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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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: 22:06 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 HOSP-CHICAGO (14-0224) {(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		52,117	395,007	-14,026		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		-33,096	4			3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		465	-18			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		19,486	394,993	-14,026		200

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

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

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

INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER
THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:

1	STREET: 2900 NORTH LAKE SHORE DRIVE	P.O. BOX:		1
2	CITY: CHICAGO	STATE: IL	ZIP CODE: 60657	COUNTY: COOK 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	PRESENCE SAINT JOSEPH HOSP-CHICAGO	14-0224	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF	REHAB UNIT	14-T224	16974	5	07/01/1985	N	P	O	5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	SKILLED CARE	14-5568	16974		01/28/1987	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19

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

	INPATIENT PPS INFORMATION	1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	Y	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES Or 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)	N	Y	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	2	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.	8,238	2,191			148		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.	161	77					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

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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.	Y			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(see instructions)	Y			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)	Y			63

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

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)			8.12	29.85	0.213853	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		FAMILY MEDICINE	1350	0.57	16.24	0.033908	65
65.01		INTERNAL MEDICINE	1400	2.88	62.28	0.044199	65.01
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)			9.23	33.94	0.213806	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		FAMILY MEDICINE	1350	0.97	17.01	0.053949	67
67.01		INTERNAL MEDICINE	1400	0.50	74.45	0.006671	67.01
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

				V	XIX	
TITLE V AND XIX SERVICES				1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97
RURAL PROVIDERS				1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N		108
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	N	N	109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	N				115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			2		118
		PREMIUMS		PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		121
TRANSPLANT CENTER INFORMATION						
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.			N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					132

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	14H082	140

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

141	NAME: PRESENCE HEALTH	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 00131	141
142	STREET: 200 S. WACKER DRIVE	P.O. BOX:		142
143	CITY: CHICAGO	STATE: IL	ZIP CODE: 60606	143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

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

MULTICAMPUS

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

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00		169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	05/08/2012	08/05/2012	170

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	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

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

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

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	04/08/2014	Y	04/08/2014	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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: 0	LAST NAME: 0	TITLE: 0	41
42	EMPLOYER: 0			42
43	PHONE NUMBER: 0	E-MAIL ADDRESS: 0		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	256	93,440			18,061	6,053	46,943	1
2	HMO AND OTHER (see instructions)						1,880	148		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)		256	93,440			18,061	6,053	46,943	7
8	INTENSIVE CARE UNIT	31	19	6,935			1,814	291	3,188	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						2,923	4,851	13
14	TOTAL (see instructions)		275	100,375			19,875	9,267	54,982	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	23	8,395			1,816	239	2,584	17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	26	9,490			4,057		5,459	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)		324							27
28	OBSERVATION BED DAYS								4,280	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					3,639	1,725	10,372	1
2	HMO AND OTHER (see instructions)					329			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)	120.57	1,121.22			3,639	1,725	10,372	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF		15.86			172	22	242	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY		21.92						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)	120.57	1,159.00						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	76,329,285		76,329,285	2,402,830.00	31.77	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE		165,500		165,500	1,616.00	102.41	4
4.01	PHYSICIAN-PART A - TEACHING		3,907,511		3,907,511	47,629.00	82.04	4.01
5	PHYSICIAN-PART B		56,613		56,613	486.00	116.49	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21		7,361,043	7,361,043	298,072.00	24.70	7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44	1,358,292		1,358,292	45,587.00	29.80	9
10	EXCLUDED AREA SALARIES (see instructions)		5,313,839		5,313,839	151,464.00	35.08	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		4,053,748		4,053,748	111,133.00	36.48	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		2,654,163		2,654,163	71,672.00	37.03	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)		14,055,998		14,055,998			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		1,269,792		1,269,792			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE		19,961		19,961			22
22.01	PHYSICIAN PART A - TEACHING		291,162		291,162			22.01
23	PHYSICIAN PART B		6,486		6,486			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)		1,488,483		1,488,483			25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		18,875		18,875	702.00	26.89	26
27	ADMINISTRATIVE & GENERAL		7,391,386	114,750	7,506,136	230,267.00	32.60	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		708,282		708,282	7,781.00	91.03	28
29	MAINTENANCE & REPAIRS		509,008		509,008	15,798.00	32.22	29
30	OPERATION OF PLANT		707,509		707,509	18,873.00	37.49	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		1,259,661		1,259,661	97,531.00	12.92	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		1,753,503	-690,218	1,063,285	64,946.00	16.37	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			690,218	690,218	43,808.00	15.76	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,781,009		1,781,009	41,101.00	43.33	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		2,339,761		2,339,761	59,451.00	39.36	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		814,432		814,432	36,960.00	22.04	41
42	SOCIAL SERVICE		1,436,570		1,436,570	36,984.00	38.84	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		73,073,443	-7,361,043	65,712,400	2,064,424.00	31.83	1
2	EXCLUDED AREA SALARIES (see instructions)		6,672,131		6,672,131	197,051.00	33.86	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		66,401,312	-7,361,043	59,040,269	1,867,373.00	31.62	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		6,707,911		6,707,911	182,805.00	36.69	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		14,075,959		14,075,959		23.84%	5

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		87,185,182	-7,361,043	79,824,139	2,050,178.00	38.94	6
7	TOTAL OVERHEAD COST (see instructions)		18,719,996	114,750	18,834,746	654,202.00	28.79	7

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

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	3,932,701	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)	6,198,062	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	174,012	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	-29,889	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	347,335	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	789,452	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	5,391,809	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	156,392	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	172,009	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	17,131,883	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	4,250,171		1
2	HOSPITAL	4,250,171		2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL	11		11	4
5	RVX				5
6	RVL	127		127	6
7	RHX	55		55	7
8	RHL	174		174	8
9	RMX	61		61	9
10	RML	50		50	10
11	RLX				11
12	RUC				12
13	RUB	7		7	13
14	RUA	36		36	14
15	RVC	51		51	15
16	RVB	186		186	16
17	RVA	614		614	17
18	RHC	190		190	18
19	RHB	541		541	19
20	RHA	961		961	20
21	RMC	62		62	21
22	RMB	216		216	22
23	RMA	184		184	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	77		77	28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1	15		15	32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	58		58	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1	19		19	40
41	LC2	9		9	41
42	LC1	4		4	42
43	LB2				43
44	LB1	34		34	44
45	CE2				45
46	CE1				46
47	CD2	7		7	47
48	CD1	15		15	48
49	CC2				49
50	CC1	21		21	50
51	CB2	5		5	51
52	CB1	38		38	52
53	CA2				53
54	CA1	174		174	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1	12		12	66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1	12		12	74
75	PB2				75
76	PB1	18		18	76
77	PA2				77
78	PA1	6		6	78
199	AAA	7		7	199
200	TOTAL	4,057		4,057	200

SNF SERVICES

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

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

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)	4,813,542			207

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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)	0.225655	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	17,260,228	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID	419,236	5
6	MEDICAID CHARGES	82,614,984	6
7	MEDICAID COST (line 1 times line 6)	18,642,484	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.	963,020	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)	963,020	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	8,205,561	502,328	8,707,889	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	1,851,626	113,353	1,964,979	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	2,653	20,089	22,742	22
23	COST OF CHARITY CARE (line 21 minus line 22)	1,848,973	93,264	1,942,237	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)	8,647,890	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,249,067	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	7,398,823	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,669,581	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	3,611,818	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	4,574,838	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		12,040,802	12,040,802	-12,040,802		954,643	954,643	1
2	00200	CAP REL COSTS-MVBLE EQUIP				12,040,802	12,040,802	479,462	12,520,264	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	18,875	29,059	47,934	15,309,987	15,357,921	379,174	15,737,095	4
5.01	00540	NONPATIENT TELEPHONES				229,396	229,396		229,396	5.01
5.02	00550	DATA PROCESSING						2,889,331	2,889,331	5.02
5.03	00560	PURCHASING,RECEIVING&STORES						283,261	283,261	5.03
5.04	00570	ADMITTING				6,258	6,258	670,468	676,726	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						4,543,603	4,543,603	5.05
5.06	00591	ADMINISTRATION & GENERAL	7,391,386	48,561,211	55,952,597	-1,581,740	54,370,857	-16,571,181	37,799,676	5.06
6	00600	MAINTENANCE & REPAIRS	509,008	947,946	1,456,954	-108,674	1,348,280		1,348,280	6
7	00700	OPERATION OF PLANT	707,509	4,640,503	5,348,012	-135,855	5,212,157	360,796	5,572,953	7
8	00800	LAUNDRY & LINEN SERVICE		1,126,750	1,126,750	-121	1,126,629		1,126,629	8
9	00900	HOUSEKEEPING	1,259,661	1,535,946	2,795,607	-547,231	2,248,376		2,248,376	9
10	01000	DIETARY	1,753,503	2,106,015	3,859,518	-2,085,120	1,774,398		1,774,398	10
11	01100	CAFETERIA				1,474,126	1,474,126	-1,264,947	209,179	11
13	01300	NURSING ADMINISTRATION	1,781,009	386,307	2,167,316	-302,245	1,865,071		1,865,071	13
14	01400	CENTRAL SERVICES & SUPPLY		-170,675	-170,675	-26,810	-197,485	509,847	312,362	14
15	01500	PHARMACY	2,339,761	4,810,634	7,150,395	-6,124,622	1,025,773		1,025,773	15
16	01600	MEDICAL RECORDS & LIBRARY	814,432	775,095	1,589,527	-220,880	1,368,647	-5,025	1,363,622	16
17	01700	SOCIAL SERVICE	1,436,570	757,832	2,194,402	-272,954	1,921,448		1,921,448	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				7,347,288	7,347,288		7,347,288	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	11,967,959	5,459,150	17,427,109	-10,106,545	7,320,564	-690,274	6,630,290	22
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	17,675,504	7,091,963	24,767,467	-4,497,772	20,269,695	-23,494	20,246,201	30
31	03100	INTENSIVE CARE UNIT	2,446,220	857,962	3,304,182	-712,408	2,591,774	108,758	2,700,532	31
41	04100	SUBPROVIDER - IRF	1,039,016	312,053	1,351,069	-243,364	1,107,705		1,107,705	41
43	04300	NURSERY	1,524,714	390,033	1,914,747	60,307	1,975,054		1,975,054	43
44	04400	SKILLED NURSING FACILITY	1,358,292	430,883	1,789,175	-357,783	1,431,392		1,431,392	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	5,213,505	13,560,856	18,774,361	-8,743,363	10,030,998	-502,026	9,528,972	50
51	05100	RECOVERY ROOM	622,628	144,946	767,574	-140,477	627,097		627,097	51
53	05300	ANESTHESIOLOGY	102,120	721,201	823,321	-277,142	546,179	-255,046	291,133	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,546,990	2,064,602	4,611,592	-563,475	4,048,117	-610,231	3,437,886	54
55	05500	RADIOLOGY-THERAPEUTIC	969,745	1,303,393	2,273,138	-205,356	2,067,782	-63,190	2,004,592	55
57	05700	CT SCAN	402,019	211,787	613,806	-144,791	469,015		469,015	57
58	05800	MRI	274,646	119,785	394,431	-59,949	334,482		334,482	58
59	05900	CARDIAC CATHETERIZATION	1,028,202	2,311,899	3,340,101	-2,130,689	1,209,412		1,209,412	59
60	06000	LABORATORY		7,554,726	7,554,726	-709,404	6,845,322	86,077	6,931,399	60
63	06300	BLOOD STORING, PROCESSING & TRANS.		11,300	11,300	705,413	716,713		716,713	63
65	06500	RESPIRATORY THERAPY	1,032,705	448,216	1,480,921	-322,129	1,158,792	-2,500	1,156,292	65
66	06600	PHYSICAL THERAPY	2,908,981	1,182,506	4,091,487	-624,551	3,466,936	-23,071	3,443,865	66
69	06900	ELECTROCARDIOLOGY	472,388	443,323	915,711	-108,528	807,183	-20,833	786,350	69
70	07000	ELECTROENCEPHALOGRAPHY	55,836	25,532	81,368	-21,346	60,022	-11,529	48,493	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				6,914,211	6,914,211		6,914,211	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				4,763,438	4,763,438		4,763,438	72
73	07300	DRUGS CHARGED TO PATIENTS				6,521,847	6,521,847		6,521,847	73
74	07400	RENAL DIALYSIS		384,260	384,260	-3,227	381,033		381,033	74
76	03950	OTHER ANCILLARY SERVICE COST CENTER								76
76.97	07697	CARDIAC REHABILITATION	62,125	15,083	77,208	-14,284	62,924	-3,650	59,274	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	332,409	105,822	438,231	-91,652	346,579		346,579	90
91	09100	EMERGENCY	1,779,230	2,305,275	4,084,505	-559,699	3,524,806	-1,620,973	1,903,833	91
91.01	09101	PARTIAL HOSPITALIZATION	227,514	57,642	285,156	-46,737	238,419	-26,071	212,348	91.01
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	
		SPECIAL PURPOSE COST CENTERS								
194	07950	OTHER	4,274,823	3,144,518	7,419,341	-1,241,348	6,177,993	-2,925,074	3,252,919	194
194.01	07951	LAKESHORE GUEST UNIT								194.01
200		TOTAL (sum of lines 118-199)	76,329,285	128,206,141	204,535,426		204,535,426	-13,353,695	191,181,731	200

