,569,293	506,383	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240637	8,293,104	1,995,628	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.397163	7,841,338	3,114,289	72
73	DRUGS CHARGED TO PATIENTS	0.286173	9,754,722	2,791,538	73
74	RENAL DIALYSIS	0.213003	1,356,746	288,991	74
76	OTHER ANCILLARY SERVICES COST CENTE				76
76.02	PSYCH	0.257993	821,194	211,862	76.02
76.03	OCCUPATIONAL HEALTH	1.047948			76.03
76.97	CARDIAC REHABILITATION	0.399354			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.133342	12,606	1,681	76.98
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT PROCEDURES	0.219451			90.01
91	EMERGENCY	0.187686	5,868,321	1,101,402	91
91.01	C'VILLE OUT	0.761998			91.01
91.02	LAKE HILL OUT				91.02
91.03	NUTRITION COUNSELING	3.547690	624	2,214	91.03
91.04	HUNTLEY OP	2.373041			91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.279497	1,915,182	535,288	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		112,637,558	19,590,393	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		112,637,558		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T217** **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		28,570,644		41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.110672	48,272	5,342	50
51	RECOVERY ROOM	0.142859	20,443	2,920	51
53	ANESTHESIOLOGY	0.031416	3,056	96	53
54	RADIOLOGY-DIAGNOSTIC	0.226870	355,492	80,650	54
54.01	VASCULAR LAB	0.088623	229,628	20,350	54.01
55	RADIOLOGY-THERAPEUTIC	0.212939	2,450	522	55
57	CT SCAN	0.022222	392,799	8,729	57
58	MRI	0.040010	91,667	3,668	58
59	CARDIAC CATHETERIZATION	0.100942	36,930	3,728	59
60	LABORATORY	0.125286	2,733,039	342,412	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.623364	92,615	57,733	62
65	RESPIRATORY THERAPY	0.167061	2,044,772	341,602	65
66	PHYSICAL THERAPY	0.326528	5,736,979	1,873,284	66
67	OCCUPATIONAL THERAPY	0.319969	5,017,831	1,605,550	67
68	SPEECH PATHOLOGY	0.233658	2,203,119	514,776	68
69	ELECTROCARDIOLOGY	0.141872	121,192	17,194	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240637	1,143,934	275,273	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.397163	3,233	1,284	72
73	DRUGS CHARGED TO PATIENTS	0.286173	4,551,246	1,302,444	73
74	RENAL DIALYSIS	0.213003	512,685	109,203	74
76	OTHER ANCILLARY SERVICES COST CENTE				76
76.02	PSYCH	0.257993			76.02
76.03	OCCUPATIONAL HEALTH	1.047948			76.03
76.97	CARDIAC REHABILITATION	0.399354			76.97
76.98	HYPERBARIC OXYGEN THERAPY	0.133342			76.98
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT PROCEDURES	0.219451			90.01
91	EMERGENCY	0.187686	120,674	22,649	91
91.01	C'VILLE OUT	0.761998			91.01
91.02	LAKE HILL OUT				91.02
91.03	NUTRITION COUNSELING	3.547690			91.03
91.04	HUNTLEY OP	2.373041			91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.279497			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		25,462,056	6,589,409	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		25,462,056		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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)	18,059,086			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	5,226,187			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)	930,552			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	2,083,818			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	136.30			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0400			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1414			31
32	SUM OF LINES 30 AND 31	0.1814			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0454			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	879,200			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)		1,142,042		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		287,857		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	287,857			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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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)	25,382,882			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)	25,382,882			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	2,131,164			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS	40,699			57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)	93,471			58
59	TOTAL (sum of amounts on lines 49 through 58)	27,648,216			59
60	PRIMARY PAYER PAYMENTS	28,258			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	27,619,958			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,068,764			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	133,123			63
64	ALLOWABLE BAD DEBTS (see instructions)	400,819			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	260,532			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	293,998			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	25,678,603			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
71	AMOUNT DUE PROVIDER (see instructions)	25,678,603			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	387,747			71.01
72	INTERIM PAYMENTS	24,784,895			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	505,961			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	61,969			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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0217** **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)	26,892			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	15,679,237			2
3	PPS PAYMENTS	12,580,062			3
4	OUTLIER PAYMENT (see instructions)	241,638			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	83,533			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	26,892			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	99,475			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)	99,475			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)	99,475			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	72,583			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)	26,892			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)	12,905,233			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	6,808			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	2,758,840			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	10,166,477			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)	10,166,477			30
31	PRIMARY PAYER PAYMENTS	1,711			31
32	SUBTOTAL (line 30 minus line 31)	10,164,766			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)	452,704			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	294,258			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	372,071			36
37	SUBTOTAL (see instructions)	10,459,024			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	10,459,024			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	157,931			40.01
41	INTERIM PAYMENTS	10,153,374			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	147,719			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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T217** **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)	1,584			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)	1,584			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	5,534			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)	5,534			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)	5,534			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	3,950			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	1,584			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)	69			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)	1,515			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)	1,515			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	1,515			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)	1,515			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,515			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	23			40.01
41	INTERIM PAYMENTS	529			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	963			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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0217** **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				24,795,738		10,204,172	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	26,210			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	07/01/2013	37,053	07/01/2013	50,798	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		-10,843		-50,798	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)				24,784,895		10,153,374	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					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-T217** **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				16,056,683		529	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	07/01/2013	11,652			3.50
			.51	12/20/2013	16,135			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		-27,787			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)				16,028,896		529	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					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							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 SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	5,796	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	13,561	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,060	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	27,000	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	665,100,977	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	20,584,008	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)	1,636,949	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	32,739	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,604,210	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,716,240	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-112,030	32