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	DRUGS	A	DRUGS CHARGED TO PATIENTS	73		6,521,847	1
2	DRUGS	A	CENTRAL SERVICES & SUPPLY	14		837	2
3	DRUGS	A					3
4	DRUGS	A					4
5	DRUGS	A					5
6	DRUGS	A					6
7	DRUGS	A					7
8	DRUGS	A					8
9	DRUGS	A					9
10	DRUGS	A					10
11	DRUGS	A					11
12	DRUGS	A					12
13	DRUGS	A					13
14	DRUGS	A					14
15	DRUGS	A					15
16	DRUGS	A					16
17	DRUGS	A					17
18	DRHGS	A					18
19	DRUGS	A					19
20	DRUGS	A					20
21	DRUGS	A					21
22	DRUGS	A					22
23	DRUGS	A					23
24	DRUGS	A					24
25	DRUGS	A					25
500	TOTAL RECLASSIFICATIONS					6,522,684	500
	CODE LETTER - A						
1	IMPLANTS	B	IMPL. DEV. CHARGED TO PATIENT	72		4,763,438	1
2	IMPLANTS	B	CENTRAL SERVICES & SUPPLY	14		719	2
3	IMPLANTS	B					3
4	IMPLANTS	B					4
5							5
500	TOTAL RECLASSIFICATIONS					4,764,157	500
	CODE LETTER - B						
1	CHARGABLE SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		6,914,211	1
2	CHARGABLE SUPPLIES	C					2
3	CHARGABLE SUPPLIES	C					3
4	CHARGABLE SUPPLIES	C					4
5	CHARGABLE SUPPLIES	C					5
6	CHARGABLE SUPPLIES	C					6
7	CHARGABLE SUPPLIES	C					7
8	CHARGABLE SUPPLIES	C					8
9	CHARGABLE SUPPLIES	C					9
10	CHARGABLE SUPPLIES	C					10
11	CHARGABLE SUPPLIES	C					11
12	CHARGABLE SUPPLIES	C					12
13	CHARGABLE SUPPLIES	C					13
14	CHARGABLE SUPPLIES	C					14
15	CHARGABLE SUPPLIES	C					15
16	CHARGABLE SUPPLIES	C					16
17	CHARGABLE SUPPLIES	C					17
18	CHARGABLE SUPPLIES	C					18
19	CHARGABLE SUPPLIES	C					19
20	CHARGABLE SUPPLIES	C					20
21	CHARGABLE SUPPLIES	C					21
22	CHARGEABLE SUPPLIES	C					22
23	CHARGEABLE SUPPLIES	C					23
24	CHARGEABLE SUPPLIES	C					24
25	CHARGABLE SUPPLIES	C					25
26	CHARGABLE SUPPLIES	C					26
27	CHARGABLE SUPPLIES	C					27
28	CHARGABLE SUPPLIES	C					28
29	CHARGABLE SUPPLIES	C					29
30	CHARGABLE SUPPLIES	C					30
31	CHARGABLE SUPPLIES	C					31
32	CHARGABLE SUPPLIES	C					32
33	CHARGABLE SUPPLIES	C					33
34	CHARGABLE SUPPLIES	C					34

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
500	TOTAL RECLASSIFICATIONS					6,914,211	500
	CODE LETTER - C						
1	NURSEY	D	NURSERY	43	294,719	124,563	1
500	TOTAL RECLASSIFICATIONS				294,719	124,563	500
	CODE LETTER - D						
1	CAFETERIA	E	CAFETERIA	11	690,218	783,908	1
500	TOTAL RECLASSIFICATIONS				690,218	783,908	500
	CODE LETTER - E						
1	PHYSICIAN DEPR CHAIRMAN	F	ADULTS & PEDIATRICS	30	180,518	13,755	1
500	TOTAL RECLASSIFICATIONS				180,518	13,755	500
	CODE LETTER - F						
1	TEACHING PHYSICIAN ADMIN	G	ADMINISTRATION & GENERAL	5.06	114,750	8,778	1
500	TOTAL RECLASSIFICATIONS				114,750	8,778	500
	CODE LETTER - G						
1	EQUIP DEPRECIATION	H	CAP REL COSTS-MVBLE EQUIP	2		12,040,802	1
500	TOTAL RECLASSIFICATIONS					12,040,802	500
	CODE LETTER - H						
1	PHONES	I	NONPATIENT TELEPHONES	5.01		229,396	1
500	TOTAL RECLASSIFICATIONS					229,396	500
	CODE LETTER - I						
1	CENTRAL SCHEDULING	J	ADMITTING	5.04		6,258	1
500	TOTAL RECLASSIFICATIONS					6,258	500
	CODE LETTER - J						
1	BENEFITS	K	EMPLOYEE BENEFITS DEPARTMENT	4		15,312,565	1
2	BENEFITS	K					2
3	BENEFITS	K					3
4	BENEFITS	K					4
5	BENEFITS	K					5
6	BENEFITS	K					6
7	BENEFITS	K					7
8	BENEFITS	K					8
9	BENEFITS	K					9
10	BENEFITS	K					10
11	BENEFITS	K					11
12	BENEFITS	K					12
13	BENEFITS	K					13
14	BENEFITS	K					14
15	BENEFITS	K					15
16	BENEFITS	K					16
17	BENEFITS	K					17
18	BENEFITS	K					18
19	BENEFITS	K					19
20	BENEFITS	K					20
21	BENEFITS	K					21
22							22
23							23
24							24
25	BENEFITS	K					25
26	BENEFITS	K					26
27	BENEFITS	K					27
28	BENEFITS	K					28
29	BENEFITS	K					29
30	BENEFITS	K					30
31	BENEFITS	K					31
32	BENEFITS	K					32
33	BENEFITS	K					33
500	TOTAL RECLASSIFICATIONS					15,312,565	500
	CODE LETTER - K						
1	INTERNS AND RESIDENTS SALARY	L	I&R SERVICES-SALARY & FRINGES	21	7,541,561		1
500	TOTAL RECLASSIFICATIONS				7,541,561		500
	CODE LETTER - L						

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	BLOOD RECLASS	M	BLOOD STORING, PROCESSING & T	63		705,413	1
500	TOTAL RECLASSIFICATIONS					705,413	500
	CODE LETTER - M						
	GRAND TOTAL (INCREASES)				8,821,766	47,426,490	

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	DRUGS	A	ADMINISTRATION & GENERAL	5.06		4,713		1
2	DRUGS	A	OPERATION OF PLANT	7		197		2
3	DRUGS	A	PHARMACY	15		5,670,254		3
4	DRUGS	A	MEDICAL RECORDS & LIBRARY	16		213		4
5	DRUGS	A	I&R SERVICES-OTHER PRGM COSTS	22		3		5
6	DRUGS	A	ADULTS & PEDIATRICS	30		195,045		6
7	DRUGS	A	INTENSIVE CARE UNIT	31		32,847		7
8	DRUGS	A	SUBPROVIDER - IRF	41		764		8
9	DRUGS	A	NURSERY	43		17,108		9
10	DRUGS	A	SKILLED NURSING FACILITY	44		5,364		10
11	DRUGS	A	OPERATING ROOM	50		102,319		11
12	DRUGS	A	RECOVERY ROOM	51		9,616		12
13	DRUGS	A	ANESTHESIOLOGY	53		58,766		13
14	DRUGS	A	RADIOLOGY-DIAGNOSTIC	54		3,922		14
15	DRUGS	A	RADIOLOGY-THERAPEUTIC	55		4,448		15
16	DRUGS	A	CT SCAN	57		8,537		16
17	DRUGS	A	MRI	58		853		17
18	DRHGS	A	CARDIAC CATHETERIZATION	59		13,921		18
19	DRUGS	A	RESPIRATORY THERAPY	65		1,015		19
20	DRUGS	A	PHYSICAL THERAPY	66		6		20
21	DRUGS	A	ELECTROCARDIOLOGY	69		36		21
22	DRUGS	A	RENAL DIALYSIS	74		447		22
23	DRUGS	A	CARDIAC REHABILITATION	76.97		3		23
24	DRUGS	A	EMERGENCY	91		65,065		24
25	DRUGS	A	OTHER	194		327,222		25
500	TOTAL RECLASSIFICATIONS					6,522,684		500
	CODE LETTER - A							
1	IMPLANTS	B	ADULTS & PEDIATRICS	30		85		1
2	IMPLANTS	B	INTENSIVE CARE UNIT	31		181		2
3	IMPLANTS	B	OPERATING ROOM	50		3,305,976		3
4	IMPLANTS	B	CARDIAC CATHETERIZATION	59		1,456,950		4
5			ELECTROCARDIOLOGY	69		965		5
500	TOTAL RECLASSIFICATIONS					4,764,157		500
	CODE LETTER - B							
1	CHARGABLE SUPPLIES	C	ADMINISTRATION & GENERAL	5.06		23,956		1
2	CHARGABLE SUPPLIES	C	MAINTENANCE & REPAIRS	6		72		2
3	CHARGABLE SUPPLIES	C	OPERATION OF PLANT	7		218		3
4	CHARGABLE SUPPLIES	C	LAUNDRY & LINEN SERVICE	8		121		4
5	CHARGABLE SUPPLIES	C	HOUSEKEEPING	9		26,206		5
6	CHARGABLE SUPPLIES	C	DIETARY	10		330		6
7	CHARGABLE SUPPLIES	C	NURSING ADMINISTRATION	13		33		7
8	CHARGABLE SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		28,366		8
9	CHARGABLE SUPPLIES	C	PHARMACY	15		19,551		9
10	CHARGABLE SUPPLIES	C	MEDICAL RECORDS & LIBRARY	16		78		10
11	CHARGABLE SUPPLIES	C	I&R SERVICES-OTHER PRGM COSTS	22		851		11
12	CHARGABLE SUPPLIES	C	ADULTS & PEDIATRICS	30		963,052		12
13	CHARGABLE SUPPLIES	C	INTENSIVE CARE UNIT	31		198,585		13
14	CHARGABLE SUPPLIES	C	SUBPROVIDER - IRF	41		15,694		14
15	CHARGABLE SUPPLIES	C	NURSERY	43		62,754		15
16	CHARGABLE SUPPLIES	C	SKILLED NURSING FACILITY	44		50,977		16
17	CHARGABLE SUPPLIES	C	OPERATING ROOM	50		4,238,108		17
18	CHARGABLE SUPPLIES	C	RECOVERY ROOM	51		15,997		18
19	CHARGABLE SUPPLIES	C	ANESTHESIOLOGY	53		187,242		19
20	CHARGABLE SUPPLIES	C	RADIOLOGY-DIAGNOSTIC	54		63,551		20
21	CHARGABLE SUPPLIES	C	RADIOLOGY-THERAPEUTIC	55		19,300		21
22	CHARGEABLE SUPPLIES	C	CT SCAN	57		59,499		22
23	CHARGEABLE SUPPLIES	C	MRI	58		7,276		23
24	CHARGEABLE SUPPLIES	C	CARDIAC CATHETERIZATION	59		477,983		24
25	CHARGABLE SUPPLIES	C	LABORATORY	60		3,991		25
26	CHARGABLE SUPPLIES	C	RESPIRATORY THERAPY	65		94,702		26
27	CHARGABLE SUPPLIES	C	PHYSICAL THERAPY	66		58,223		27
28	CHARGABLE SUPPLIES	C	ELECTROCARDIOLOGY	69		8,777		28
29	CHARGABLE SUPPLIES	C	ELECTROENCEPHALOGRAPHY	70		2,812		29
30	CHARGABLE SUPPLIES	C	RENAL DIALYSIS	74		2,780		30
31	CHARGABLE SUPPLIES	C	CARDIAC REHABILITATION	76.97		362		31
32	CHARGABLE SUPPLIES	C	CLINIC	90		17,677		32
33	CHARGABLE SUPPLIES	C	EMERGENCY	91		130,293		33

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	
34	CHARGABLE SUPPLIES	C	OTHER	194		134,794		34
500	TOTAL RECLASSIFICATIONS					6,914,211		500
	CODE LETTER - C							
1	NURSEY	D	ADULTS & PEDIATRICS	30	294,719	124,563		1
500	TOTAL RECLASSIFICATIONS				294,719	124,563		500
	CODE LETTER - D							
1	CAFETERIA	E	DIETARY	10	690,218	783,908		1
500	TOTAL RECLASSIFICATIONS				690,218	783,908		500
	CODE LETTER - E							
1	PHYSICIAN DEPR CHAIRMAN	F	I&R SERVICES-SALARY & FRINGES	21	180,518	13,755		1
500	TOTAL RECLASSIFICATIONS				180,518	13,755		500
	CODE LETTER - F							
1	TEACHING PHYSICIAN ADMIN	G	I&R SERVICES-OTHER PRGM COSTS	22	114,750	8,778		1
500	TOTAL RECLASSIFICATIONS				114,750	8,778		500
	CODE LETTER - G							
1	EQUIP DEPRECIATION	H	CAP REL COSTS-BLDG & FIXT	1		12,040,802	9	1
500	TOTAL RECLASSIFICATIONS					12,040,802		500
	CODE LETTER - H							
1	PHONES	I	ADMINISTRATION & GENERAL	5.06		229,396		1
500	TOTAL RECLASSIFICATIONS					229,396		500
	CODE LETTER - I							
1	CENTRAL SCHEDULING	J	ADMINISTRATION & GENERAL	5.06		6,258		1
500	TOTAL RECLASSIFICATIONS					6,258		500
	CODE LETTER - J							
1	BENEFITS	K	EMPLOYEE BENEFITS DEPARTMENT	4		2,578		1
2	BENEFITS	K	ADMINISTRATION & GENERAL	5.06		1,440,945		2
3	BENEFITS	K	MAINTENANCE & REPAIRS	6		108,602		3
4	BENEFITS	K	OPERATION OF PLANT	7		135,440		4
5	BENEFITS	K	HOUSEKEEPING	9		521,025		5
6	BENEFITS	K	DIETARY	10		610,664		6
7	BENEFITS	K	NURSING ADMINISTRATION	13		302,212		7
8	BENEFITS	K	PHARMACY	15		434,817		8
9	BENEFITS	K	MEDICAL RECORDS & LIBRARY	16		220,589		9
10	BENEFITS	K	SOCIAL SERVICE	17		272,954		10
11	BENEFITS	K	I&R SERVICES-OTHER PRGM COSTS	22		2,440,602		11
12	BENEFITS	K	ADULTS & PEDIATRICS	30		3,114,581		12
13	BENEFITS	K	INTENSIVE CARE UNIT	31		480,795		13
14	BENEFITS	K	SUBPROVIDER - IRF	41		226,906		14
15	BENEFITS	K	NURSERY	43		279,113		15
16	BENEFITS	K	SKILLED NURSING FACILITY	44		301,442		16
17	BENEFITS	K	OPERATING ROOM	50		1,096,960		17
18	BENEFITS	K	RECOVERY ROOM	51		114,864		18
19	BENEFITS	K	ANESTHESIOLOGY	53		31,134		19
20	BENEFITS	K	RADIOLOGY-DIAGNOSTIC	54		496,002		20
21	BENEFITS	K	RADIOLOGY-THERAPEUTIC	55		181,608		21
22			CT SCAN	57		76,755		22
23			MRI	58		51,820		23
24			CARDIAC CATHETERIZATION	59		181,835		24
25	BENEFITS	K	RESPIRATORY THERAPY	65		226,412		25
26	BENEFITS	K	PHYSICAL THERAPY	66		566,322		26
27	BENEFITS	K	ELECTROCARDIOLOGY	69		98,750		27
28	BENEFITS	K	ELECTROENCEPHALOGRAPHY	70		18,534		28
29	BENEFITS	K	CARDIAC REHABILITATION	76.97		13,919		29
30	BENEFITS	K	CLINIC	90		73,975		30
31	BENEFITS	K	EMERGENCY	91		364,341		31
32	BENEFITS	K	PARTIAL HOSPITALIZATION	91.01		46,737		32
33	BENEFITS	K	OTHER	194		779,332		33
500	TOTAL RECLASSIFICATIONS					15,312,565		500
	CODE LETTER - K							
1	INTERNS AND RESIDENTS SALARY	L	I&R SERVICES-OTHER PRGM COSTS	22	7,541,561			1

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
500	TOTAL RECLASSIFICATIONS				7,541,561			500
	CODE LETTER - L							
1	BLOOD RECLASS	M	LABORATORY	60		705,413		1
500	TOTAL RECLASSIFICATIONS					705,413		500
	CODE LETTER - M							
	GRAND TOTAL (DECREASES)				8,821,766	47,426,490		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	7,327,665					7,327,665		1
2	LAND IMPROVEMENTS	11,980,239					11,980,239		2
3	BUILDINGS AND FIXTURES	57,482,111	8,112,555		8,112,555		65,594,666		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	49,013,214	5,205,684		5,205,684	555	54,218,343		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	125,803,229	13,318,239		13,318,239	555	139,120,913		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	125,803,229	13,318,239		13,318,239	555	139,120,913		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	12,040,802						12,040,802	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)	12,040,802						12,040,802	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	84,902,570		84,902,570	0.610279					1
2	CAP REL COSTS-MVBLE EQU	54,218,343		54,218,343	0.389721					2
3	TOTAL (sum of lines 1-2)	139,120,913		139,120,913	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	68,043		886,600				954,643	1
2	CAP REL COSTS-MVBLE EQUIP	12,520,264						12,520,264	2
3	TOTAL (sum of lines 1-2)	12,588,307		886,600				13,474,907	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,252,406				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-3,840,198				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,264,947	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	-5,025	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			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							33
34	MISC REVENUE	B	-10,231	RADIOLOGY-DIAGNOSTIC	54		34
35							35
36							36
37							37
38	ASBESTOS AMORTIZATION	A	360,796	OPERATION OF PLANT	7		38
39	MOONLIGHTERS	A	-77,420	I&R SERVICES-OTHER PRGM COSTS APPRVD	22		39
40	MEDICARE TO BOOK DEPRECIATION	A	1	CAP REL COSTS-MVBLE EQUIP	2	9	40
41							41
42	PHYS FEES	A	-2,925,074	OTHER	194		42
43							43
43.03	MISC INCOME	B	-1,349,062	ADMINISTRATION & GENERAL	5.06		43.03
43.04	MISC INCOME	B	-38,069	RADIOLOGY-THERAPEUTIC	55		43.04
43.05	MISC INCOME	B	-52	ADULTS & PEDIATRICS	30		43.05
43.10	AHA DUES	A	-11,887	ADMINISTRATION & GENERAL	5.06		43.10
44	MISC INCOME	B	-612,854	I&R SERVICES-OTHER PRGM COSTS APPRVD	22		44
45	MISC INCOME	B	-11,529	ELECTROENCEPHALOGRAPHY	70		45
46	MISC INCOME	B	-2,500	RESPIRATORY THERAPY	65		46
47	MISC INCOME	B	-3,650	CARDIAC REHABILITATION	76.97		47
48	BENEFITS ON PART B DOCS	A	-309,588	EMPLOYEE BENEFITS DEPARTMENT	4		48
49							49

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-13,353,695				50

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

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

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	4	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	688,762		688,762		1
2	5.05	CASHIERING/ACCTS RECEIVABLE	PFS	2,685,844		2,685,844		2
3	5.03	PURCHASING,RECEIVING&STORES	PURCH, RECEIVING	283,261		283,261		3
3.01	5.02	DATA PROCESSING	IS	2,889,331		2,889,331		3.01
3.02	5.06	ADMINISTRATION & GENERAL	A & G	12,056,631	20,799,618	-8,742,987		3.02
3.03	14	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	293,990		293,990		3.03
3.04	31	INTENSIVE CARE UNIT	EICU	78,658		78,658		3.04
3.05	2	CAP REL COSTS-MVBLE EQUIP	CRC	479,461		479,461	9	3.05
3.06	1	CAP REL COSTS-BLDG & FIXT	CRC	68,043		68,043	9	3.06
3.07	60	LABORATORY	ALVERNO LAB	6,717,556	6,762,406	-44,850		3.07
4	5.04	ADMITTING	ADMITTING	670,468		670,468		4
4.01	5.05	CASHIERING/ACCTS RECEIVABLE	CASHIERING/AR	1,857,759		1,857,759		4.01
4.02	5.06	ADMINISTRATION & GENERAL	A&G	5,897,155	12,208,577	-6,311,422		4.02
4.03	14	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	215,857		215,857		4.03
4.04	31	INTENSIVE CARE UNIT	ICU	30,100		30,100		4.04
4.05	1	CAP REL COSTS-BLDG & FIXT	CAP REL BLDG	886,600		886,600	11	4.05
4.06	60	LABORATORY	LAB	3,277,654	3,146,727	130,927		4.06
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			39,077,130	42,917,328	-3,840,198		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B		100.00	RESURRECTION HEALTH CARE	100.00	SOLE CORPORATE MEMBER	6
7							7
8							8
9							9
10							10

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

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

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
3	30	ADULTS & PEDIATRICS ADULTS & PEDS	101,857		101,857	177,200	1,040	88,600	4,430	3
4	30	ADULTS & PEDIATRICS ADULTS PEDS	45,625		45,625	177,200	416	35,440	1,772	4
5	50	OPERATING ROOM OR	502,026	502,026						5
6	53	ANESTHESIOLOGY ANESTHESIOLOGY	255,046	255,046						6
7	54	RADIOLOGY-DIAGNOSTIC RAD DIAGNOSTIC	600,000	600,000						7
8	55	RADIOLOGY-THERAPEUTI RAD THERAP	25,121	25,121						8
9	66	PHYSICAL THERAPY PT	23,071	23,071						9
10	69	ELECTROCARDIOLOGY EKG	20,833	20,833						10
11	91	EMERGENCY ER	1,620,973	1,620,973						11
12	91.01	PARTIAL HOSPITALIZAT PARTIAL HOSP	26,071	26,071						12
13	5.06	ADMINISTRATION & GEN A & G	319,392		319,392	177,200	1,920	163,569	8,178	13
200		TOTAL	3,540,015	3,073,141	466,874		3,376	287,609	14,380	200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATIO N	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT - ICE INSURANC E	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
3	30	ADULTS & PEDIATRICS ADULTS & PEDS					88,600	13,257	13,257	3
4	30	ADULTS & PEDIATRICS ADULTS PEDS					35,440	10,185	10,185	4
5	50	OPERATING ROOM OR							502,026	5
6	53	ANESTHESIOLOGY ANESTHESIOLOGY							255,046	6
7	54	RADIOLOGY-DIAGNOSTIC RAD DIAGNOSTIC							600,000	7
8	55	RADIOLOGY-THERAPEUTI RAD THERAP							25,121	8
9	66	PHYSICAL THERAPY PT							23,071	9
10	69	ELECTROCARDIOLOGY EKG							20,833	10
11	91	EMERGENCY ER							1,620,973	11
12	91.01	PARTIAL HOSPITALIZAT PARTIAL HOSP							26,071	12
13	5.06	ADMINISTRATION & GEN A & G					163,569	155,823	155,823	13
200		TOTAL					287,609	179,265	3,252,406	200