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T217** **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)	11,816,455	4,417,325	1
2	MEDICARE SSI RATIO (see instructions)	0.013000		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	86,260	22,087	3
4	OUTLIER PAYMENTS	190,897		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)	37.567123		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	16,533,024		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)	16,533,024		17
18	PRIMARY PAYER PAYMENTS	2,026		18
19	SUBTOTAL (line 17 less line 18)	16,530,998		19
20	DEDUCTIBLES	133,652		20
21	SUBTOTAL (line 19 minus line 20)	16,397,346		21
22	COINSURANCE	109,168		22
23	SUBTOTAL (line 21 minus line 22)	16,288,178		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	1,132		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	736		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			26
27	SUBTOTAL (sum of lines 23 and 25)	16,288,914		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)	6,401		29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	16,295,315		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	246,059		32.01
33	INTERIM PAYMENTS	16,028,896		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	20,360		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	5,409		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (see instructions)			50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)			51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)			52
53	TIME VALUE OF MONEY (see instructions)			53

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	6,576,000				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	22,614,000				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	4,151,000				7
8	PREPAID EXPENSES	1,930,000				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS	1,945,000				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	37,216,000				11
	FIXED ASSETS					
12	LAND	2,549,055				12
13	LAND IMPROVEMENTS	1,671,230				13
14	ACCUMULATED DEPRECIATION	-262,260				14
15	BUILDINGS	43,311,766				15
16	ACCUMULATED DEPRECIATION	-4,464,134				16
17	LEASEHOLD IMPROVEMENTS	606,407				17
18	ACCUMULATED AMORTIZATION	-71,573				18
19	FIXED EQUIPMENT	3,515				19
20	ACCUMULATED DEPRECIATION	-1,439				20
21	AUTOMOBILES AND TRUCKS	4,222				21
22	ACCUMULATED DEPRECIATION	-4,222				22
23	MAJOR MOVABLE EQUIPMENT	10,349,263				23
24	ACCUMULATED DEPRECIATION	-5,018,924				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	48,672,906				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	3,907,000				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	3,907,000				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	89,795,906				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	9,269,000				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	11,068,000				43
44	OTHER CURRENT LIABILITIES	13,281,000				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	33,618,000				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	783,000				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	783,000				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	34,401,000				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	55,394,906				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)	55,394,906				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	89,795,906				60

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		60,924,459			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-3,398,587			2
3	TOTAL (sun of line 1 and line 2)		57,525,872			3
4	ADDITIONS (credit adjustments)					4
5						5
6	NET ASSET TRANSFER					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		57,525,872			11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSET TRANSFER	2,130,966				13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		2,130,966			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		55,394,906			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	NET ASSET TRANSFER					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	NET ASSET TRANSFER					13
14						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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 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	65,617,169		65,617,169	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	33,197,416		33,197,416	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	98,814,585		98,814,585	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	17,824,295		17,824,295	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)	17,824,295		17,824,295	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	116,638,880		116,638,880	17
18	ANCILLARY SERVICES	244,107,207	304,354,890	548,462,097	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)	360,746,087	304,354,890	665,100,977	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		141,374,240	29
30	ADD (SPECIFY)			30
31				31
32	RECONCILING ITEM			32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		141,374,240	43

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	665,100,977	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	531,830,575	2
3	NET PATIENT REVENUES (line 1 minus line 2)	133,270,402	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	141,374,240	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-8,103,838	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,780	6
7	INCOME FROM INVESTMENTS	293,684	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER OPERATING REVENUE)	4,313,536	24
24.01	OTHER (NET ASSETS RELEASED FROM RESTRICTION)	96,251	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	4,705,251	25
26	TOTAL (line 5 plus line 25)	-3,398,587	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-3,398,587	29

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0217** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	1,853,773	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	208,060	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)	74.28	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0400	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1414	8
9	SUM OF LINES 7 AND 8	0.1814	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0374	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	69,331	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	2,131,164	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

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSPITAL ELGIN Provider CCN: 14-0217	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 09:15 Version: 2014.03

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	PURCH, RCVING, STORING							5.02
5.03	ADMITTING							5.03
5.04	CASHIERING							5.04
5.05	OTHER ADMIN AND GENERAL							5.05
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
41	SUBPROVIDER - IRF							41
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	VASCULAR LAB							54.01
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICES COST CENTE							76
76.02	PSYCH							76.02
76.03	OCCUPATIONAL HEALTH							76.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PROCEDURES							90.01
91	EMERGENCY							91
91.01	C'VILLE OUT							91.01
91.02	LAKE HILL OUT							91.02
91.03	NUTRITION COUNSELING							91.03
91.04	HUNTLEY OP							91.04
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
194	OTHER NONREIMBURSABLE COST CENTER							194
194.01	MOB							194.01
194.02	COMMUNITY WELLNESS							194.02
194.03	FUND DEVELOPMENT							194.03
194.04	PHYSICIAN PRACTICE MANAGEMENT							194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202