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

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

PART I - GENERAL INFORMATION

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

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

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

PART I - GENERAL INFORMATION

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

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

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

PART I - GENERAL INFORMATION

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

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

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

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

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

PART I - GENERAL INFORMATION

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

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

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	NONPATIENT TELEPHONES	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	954,643	954,643					1
2	CAP REL COSTS-MVBLE EQUIP	12,520,264		12,520,264				2
4	EMPLOYEE BENEFITS DEPARTMENT	15,737,095	6,906	90,573	15,834,574			4
5.01	NONPATIENT TELEPHONES	229,396				229,396		5.01
5.02	DATA PROCESSING	2,889,331	10,297	135,050			3,034,678	5.02
5.03	PURCHASING,RECEIVING&STORES	283,261				3,710		5.03
5.04	ADMITTING	676,726				6,595		5.04
5.05	CASHIERING/ACCTS RECEIVABLE	4,543,603				10,305		5.05
5.06	ADMINISTRATION & GENERAL	37,799,676	274,795	3,603,966	1,557,538	28,030	3,034,678	5.06
6	MAINTENANCE & REPAIRS	1,348,280			105,620			6
7	OPERATION OF PLANT	5,572,953	64,638	847,733	146,810	9,481		7
8	LAUNDRY & LINEN SERVICE	1,126,629	1,798	23,578		824		8
9	HOUSEKEEPING	2,248,376	31,753	416,450	261,382	1,237		9
10	DIETARY	1,774,398	30,303	397,422	220,634	1,649		10
11	CAFETERIA	209,179			143,222	2,473		11
13	NURSING ADMINISTRATION	1,865,071	3,057	40,093	369,563	9,893		13
14	CENTRAL SERVICES & SUPPLY	312,362	27,973	366,863		1,031		14
15	PHARMACY	1,025,773	5,856	76,800	485,505	4,122		15
16	MEDICAL RECORDS & LIBRARY	1,363,622	12,097	158,649	168,996	7,832		16
17	SOCIAL SERVICE	1,921,448			298,091	3,092		17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD	7,347,288			1,527,431			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	6,630,290	15,912	208,693	894,676	10,924		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	20,246,201	191,602	2,512,890	3,644,015	35,039		30
31	INTENSIVE CARE UNIT	2,700,532	22,644	296,981	507,596	8,038		31
41	SUBPROVIDER - IRF	1,107,705	10,221	134,053	215,598	4,740		41
43	NURSERY	1,975,054	1,492	19,569	377,536	1,649		43
44	SKILLED NURSING FACILITY	1,431,392	24,011	314,908	281,848	2,473		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	9,528,972	64,171	841,605	1,081,813	16,901		50
51	RECOVERY ROOM	627,097	3,277	42,981	129,197			51
53	ANESTHESIOLOGY	291,133	1,386	18,177	21,190	412		53
54	RADIOLOGY-DIAGNOSTIC	3,437,886	42,048	551,458	528,506	16,695		54
55	RADIOLOGY-THERAPEUTIC	2,004,592	14,702	192,821	201,224			55
57	CT SCAN	469,015			83,420			57
58	MRI	334,482			56,990			58
59	CARDIAC CATHETERIZATION	1,209,412			213,354			59
60	LABORATORY	6,931,399	17,282	226,662		11,954		60
63	BLOOD STORING, PROCESSING & TRANS.	716,713						63
65	RESPIRATORY THERAPY	1,156,292	5,091	66,767	214,288	2,885		65
66	PHYSICAL THERAPY	3,443,865	10,381	136,151	603,619	5,771		66
69	ELECTROCARDIOLOGY	786,350	15,592	204,496	98,021	3,298		69
70	ELECTROENCEPHALOGRAPHY	48,493	60	789	11,586	2,679		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,914,211						71
72	IMPL. DEV. CHARGED TO PATIENTS	4,763,438						72
73	DRUGS CHARGED TO PATIENTS	6,521,847						73
74	RENAL DIALYSIS	381,033				1,237		74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	59,274			12,891	618		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	346,579	10,769	141,240	68,976	8,656		90
91	EMERGENCY	1,903,833			369,194	5,153		91
91.01	PARTIAL HOSPITALIZATION	212,348	3,089	40,509	47,210			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	187,928,812	923,203	12,107,927	14,947,540	229,396	3,034,678	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER	3,252,919	31,440	412,337	887,034			194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	191,181,731	954,643	12,520,264	15,834,574	229,396	3,034,678	202

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PURCHASING ,RECEIVING &STORES	ADMITTING	CASHIERING /ACCTS REC EIVABLE	SUBTOTAL (cols.0-4)	ADMINISTRA TION & GEN ERAL	MAIN-TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
	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	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES	286,971						5.03
5.04	ADMITTING		683,321					5.04
5.05	CASHIERING/ACCTS RECEIVABLE			4,553,908				5.05
5.06	ADMINISTRATION & GENERAL	8,571			46,307,254	46,307,254		5.06
6	MAINTENANCE & REPAIRS	254			1,454,154	464,801	1,918,955	6
7	OPERATION OF PLANT	13			6,641,628	2,122,910	187,185	7
8	LAUNDRY & LINEN SERVICE				1,152,829	368,487	5,206	8
9	HOUSEKEEPING	5,778			2,964,976	947,716	91,955	9
10	DIETARY	5,327			2,429,733	776,633	87,753	10
11	CAFETERIA				354,874	113,431		11
13	NURSING ADMINISTRATION	285			2,287,962	731,317	8,853	13
14	CENTRAL SERVICES & SUPPLY	2,891			711,120	227,300	81,006	14
15	PHARMACY	834			1,598,890	511,064	16,958	15
16	MEDICAL RECORDS & LIBRARY	292			1,711,488	547,055	35,031	16
17	SOCIAL SERVICE	58			2,222,689	710,454		17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD				8,874,719	2,836,689		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	6,235			7,766,730	2,482,534	46,081	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	7,473	176,670	783,113	27,597,003	8,821,033	554,860	30
31	INTENSIVE CARE UNIT	373	18,429	75,259	3,629,852	1,160,235	65,575	31
41	SUBPROVIDER - IRF	327	7,214	29,460	1,509,318	482,434	29,600	41
43	NURSERY	286	14,207	58,017	2,447,810	782,411	4,321	43
44	SKILLED NURSING FACILITY	282	7,291	29,773	2,091,978	668,674	69,534	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,467	47,769	596,241	12,190,939	3,896,675	185,832	50
51	RECOVERY ROOM	44	7,261	86,145	896,002	286,395	9,490	51
53	ANESTHESIOLOGY	90	11,659	126,929	470,976	150,541	4,014	53
54	RADIOLOGY-DIAGNOSTIC	851	24,257	263,856	4,865,557	1,555,212	121,765	54
55	RADIOLOGY-THERAPEUTIC	519	325	53,850	2,468,033	788,875	42,576	55
57	CT SCAN	100	12,309	141,845	706,689	225,884		57
58	MRI	3	7,170	90,695	489,340	156,411		58
59	CARDIAC CATHETERIZATION	2,223	16,472	109,715	1,551,176	495,813		59
60	LABORATORY	88	75,608	485,044	7,748,037	2,476,559	50,048	60
63	BLOOD STORING, PROCESSING & TRANS.		5,603	27,718	750,034	239,739		63
65	RESPIRATORY THERAPY	134	15,835	69,662	1,530,954	489,350	14,742	65
66	PHYSICAL THERAPY	283	13,450	97,141	4,310,661	1,377,847	30,063	66
69	ELECTROCARDIOLOGY	126	12,669	114,727	1,235,279	394,841	45,154	69
70	ELECTROENCEPHALOGRAPHY	19	748	9,495	73,869	23,611	174	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	227,079	41,396	274,892	7,457,578	2,383,718		71
72	IMPL. DEV. CHARGED TO PATIENTS		18,458	122,472	4,904,368	1,567,617		72
73	DRUGS CHARGED TO PATIENTS		127,830	668,184	7,317,861	2,339,059		73
74	RENAL DIALYSIS		2,471	10,898	395,639	126,461		74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	17	2	1,491	74,293	23,747		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		326	16,892	593,438	189,685	31,187	90
91	EMERGENCY	957	17,892	203,827	2,500,856	799,366		91
91.01	PARTIAL HOSPITALIZATION	34		6,567	309,757	99,010	8,945	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	285,313	683,321	4,553,908	186,596,343	44,841,594	1,827,908	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER	1,658			4,585,388	1,465,660	91,047	194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	286,971	683,321	4,553,908	191,181,731	46,307,254	1,918,955	202

KPMG LLP COMPU-MAX

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	8,951,723						7
8	LAUNDRY & LINEN SERVICE	26,911	1,553,433					8
9	HOUSEKEEPING	475,325	1,865	4,481,837				9
10	DIETARY	453,606		240,605	3,988,330			10
11	CAFETERIA					468,305		11
13	NURSING ADMINISTRATION	45,761		24,273		9,968	3,108,134	13
14	CENTRAL SERVICES & SUPPLY	418,728	1,180	222,105				14
15	PHARMACY	87,658		46,496		14,418		15
16	MEDICAL RECORDS & LIBRARY	181,077		96,048		8,964		16
17	SOCIAL SERVICE					8,969		17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD					87,732		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	238,196		126,346				22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,868,145	727,476	1,521,341	3,218,342	138,960	1,517,671	30
31	INTENSIVE CARE UNIT	338,966	73,807	179,797	218,558	16,380	178,904	31
41	SUBPROVIDER - IRF	153,004	58,186	81,158	177,160	8,001	87,383	41
43	NURSERY	22,335		11,847		9,141	99,854	43
44	SKILLED NURSING FACILITY	359,428	106,925	190,650	374,270	11,058	120,753	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	960,585	213,560	509,520		38,476	420,225	50
51	RECOVERY ROOM	49,057	35,030	26,021		3,809	41,600	51
53	ANESTHESIOLOGY	20,747		11,005		1,241		53
54	RADIOLOGY-DIAGNOSTIC	629,420	117,847	333,861		16,748	182,922	54
55	RADIOLOGY-THERAPEUTIC	220,081	12,511	116,737		6,412	70,046	55
57	CT SCAN		17,092			2,578	28,171	57
58	MRI					1,791	19,541	58
59	CARDIAC CATHETERIZATION		37,196			5,751	62,794	59
60	LABORATORY	258,706	15,572	137,225				60
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY	76,206	2	40,422		8,263	91,931	65
66	PHYSICAL THERAPY	155,399	7,284	82,428		19,059		66
69	ELECTROCARDIOLOGY	233,407	13,246	123,805		3,415	37,309	69
70	ELECTROENCEPHALOGRAPHY	901	1,612	478		726	7,933	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION		1,029			484		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	161,208	24,934	85,509		2,679		90
91	EMERGENCY		83,847			12,919	141,097	91
91.01	PARTIAL HOSPITALIZATION	46,236		24,525		1,629		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	8,481,093	1,550,201	4,232,202	3,988,330	439,571	3,108,134	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER	470,630	3,232	249,635		28,734		194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	8,951,723	1,553,433	4,481,837	3,988,330	468,305	3,108,134	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		14	15	16	17	21	22	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	1,661,439						14
15	PHARMACY		2,275,484					15
16	MEDICAL RECORDS & LIBRARY			2,579,663				16
17	SOCIAL SERVICE				2,942,112			17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD					11,799,140		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						10,659,887	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			443,672	2,191,378	8,136,558	7,350,941	30
31	INTENSIVE CARE UNIT			42,631	148,821	1,949,358	1,761,140	31
41	SUBPROVIDER - IRF			16,688	120,625			41
43	NURSERY			32,864	226,453			43
44	SKILLED NURSING FACILITY			16,865	254,835			44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			337,745		472,267	426,668	50
51	RECOVERY ROOM			48,797				51
53	ANESTHESIOLOGY			71,900				53
54	RADIOLOGY-DIAGNOSTIC			149,463		256,230	231,490	54
55	RADIOLOGY-THERAPEUTIC			30,504				55
57	CT SCAN			80,349				57
58	MRI			51,375				58
59	CARDIAC CATHETERIZATION			62,149				59
60	LABORATORY			274,756		102,994	93,050	60
63	BLOOD STORING, PROCESSING & TRANS.			15,701				63
65	RESPIRATORY THERAPY			39,461		204,733	184,965	65
66	PHYSICAL THERAPY			55,026		204,733	184,965	66
69	ELECTROCARDIOLOGY			64,988				69
70	ELECTROENCEPHALOGRAPHY			5,378		472,267	426,668	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	983,721		155,715				71
72	IMPL. DEV. CHARGED TO PATIENTS	677,718		69,375				72
73	DRUGS CHARGED TO PATIENTS		2,275,484	378,497				73
74	RENAL DIALYSIS			6,173				74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION			844				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC			9,568				90
91	EMERGENCY			115,459				91
91.01	PARTIAL HOSPITALIZATION			3,720				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,661,439	2,275,484	2,579,663	2,942,112	11,799,140	10,659,887	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER							194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,661,439	2,275,484	2,579,663	2,942,112	11,799,140	10,659,887	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	65,087,380	-15,487,499	49,599,881				30
31	INTENSIVE CARE UNIT	9,764,024	-3,710,498	6,053,526				31
41	SUBPROVIDER - IRF	2,723,557		2,723,557				41
43	NURSERY	3,637,036		3,637,036				43
44	SKILLED NURSING FACILITY	4,264,970		4,264,970				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	19,652,492	-898,935	18,753,557				50
51	RECOVERY ROOM	1,396,201		1,396,201				51
53	ANESTHESIOLOGY	730,424		730,424				53
54	RADIOLOGY-DIAGNOSTIC	8,460,515	-487,720	7,972,795				54
55	RADIOLOGY-THERAPEUTIC	3,755,775		3,755,775				55
57	CT SCAN	1,060,763		1,060,763				57
58	MRI	718,458		718,458				58
59	CARDIAC CATHETERIZATION	2,214,879		2,214,879				59
60	LABORATORY	11,156,947	-196,044	10,960,903				60
63	BLOOD STORING, PROCESSING & TRANS.	1,005,474		1,005,474				63
65	RESPIRATORY THERAPY	2,681,029	-389,698	2,291,331				65
66	PHYSICAL THERAPY	6,427,465	-389,698	6,037,767				66
69	ELECTROCARDIOLOGY	2,151,444		2,151,444				69
70	ELECTROENCEPHALOGRAPHY	1,013,617	-898,935	114,682				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,980,732		10,980,732				71
72	IMPL. DEV. CHARGED TO PATIENTS	7,219,078		7,219,078				72
73	DRUGS CHARGED TO PATIENTS	12,310,901		12,310,901				73
74	RENAL DIALYSIS	528,273		528,273				74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	100,397		100,397				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,098,208		1,098,208				90
91	EMERGENCY	3,653,544		3,653,544				91
91.01	PARTIAL HOSPITALIZATION	493,822		493,822				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	184,287,405	-22,459,027	161,828,378				118
	NONREIMBURSABLE COST CENTERS							
194	OTHER	6,894,326		6,894,326				194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	191,181,731	-22,459,027	168,722,704				202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	DATA PROCESSING	
		0	1	2	2A	4	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		6,906	90,573	97,479	97,479		4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING		10,297	135,050	145,347		145,347	5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL		274,795	3,603,966	3,878,761	9,585	145,347	5.06
6	MAINTENANCE & REPAIRS					650		6
7	OPERATION OF PLANT		64,638	847,733	912,371	903		7
8	LAUNDRY & LINEN SERVICE		1,798	23,578	25,376			8
9	HOUSEKEEPING		31,753	416,450	448,203	1,609		9
10	DIETARY		30,303	397,422	427,725	1,358		10
11	CAFETERIA					881		11
13	NURSING ADMINISTRATION		3,057	40,093	43,150	2,274		13
14	CENTRAL SERVICES & SUPPLY		27,973	366,863	394,836			14
15	PHARMACY		5,856	76,800	82,656	2,988		15
16	MEDICAL RECORDS & LIBRARY		12,097	158,649	170,746	1,040		16
17	SOCIAL SERVICE					1,834		17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD					9,400		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		15,912	208,693	224,605	5,506		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		191,602	2,512,890	2,704,492	22,458		30
31	INTENSIVE CARE UNIT		22,644	296,981	319,625	3,124		31
41	SUBPROVIDER - IRF		10,221	134,053	144,274	1,327		41
43	NURSERY		1,492	19,569	21,061	2,323		43
44	SKILLED NURSING FACILITY		24,011	314,908	338,919	1,735		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		64,171	841,605	905,776	6,658		50
51	RECOVERY ROOM		3,277	42,981	46,258	795		51
53	ANESTHESIOLOGY		1,386	18,177	19,563	130		53
54	RADIOLOGY-DIAGNOSTIC		42,048	551,458	593,506	3,253		54
55	RADIOLOGY-THERAPEUTIC		14,702	192,821	207,523	1,238		55
57	CT SCAN					513		57
58	MRI					351		58
59	CARDIAC CATHETERIZATION					1,313		59
60	LABORATORY		17,282	226,662	243,944			60
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY		5,091	66,767	71,858	1,319		65
66	PHYSICAL THERAPY		10,381	136,151	146,532	3,715		66
69	ELECTROCARDIOLOGY		15,592	204,496	220,088	603		69
70	ELECTROENCEPHALOGRAPHY		60	789	849	71		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION					79		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		10,769	141,240	152,009	424		90
91	EMERGENCY					2,272		91
91.01	PARTIAL HOSPITALIZATION		3,089	40,509	43,598	291		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		923,203	12,107,927	13,031,130	92,020	145,347	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER		31,440	412,337	443,777	5,459		194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		954,643	12,520,264	13,474,907	97,479	145,347	202

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	6	7	8	9	10	
	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	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL	4,033,693						5.06
6	MAINTENANCE & REPAIRS	40,488	41,138					6
7	OPERATION OF PLANT	184,923	4,013	1,102,210				7
8	LAUNDRY & LINEN SERVICE	32,098	112	3,314	60,900			8
9	HOUSEKEEPING	82,554	1,971	58,526	73	592,936		9
10	DIETARY	67,651	1,881	55,852		31,831	586,298	10
11	CAFETERIA	9,881						11
13	NURSING ADMINISTRATION	63,704	190	5,635		3,211		13
14	CENTRAL SERVICES & SUPPLY	19,800	1,737	51,557	46	29,384		14
15	PHARMACY	44,518	364	10,793		6,151		15
16	MEDICAL RECORDS & LIBRARY	47,653	751	22,296		12,707		16
17	SOCIAL SERVICE	61,886						17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD	247,099						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	216,249	988	29,329		16,715		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	768,337	11,892	353,149	28,522	201,270	473,107	30
31	INTENSIVE CARE UNIT	101,066	1,406	41,736	2,893	23,787	32,129	31
41	SUBPROVIDER - IRF	42,024	635	18,839	2,281	10,737	26,043	41
43	NURSERY	68,154	93	2,750		1,567		43
44	SKILLED NURSING FACILITY	58,247	1,491	44,256	4,192	25,223	55,019	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	339,432	3,984	118,275	8,372	67,408		50
51	RECOVERY ROOM	24,947	203	6,040	1,373	3,443		51
53	ANESTHESIOLOGY	13,113	86	2,555		1,456		53
54	RADIOLOGY-DIAGNOSTIC	135,472	2,610	77,499	4,620	44,169		54
55	RADIOLOGY-THERAPEUTIC	68,717	913	27,098	490	15,444		55
57	CT SCAN	19,676			670			57
58	MRI	13,625						58
59	CARDIAC CATHETERIZATION	43,189			1,458			59
60	LABORATORY	215,729	1,073	31,854	610	18,154		60
63	BLOOD STORING, PROCESSING & TRANS.	20,883						63
65	RESPIRATORY THERAPY	42,626	316	9,383		5,348		65
66	PHYSICAL THERAPY	120,022	644	19,134	286	10,905		66
69	ELECTROCARDIOLOGY	34,394	968	28,739	519	16,379		69
70	ELECTROENCEPHALOGRAPHY	2,057	4	111	63	63		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	207,641						71
72	IMPL. DEV. CHARGED TO PATIENTS	136,552						72
73	DRUGS CHARGED TO PATIENTS	203,751						73
74	RENAL DIALYSIS	11,016						74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	2,069			40			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	16,523	669	19,849	978	11,313		90
91	EMERGENCY	69,631			3,287			91
91.01	PARTIAL HOSPITALIZATION	8,625	192	5,693		3,245		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,906,022	39,186	1,044,262	60,773	559,910	586,298	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER	127,671	1,952	57,948	127	33,026		194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,033,693	41,138	1,102,210	60,900	592,936	586,298	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA	10,762						11
13	NURSING ADMINISTRATION	229	118,393					13
14	CENTRAL SERVICES & SUPPLY			497,360				14
15	PHARMACY	331			147,801			15
16	MEDICAL RECORDS & LIBRARY	206				255,399		16
17	SOCIAL SERVICE	206					63,926	17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD	2,016						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,195	57,808			43,997	47,614	30
31	INTENSIVE CARE UNIT	376	6,815			4,219	3,234	31
41	SUBPROVIDER - IRF	184	3,329			1,652	2,621	41
43	NURSERY	210	3,804			3,253	4,920	43
44	SKILLED NURSING FACILITY	254	4,600			1,669	5,537	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	884	16,007			33,427		50
51	RECOVERY ROOM	88	1,585			4,830		51
53	ANESTHESIOLOGY	29				7,116		53
54	RADIOLOGY-DIAGNOSTIC	385	6,968			14,793		54
55	RADIOLOGY-THERAPEUTIC	147	2,668			3,019		55
57	CT SCAN	59	1,073			7,952		57
58	MRI	41	744			5,085		58
59	CARDIAC CATHETERIZATION	132	2,392			6,151		59
60	LABORATORY					27,193		60
63	BLOOD STORING, PROCESSING & TRANS.					1,554		63
65	RESPIRATORY THERAPY	190	3,502			3,905		65
66	PHYSICAL THERAPY	438				5,446		66
69	ELECTROCARDIOLOGY	78	1,421			6,432		69
70	ELECTROENCEPHALOGRAPHY	17	302			532		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			294,480		15,411		71
72	IMPL. DEV. CHARGED TO PATIENTS			202,880		6,866		72
73	DRUGS CHARGED TO PATIENTS				147,801	37,460		73
74	RENAL DIALYSIS					611		74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	11				84		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	62				947		90
91	EMERGENCY	297	5,375			11,427		91
91.01	PARTIAL HOSPITALIZATION	37				368		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,102	118,393	497,360	147,801	255,399	63,926	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER	660						194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	10,762	118,393	497,360	147,801	255,399	63,926	202

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		21	22	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	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD	258,515						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		493,392					22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			4,715,841		4,715,841		30
31	INTENSIVE CARE UNIT			540,410		540,410		31
41	SUBPROVIDER - IRF			253,946		253,946		41
43	NURSERY			108,135		108,135		43
44	SKILLED NURSING FACILITY			541,142		541,142		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			1,500,223		1,500,223		50
51	RECOVERY ROOM			89,562		89,562		51
53	ANESTHESIOLOGY			44,048		44,048		53
54	RADIOLOGY-DIAGNOSTIC			883,275		883,275		54
55	RADIOLOGY-THERAPEUTIC			327,257		327,257		55
57	CT SCAN			29,943		29,943		57
58	MRI			19,846		19,846		58
59	CARDIAC CATHETERIZATION			54,635		54,635		59
60	LABORATORY			538,557		538,557		60
63	BLOOD STORING, PROCESSING & TRANS.			22,437		22,437		63
65	RESPIRATORY THERAPY			138,447		138,447		65
66	PHYSICAL THERAPY			307,122		307,122		66
69	ELECTROCARDIOLOGY			309,621		309,621		69
70	ELECTROENCEPHALOGRAPHY			4,069		4,069		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			517,532		517,532		71
72	IMPL. DEV. CHARGED TO PATIENTS			346,298		346,298		72
73	DRUGS CHARGED TO PATIENTS			389,012		389,012		73
74	RENAL DIALYSIS			11,627		11,627		74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION			2,283		2,283		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC			202,774		202,774		90
91	EMERGENCY			92,289		92,289		91
91.01	PARTIAL HOSPITALIZATION			62,049		62,049		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)			12,052,380		12,052,380		118
	NONREIMBURSABLE COST CENTERS							
194	OTHER			670,620		670,620		194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS	258,515	493,392	751,907		751,907		200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	258,515	493,392	13,474,907		13,474,907		202

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONES NUMBER OF PHONES	DATA PROCESSING TIME SPENT	PURCHASING,RECEIVING &STORES SUPPLY EXPENSE	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	602,698						1
2	CAP REL COSTS-MVBLE EQUIP		602,698					2
4	EMPLOYEE BENEFITS DEPARTMENT	4,360	4,360	76,310,410				4
5.01	NONPATIENT TELEPHONES				1,113			5.01
5.02	DATA PROCESSING	6,501	6,501			100		5.02
5.03	PURCHASING,RECEIVING&STORES				18		8,737,899	5.03
5.04	ADMITTING				32			5.04
5.05	CASHIERING/ACCTS RECEIVABLE				50			5.05
5.06	ADMINISTRATION & GENERAL	173,487	173,487	7,506,136	136	100	260,980	5.06
6	MAINTENANCE & REPAIRS			509,008			7,745	6
7	OPERATION OF PLANT	40,808	40,808	707,509	46		405	7
8	LAUNDRY & LINEN SERVICE	1,135	1,135		4			8
9	HOUSEKEEPING	20,047	20,047	1,259,661	6		175,945	9
10	DIETARY	19,131	19,131	1,063,285	8		162,215	10
11	CAFETERIA			690,218	12			11
13	NURSING ADMINISTRATION	1,930	1,930	1,781,009	48		8,677	13
14	CENTRAL SERVICES & SUPPLY	17,660	17,660		5		88,037	14
15	PHARMACY	3,697	3,697	2,339,761	20		25,395	15
16	MEDICAL RECORDS & LIBRARY	7,637	7,637	814,432	38		8,904	16
17	SOCIAL SERVICE			1,436,570	15		1,763	17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD			7,361,043				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	10,046	10,046	4,311,648	53		189,838	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	120,965	120,965	17,561,303	170		227,551	30
31	INTENSIVE CARE UNIT	14,296	14,296	2,446,220	39		11,360	31
41	SUBPROVIDER - IRF	6,453	6,453	1,039,016	23		9,963	41
43	NURSERY	942	942	1,819,433	8		8,698	43
44	SKILLED NURSING FACILITY	15,159	15,159	1,358,292	12		8,587	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	40,513	40,513	5,213,505	82		410,059	50
51	RECOVERY ROOM	2,069	2,069	622,628			1,354	51
53	ANESTHESIOLOGY	875	875	102,120	2		2,747	53
54	RADIOLOGY-DIAGNOSTIC	26,546	26,546	2,546,990	81		25,897	54
55	RADIOLOGY-THERAPEUTIC	9,282	9,282	969,745			15,792	55
57	CT SCAN			402,019			3,037	57
58	MRI			274,646			100	58
59	CARDIAC CATHETERIZATION			1,028,202			67,688	59
60	LABORATORY	10,911	10,911		58		2,688	60
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY	3,214	3,214	1,032,705	14		4,083	65
66	PHYSICAL THERAPY	6,554	6,554	2,908,981	28		8,611	66
69	ELECTROCARDIOLOGY	9,844	9,844	472,388	16		3,829	69
70	ELECTROENCEPHALOGRAPHY	38	38	55,836	13		581	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						6,914,210	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS				6			74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION			62,125	3		506	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	6,799	6,799	332,409	42			90
91	EMERGENCY			1,779,230	25		29,147	91
91.01	PARTIAL HOSPITALIZATION	1,950	1,950	227,514			1,029	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	582,849	582,849	72,035,587	1,113	100	8,687,421	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER	19,849	19,849	4,274,823			50,478	194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONES NUMBER OF PHONES	DATA PROCESSING TIME SPENT	PURCHASING ,RECEIVING &STORES SUPPLY EXPENSE	
		1	2	4	5.01	5.02	5.03	
202	COST TO BE ALLOC PER B PT I	954,643	12,520,264	15,834,574	229,396	3,034,678	286,971	202
203	UNIT COST MULT-WS B PT I	1.583949	20.773694	0.207502	206.106020	30,346.780000	0.032842	203
204	COST TO BE ALLOC PER B PT II			97,479		145,347		204
205	UNIT COST MULT-WS B PT II			0.001277		1,453.470000		205

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	CASHIERING /ACCTS REC EIVABLE GROSS REVENUE	RECON-CILIATION	ADMINISTRATION & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	5A.06	5.06	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	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING	439,520,668						5.04
5.05	CASHIERING/ACCTS RECEIVABLE		717,149,449					5.05
5.06	ADMINISTRATION & GENERAL			-46,307,254	144,874,477			5.06
6	MAINTENANCE & REPAIRS				1,454,154	418,350		6
7	OPERATION OF PLANT				6,641,628	40,808	377,542	7
8	LAUNDRY & LINEN SERVICE				1,152,829	1,135	1,135	8
9	HOUSEKEEPING				2,964,976	20,047	20,047	9
10	DIETARY				2,429,733	19,131	19,131	10
11	CAFETERIA				354,874			11
13	NURSING ADMINISTRATION				2,287,962	1,930	1,930	13
14	CENTRAL SERVICES & SUPPLY				711,120	17,660	17,660	14
15	PHARMACY				1,598,890	3,697	3,697	15
16	MEDICAL RECORDS & LIBRARY				1,711,488	7,637	7,637	16
17	SOCIAL SERVICE				2,222,689			17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD				8,874,719			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				7,766,730	10,046	10,046	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	113,700,412	123,323,936		27,597,003	120,965	120,965	30
31	INTENSIVE CARE UNIT	11,851,763	11,851,763		3,629,852	14,296	14,296	31
41	SUBPROVIDER - IRF	4,639,302	4,639,302		1,509,318	6,453	6,453	41
43	NURSERY	9,136,542	9,136,542		2,447,810	942	942	43
44	SKILLED NURSING FACILITY	4,688,617	4,688,617		2,091,978	15,159	15,159	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	30,719,556	93,896,171		12,190,939	40,513	40,513	50
51	RECOVERY ROOM	4,669,294	13,566,148		896,002	2,069	2,069	51
53	ANESTHESIOLOGY	7,497,773	19,988,761		470,976	875	875	53
54	RADIOLOGY-DIAGNOSTIC	15,599,518	41,552,062		4,865,557	26,546	26,546	54
55	RADIOLOGY-THERAPEUTIC	208,902	8,480,375		2,468,033	9,282	9,282	55
57	CT SCAN	7,915,873	22,337,731		706,689			57
58	MRI	4,610,627	14,282,735		489,340			58
59	CARDIAC CATHETERIZATION	10,592,728	17,277,945		1,551,176			59
60	LABORATORY	48,622,549	76,384,829		7,748,037	10,911	10,911	60
63	BLOOD STORING, PROCESSING & TRANS.	3,603,003	4,365,082		750,034			63
65	RESPIRATORY THERAPY	10,183,244	10,970,400		1,530,954	3,214	3,214	65
66	PHYSICAL THERAPY	8,649,472	15,297,722		4,310,661	6,554	6,554	66
69	ELECTROCARDIOLOGY	8,147,286	18,067,247		1,235,279	9,844	9,844	69
70	ELECTROENCEPHALOGRAPHY	481,153	1,495,242		73,869	38	38	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,621,057	43,290,105		7,457,578			71
72	IMPL. DEV. CHARGED TO PATIENTS	11,870,221	19,286,856		4,904,368			72
73	DRUGS CHARGED TO PATIENTS	82,205,776	105,225,880		7,317,861			73
74	RENAL DIALYSIS	1,589,002	1,716,164		395,639			74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	1,520	234,764		74,293			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	209,345	2,660,108		593,438	6,799	6,799	90
91	EMERGENCY	11,506,133	32,098,722		2,500,856			91
91.01	PARTIAL HOSPITALIZATION		1,034,240		309,757	1,950	1,950	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	439,520,668	717,149,449	-46,307,254	140,289,089	398,501	357,693	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER				4,585,388	19,849	19,849	194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	683,321	4,553,908		46,307,254	1,918,955	8,951,723	202

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	CASHIERING /ACCTS RECEIVABLE GROSS REVENUE	RECON-CILIATION	ADMINISTRATION & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	5A.06	5.06	6	7	
203	UNIT COST MULT-WS B PT I	0.001555	0.006350		0.319637	4.586961	23.710536	203
204	COST TO BE ALLOC PER B PT II				4,033,693	41,138	1,102,210	204
205	UNIT COST MULT-WS B PT II				0.027843	0.098334	2.919437	205

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE LAUNDRY POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINISTRATION DIRECT NRSG HRS	CENTRAL SERVICES & SUPPLY SUPPLY EXPENSE	
		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	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	1,988,825						8
9	HOUSEKEEPING	2,388	356,360					9
10	DIETARY		19,131	218,305				10
11	CAFETERIA				92,832			11
13	NURSING ADMINISTRATION		1,930		1,976	1,173,388		13
14	CENTRAL SERVICES & SUPPLY	1,511	17,660				11,677,648	14
15	PHARMACY		3,697		2,858			15
16	MEDICAL RECORDS & LIBRARY		7,637		1,777			16
17	SOCIAL SERVICE				1,778			17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD				17,391			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		10,046					22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	931,369	120,965	176,159	27,546	572,954		30
31	INTENSIVE CARE UNIT	94,493	14,296	11,963	3,247	67,540		31
41	SUBPROVIDER - IRF	74,494	6,453	9,697	1,586	32,989		41
43	NURSERY		942		1,812	37,697		43
44	SKILLED NURSING FACILITY	136,894	15,159	20,486	2,192	45,587		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	273,416	40,513		7,627	158,644		50
51	RECOVERY ROOM	44,848	2,069		755	15,705		51
53	ANESTHESIOLOGY		875		246			53
54	RADIOLOGY-DIAGNOSTIC	150,877	26,546		3,320	69,057		54
55	RADIOLOGY-THERAPEUTIC	16,017	9,282		1,271	26,444		55
57	CT SCAN	21,883			511	10,635		57
58	MRI				355	7,377		58
59	CARDIAC CATHETERIZATION	47,621			1,140	23,706		59
60	LABORATORY	19,936	10,911					60
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY	3	3,214		1,638	34,706		65
66	PHYSICAL THERAPY	9,326	6,554		3,778			66
69	ELECTROCARDIOLOGY	16,959	9,844		677	14,085		69
70	ELECTROENCEPHALOGRAPHY	2,064	38		144	2,995		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						6,914,210	71
72	IMPL. DEV. CHARGED TO PATIENTS						4,763,438	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	1,318			96			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	31,923	6,799		531			90
91	EMERGENCY	107,347			2,561	53,267		91
91.01	PARTIAL HOSPITALIZATION		1,950		323			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,984,687	336,511	218,305	87,136	1,173,388	11,677,648	118
	NONREIMBURSABLE COST CENTERS							
194	OTHER	4,138	19,849		5,696			194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,553,433	4,481,837	3,988,330	468,305	3,108,134	1,661,439	202

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE LAUNDRY POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED)	CAFETERIA MEALS SERVED)	NURSING ADMINISTRATION DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY SUPPLY EXPENSE	
		8	9	10	11	13	14	
203	UNIT COST MULT-WS B PT I	0.781081	12.576712	18.269531	5.044651	2.648854	0.142275	203
204	COST TO BE ALLOC PER B PT II	60,900	592,936	586,298	10,762	118,393	497,360	204
205	UNIT COST MULT-WS B PT II	0.030621	1.663868	2.685683	0.115930	0.100898	0.042591	205

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	I&R SALARY & FRINGES ASSIGNED TIME)	I&R PROGRAM COSTS ASSIGNED TIME)		
		15	16	17	21	22		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	6,954,734						15
16	MEDICAL RECORDS & LIBRARY		717,149,449					16
17	SOCIAL SERVICE			63,025				17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD				9,394			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					9,394		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		123,323,936	46,943	6,478	6,478		30
31	INTENSIVE CARE UNIT		11,851,763	3,188	1,552	1,552		31
41	SUBPROVIDER - IRF		4,639,302	2,584				41
43	NURSERY		9,136,542	4,851				43
44	SKILLED NURSING FACILITY		4,688,617	5,459				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		93,896,171		376	376		50
51	RECOVERY ROOM		13,566,148					51
53	ANESTHESIOLOGY		19,988,761					53
54	RADIOLOGY-DIAGNOSTIC		41,552,062		204	204		54
55	RADIOLOGY-THERAPEUTIC		8,480,375					55
57	CT SCAN		22,337,731					57
58	MRI		14,282,735					58
59	CARDIAC CATHETERIZATION		17,277,945					59
60	LABORATORY		76,384,829		82	82		60
63	BLOOD STORING, PROCESSING & TRANS.		4,365,082					63
65	RESPIRATORY THERAPY		10,970,400		163	163		65
66	PHYSICAL THERAPY		15,297,722		163	163		66
69	ELECTROCARDIOLOGY		18,067,247					69
70	ELECTROENCEPHALOGRAPHY		1,495,242		376	376		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		43,290,105					71
72	IMPL. DEV. CHARGED TO PATIENTS		19,286,856					72
73	DRUGS CHARGED TO PATIENTS	6,954,734	105,225,880					73
74	RENAL DIALYSIS		1,716,164					74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION		234,764					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		2,660,108					90
91	EMERGENCY		32,098,722					91
91.01	PARTIAL HOSPITALIZATION		1,034,240					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	6,954,734	717,149,449	63,025	9,394	9,394		118
	NONREIMBURSABLE COST CENTERS							
194	OTHER							194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	I&R SALARY & FRINGES ASSIGNED T IME)	I&R PROGRAM COSTS ASSIGNED T IME)		
		15	16	17	21	22		
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,275,484	2,579,663	2,942,112	11,799,140	10,659,887		202
203	UNIT COST MULT-WS B PT I	0.327185	0.003597	46.681666	1,256.029380	1,134.754844		203
204	COST TO BE ALLOC PER B PT II	147,801	255,399	63,926	258,515	493,392		204
205	UNIT COST MULT-WS B PT II	0.021252	0.000356	1.014296	27.519161	52.522035		205

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	49,599,881		49,599,881	23,442	49,623,323	30
31	INTENSIVE CARE UNIT	6,053,526		6,053,526		6,053,526	31
41	SUBPROVIDER - IRF	2,723,557		2,723,557		2,723,557	41
43	NURSERY	3,637,036		3,637,036		3,637,036	43
44	SKILLED NURSING FACILITY	4,264,970		4,264,970		4,264,970	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	18,753,557		18,753,557		18,753,557	50
51	RECOVERY ROOM	1,396,201		1,396,201		1,396,201	51
53	ANESTHESIOLOGY	730,424		730,424		730,424	53
54	RADIOLOGY-DIAGNOSTIC	7,972,795		7,972,795		7,972,795	54
55	RADIOLOGY-THERAPEUTIC	3,755,775		3,755,775		3,755,775	55
57	CT SCAN	1,060,763		1,060,763		1,060,763	57
58	MRI	718,458		718,458		718,458	58
59	CARDIAC CATHETERIZATION	2,214,879		2,214,879		2,214,879	59
60	LABORATORY	10,960,903		10,960,903		10,960,903	60
63	BLOOD STORING, PROCESSING & TRANS.	1,005,474		1,005,474		1,005,474	63
65	RESPIRATORY THERAPY	2,291,331		2,291,331		2,291,331	65
66	PHYSICAL THERAPY	6,037,767		6,037,767		6,037,767	66
69	ELECTROCARDIOLOGY	2,151,444		2,151,444		2,151,444	69
70	ELECTROENCEPHALOGRAPHY	114,682		114,682		114,682	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,980,732		10,980,732		10,980,732	71
72	IMPL. DEV. CHARGED TO PATIENTS	7,219,078		7,219,078		7,219,078	72
73	DRUGS CHARGED TO PATIENTS	12,310,901		12,310,901		12,310,901	73
74	RENAL DIALYSIS	528,273		528,273		528,273	74
76	OTHER ANCILLARY SERVICE COST CENTER						76
76.97	CARDIAC REHABILITATION	100,397		100,397		100,397	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,098,208		1,098,208		1,098,208	90
91	EMERGENCY	3,653,544		3,653,544		3,653,544	91
91.01	PARTIAL HOSPITALIZATION	493,822		493,822		493,822	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	4,146,336		4,146,336		4,146,336	92
	OTHER REIMBURSABLE COST CENTERS						
200	SUBTOTAL (SEE INSTRUCTIONS)	165,974,714		165,974,714	23,442	165,998,156	200
201	LESS OBSERVATION BEDS	4,146,336		4,146,336		4,146,336	201
202	TOTAL (SEE INSTRUCTIONS)	161,828,378		161,828,378		161,851,820	202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	113,700,412		113,700,412				30
31	INTENSIVE CARE UNIT	11,851,763		11,851,763				31
41	SUBPROVIDER - IRF	4,639,302		4,639,302				41
43	NURSERY	9,136,542		9,136,542				43
44	SKILLED NURSING FACILITY	4,688,617		4,688,617				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	30,719,556	63,176,615	93,896,171	0.199727	0.199727	0.199727	50
51	RECOVERY ROOM	4,669,294	8,896,854	13,566,148	0.102918	0.102918	0.102918	51
53	ANESTHESIOLOGY	7,497,773	12,490,988	19,988,761	0.036542	0.036542	0.036542	53
54	RADIOLOGY-DIAGNOSTIC	15,599,518	25,952,544	41,552,062	0.191875	0.191875	0.191875	54
55	RADIOLOGY-THERAPEUTIC	208,902	8,271,473	8,480,375	0.442878	0.442878	0.442878	55
57	CT SCAN	7,915,873	14,421,858	22,337,731	0.047488	0.047488	0.047488	57
58	MRI	4,610,627	9,672,108	14,282,735	0.050303	0.050303	0.050303	58
59	CARDIAC CATHETERIZATION	10,592,728	6,685,217	17,277,945	0.128191	0.128191	0.128191	59
60	LABORATORY	48,622,549	27,762,280	76,384,829	0.143496	0.143496	0.143496	60
63	BLOOD STORING, PROCESSING & TRANS.	3,603,003	762,079	4,365,082	0.230345	0.230345	0.230345	63
65	RESPIRATORY THERAPY	10,183,244	787,156	10,970,400	0.208865	0.208865	0.208865	65
66	PHYSICAL THERAPY	8,649,472	6,648,250	15,297,722	0.394684	0.394684	0.394684	66
69	ELECTROCARDIOLOGY	8,147,286	9,919,961	18,067,247	0.119080	0.119080	0.119080	69
70	ELECTROENCEPHALOGRAPHY	481,153	1,014,089	1,495,242	0.076698	0.076698	0.076698	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,621,057	16,669,048	43,290,105	0.253655	0.253655	0.253655	71
72	IMPL. DEV. CHARGED TO PATIENTS	11,870,221	7,416,635	19,286,856	0.374300	0.374300	0.374300	72
73	DRUGS CHARGED TO PATIENTS	82,205,776	23,020,104	105,225,880	0.116995	0.116995	0.116995	73
74	RENAL DIALYSIS	1,589,002	127,162	1,716,164	0.307822	0.307822	0.307822	74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	1,520	233,244	234,764	0.427651	0.427651	0.427651	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	209,345	2,450,763	2,660,108	0.412843	0.412843	0.412843	90
91	EMERGENCY	11,506,133	20,592,589	32,098,722	0.113822	0.113822	0.113822	91
91.01	PARTIAL HOSPITALIZATION		1,034,240	1,034,240	0.477473	0.477473	0.477473	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,506,686	8,116,838	9,623,524	0.430854	0.430854	0.430854	92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	441,027,354	276,122,095	717,149,449				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	441,027,354	276,122,095	717,149,449				202

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	4,715,841		4,715,841	51,223	92.06	18,061	1,662,696	30
31	INTENSIVE CARE UNIT	540,410		540,410	3,188	169.51	1,814	307,491	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	253,946		253,946	2,584	98.28	1,816	178,476	41
42	SUBPROVIDER I								42
43	NURSERY	108,135		108,135	4,851	22.29			43
44	SKILLED NURSING FACILITY	541,142		541,142	5,459	99.13	4,057	402,170	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	6,159,474		6,159,474	67,305		25,748	2,550,833	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0224** **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	1,500,223	93,896,171	0.015977	11,304,741	180,616	50
51	RECOVERY ROOM	89,562	13,566,148	0.006602	1,738,375	11,477	51
53	ANESTHESIOLOGY	44,048	19,988,761	0.002204	2,339,687	5,157	53
54	RADIOLOGY-DIAGNOSTIC	883,275	41,552,062	0.021257	6,397,923	136,001	54
55	RADIOLOGY-THERAPEUTIC	327,257	8,480,375	0.038590	73,284	2,828	55
57	CT SCAN	29,943	22,337,731	0.001340	3,855,514	5,166	57
58	MRI	19,846	14,282,735	0.001390	1,516,594	2,108	58
59	CARDIAC CATHETERIZATION	54,635	17,277,945	0.003162	6,649,493	21,026	59
60	LABORATORY	538,557	76,384,829	0.007051	21,392,298	150,837	60
63	BLOOD STORING, PROCESSING & TRANS.	22,437	4,365,082	0.005140	1,943,671	9,990	63
65	RESPIRATORY THERAPY	138,447	10,970,400	0.012620	5,437,574	68,622	65
66	PHYSICAL THERAPY	307,122	15,297,722	0.020076	1,934,824	38,844	66
69	ELECTROCARDIOLOGY	309,621	18,067,247	0.017137	4,003,373	68,606	69
70	ELECTROENCEPHALOGRAPHY	4,069	1,495,242	0.002721	246,443	671	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	517,532	43,290,105	0.011955	12,260,379	146,573	71
72	IMPL. DEV. CHARGED TO PATIENTS	346,298	19,286,856	0.017955	5,715,208	102,617	72
73	DRUGS CHARGED TO PATIENTS	389,012	105,225,880	0.003697	30,457,756	112,602	73
74	RENAL DIALYSIS	11,627	1,716,164	0.006775	1,103,329	7,475	74
76	OTHER ANCILLARY SERVICE COST CENTER						76
76.97	CARDIAC REHABILITATION	2,283	234,764	0.009725	760	7	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	202,774	2,660,108	0.076228	79,512	6,061	90
91	EMERGENCY	92,289	32,098,722	0.002875	6,178,235	17,762	91
91.01	PARTIAL HOSPITALIZATION	62,049	1,034,240	0.059995			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	394,039	9,623,524	0.040945	1,120,005	45,859	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,286,945	573,132,813		125,748,978	1,140,905	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

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

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	51,223		18,061		30
31	INTENSIVE CARE UNIT	3,188		1,814		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	2,584		1,816		41
42	SUBPROVIDER I					42
43	NURSERY	4,851				43
44	SKILLED NURSING FACILITY	5,459		4,057		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	67,305		25,748		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0224** **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
91.01	PARTIAL HOSPITALIZATION							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0224** **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	93,896,171			11,304,741		12,450,875		50
51	RECOVERY ROOM	13,566,148			1,738,375		1,262,525		51
53	ANESTHESIOLOGY	19,988,761			2,339,687		2,411,128		53
54	RADIOLOGY-DIAGNOSTIC	41,552,062			6,397,923		7,189,574		54
55	RADIOLOGY-THERAPEUTIC	8,480,375			73,284		2,911,036		55
57	CT SCAN	22,337,731			3,855,514		5,004,207		57
58	MRI	14,282,735			1,516,594		2,713,689		58
59	CARDIAC CATHETERIZATION	17,277,945			6,649,493		3,726,962		59
60	LABORATORY	76,384,829			21,392,298		1,622,121		60
63	BLOOD STORING, PROCESSING & TRANS.	4,365,082			1,943,671		159,877		63
65	RESPIRATORY THERAPY	10,970,400			5,437,574		311,582		65
66	PHYSICAL THERAPY	15,297,722			1,934,824		300,804		66
69	ELECTROCARDIOLOGY	18,067,247			4,003,373		3,751,121		69
70	ELECTROENCEPHALOGRAPHY	1,495,242			246,443		346,784		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,290,105			12,260,379		3,643,213		71
72	IMPL. DEV. CHARGED TO PATIENTS	19,286,856			5,715,208		2,266,719		72
73	DRUGS CHARGED TO PATIENTS	105,225,880			30,457,756		7,395,529		73
74	RENAL DIALYSIS	1,716,164			1,103,329		99,180		74
76	OTHER ANCILLARY SERVICE COST CENTER								76
76.97	CARDIAC REHABILITATION	234,764			760		122,224		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,660,108			79,512		397,335		90
91	EMERGENCY	32,098,722			6,178,235		4,899,032		91
91.01	PARTIAL HOSPITALIZATION	1,034,240					116,730		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	9,623,524			1,120,005		3,279,787		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	573,132,813			125,748,978		66,382,034		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0224** **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	0.199727	12,450,875	1,824		2,486,776	364		50
51	RECOVERY ROOM	0.102918	1,262,525			129,937			51
53	ANESTHESIOLOGY	0.036542	2,411,128			88,107			53
54	RADIOLOGY-DIAGNOSTIC	0.191875	7,189,574			1,379,500			54
55	RADIOLOGY-THERAPEUTIC	0.442878	2,911,036			1,289,234			55
57	CT SCAN	0.047488	5,004,207			237,640			57
58	MRI	0.050303	2,713,689			136,507			58
59	CARDIAC CATHETERIZATION	0.128191	3,726,962			477,763			59
60	LABORATORY	0.143496	1,622,121	1,281		232,768	184		60
63	BLOOD STORING, PROCESSING & TRANS.	0.230345	159,877			36,827			63
65	RESPIRATORY THERAPY	0.208865	311,582			65,079			65
66	PHYSICAL THERAPY	0.394684	300,804			118,723			66
69	ELECTROCARDIOLOGY	0.119080	3,751,121			446,683			69
70	ELECTROENCEPHALOGRAPHY	0.076698	346,784			26,598			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.253655	3,643,213	9,616		924,119	2,439		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.374300	2,266,719	59,400		848,433	22,233		72
73	DRUGS CHARGED TO PATIENTS	0.116995	7,395,529	371		865,240	43		73
74	RENAL DIALYSIS	0.307822	99,180			30,530			74
76	OTHER ANCILLARY SERVICE COST CENTER								76
76.97	CARDIAC REHABILITATION	0.427651	122,224			52,269			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.412843	397,335			164,037			90
91	EMERGENCY	0.113822	4,899,032			557,618			91
91.01	PARTIAL HOSPITALIZATION	0.477473	116,730			55,735			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.430854	3,279,787			1,413,109			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		66,382,034	72,492		12,063,232	25,263		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		66,382,034	72,492		12,063,232	25,263		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T224** **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

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,500,223	93,896,171	0.015977	14,275	228	50
51	RECOVERY ROOM	89,562	13,566,148	0.006602			51
53	ANESTHESIOLOGY	44,048	19,988,761	0.002204	911	2	53
54	RADIOLOGY-DIAGNOSTIC	883,275	41,552,062	0.021257	121,018	2,572	54
55	RADIOLOGY-THERAPEUTIC	327,257	8,480,375	0.038590			55
57	CT SCAN	29,943	22,337,731	0.001340	72,036	97	57
58	MRI	19,846	14,282,735	0.001390	8,216	11	58
59	CARDIAC CATHETERIZATION	54,635	17,277,945	0.003162			59
60	LABORATORY	538,557	76,384,829	0.007051	560,539	3,952	60
63	BLOOD STORING, PROCESSING & TRANS.	22,437	4,365,082	0.005140	19,204	99	63
65	RESPIRATORY THERAPY	138,447	10,970,400	0.012620	273,512	3,452	65
66	PHYSICAL THERAPY	307,122	15,297,722	0.020076	1,916,983	38,485	66
69	ELECTROCARDIOLOGY	309,621	18,067,247	0.017137	24,306	417	69
70	ELECTROENCEPHALOGRAPHY	4,069	1,495,242	0.002721	3,044	8	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	517,532	43,290,105	0.011955	297,471	3,556	71
72	IMPL. DEV. CHARGED TO PATIENTS	346,298	19,286,856	0.017955			72
73	DRUGS CHARGED TO PATIENTS	389,012	105,225,880	0.003697	1,126,288	4,164	73
74	RENAL DIALYSIS	11,627	1,716,164	0.006775	94,120	638	74
76	OTHER ANCILLARY SERVICE COST CENTER						76
76.97	CARDIAC REHABILITATION	2,283	234,764	0.009725			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	202,774	2,660,108	0.076228			90
91	EMERGENCY	92,289	32,098,722	0.002875			91
91.01	PARTIAL HOSPITALIZATION	62,049	1,034,240	0.059995			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		9,623,524				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	5,892,906	573,132,813		4,531,923	57,681	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T224** **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							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
91.01	PARTIAL HOSPITALIZATION							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T224** **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	93,896,171			14,275				50
51	RECOVERY ROOM	13,566,148							51
53	ANESTHESIOLOGY	19,988,761			911				53
54	RADIOLOGY-DIAGNOSTIC	41,552,062			121,018		1,552		54
55	RADIOLOGY-THERAPEUTIC	8,480,375							55
57	CT SCAN	22,337,731			72,036		2,279		57
58	MRI	14,282,735			8,216				58
59	CARDIAC CATHETERIZATION	17,277,945							59
60	LABORATORY	76,384,829			560,539				60
63	BLOOD STORING, PROCESSING & TRANS.	4,365,082			19,204				63
65	RESPIRATORY THERAPY	10,970,400			273,512				65
66	PHYSICAL THERAPY	15,297,722			1,916,983				66
69	ELECTROCARDIOLOGY	18,067,247			24,306		3,561		69
70	ELECTROENCEPHALOGRAPHY	1,495,242			3,044				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,290,105			297,471				71
72	IMPL. DEV. CHARGED TO PATIENTS	19,286,856							72
73	DRUGS CHARGED TO PATIENTS	105,225,880			1,126,288				73
74	RENAL DIALYSIS	1,716,164			94,120				74
76	OTHER ANCILLARY SERVICE COST CENTER								76
76.97	CARDIAC REHABILITATION	234,764							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,660,108							90
91	EMERGENCY	32,098,722							91
91.01	PARTIAL HOSPITALIZATION	1,034,240							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	9,623,524							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	573,132,813			4,531,923		7,392		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T224** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.199727							50
51	RECOVERY ROOM	0.102918							51
53	ANESTHESIOLOGY	0.036542							53
54	RADIOLOGY-DIAGNOSTIC	0.191875	1,552			298			54
55	RADIOLOGY-THERAPEUTIC	0.442878							55
57	CT SCAN	0.047488	2,279			108			57
58	MRI	0.050303							58
59	CARDIAC CATHETERIZATION	0.128191							59
60	LABORATORY	0.143496							60
63	BLOOD STORING, PROCESSING & TRANS.	0.230345							63
65	RESPIRATORY THERAPY	0.208865							65
66	PHYSICAL THERAPY	0.394684							66
69	ELECTROCARDIOLOGY	0.119080	3,561			424			69
70	ELECTROENCEPHALOGRAPHY	0.076698							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.253655							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.374300							72
73	DRUGS CHARGED TO PATIENTS	0.116995							73
74	RENAL DIALYSIS	0.307822							74
76	OTHER ANCILLARY SERVICE COST CENTER								76
76.97	CARDIAC REHABILITATION	0.427651							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.412843							90
91	EMERGENCY	0.113822							91
91.01	PARTIAL HOSPITALIZATION	0.477473							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.430854							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		7,392			830			200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		7,392			830			202

(A) Worksheet A line numbers

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5568** **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
91.01	PARTIAL HOSPITALIZATION							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5568** **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	93,896,171			8,840				50
51	RECOVERY ROOM	13,566,148							51
53	ANESTHESIOLOGY	19,988,761			3,913				53
54	RADIOLOGY-DIAGNOSTIC	41,552,062			165,365				54
55	RADIOLOGY-THERAPEUTIC	8,480,375			57,678				55
57	CT SCAN	22,337,731							57
58	MRI	14,282,735			9,470				58
59	CARDIAC CATHETERIZATION	17,277,945							59
60	LABORATORY	76,384,829			960,363				60
63	BLOOD STORING, PROCESSING & TRANS.	4,365,082			10,040				63
65	RESPIRATORY THERAPY	10,970,400			334,659				65
66	PHYSICAL THERAPY	15,297,722			2,080,389				66
69	ELECTROCARDIOLOGY	18,067,247			48,607				69
70	ELECTROENCEPHALOGRAPHY	1,495,242			5,459				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,290,105							71
72	IMPL. DEV. CHARGED TO PATIENTS	19,286,856							72
73	DRUGS CHARGED TO PATIENTS	105,225,880							73
74	RENAL DIALYSIS	1,716,164							74
76	OTHER ANCILLARY SERVICE COST CENTER								76
76.97	CARDIAC REHABILITATION	234,764							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,660,108							90
91	EMERGENCY	32,098,722							91
91.01	PARTIAL HOSPITALIZATION	1,034,240							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	9,623,524			120				92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	573,132,813			3,684,903				200

(A) Worksheet A line numbers

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5568** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.199727							50
51	RECOVERY ROOM	0.102918							51
53	ANESTHESIOLOGY	0.036542							53
54	RADIOLOGY-DIAGNOSTIC	0.191875							54
55	RADIOLOGY-THERAPEUTIC	0.442878							55
57	CT SCAN	0.047488							57
58	MRI	0.050303							58
59	CARDIAC CATHETERIZATION	0.128191							59
60	LABORATORY	0.143496							60
63	BLOOD STORING, PROCESSING & TRANS.	0.230345							63
65	RESPIRATORY THERAPY	0.208865							65
66	PHYSICAL THERAPY	0.394684							66
69	ELECTROCARDIOLOGY	0.119080							69
70	ELECTROENCEPHALOGRAPHY	0.076698							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.253655							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.374300							72
73	DRUGS CHARGED TO PATIENTS	0.116995			135			16	73
74	RENAL DIALYSIS	0.307822							74
76	OTHER ANCILLARY SERVICE COST CENTER								76
76.97	CARDIAC REHABILITATION	0.427651							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.412843							90
91	EMERGENCY	0.113822							91
91.01	PARTIAL HOSPITALIZATION	0.477473							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.430854							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)				135			16	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)				135			16	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0224** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	51,223	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	51,223	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)	46,943	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)	18,061	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)	49,623,323	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	49,623,323	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)	49,623,323	37

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0224** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					968.77	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					17,496,955	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)					17,496,955	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	6,053,526	3,188	1,898.85	1,814	3,444,514	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)					21,177,593	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					42,119,062	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	1,970,187	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	1,140,905	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	3,111,092	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	39,007,970	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0224** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					4,280	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					968.77	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					4,146,336	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	4,715,841	49,623,323	0.095033	4,146,336	394,039	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T224** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	2,584	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,584	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)	2,584	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,816	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,723,557	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,723,557	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,723,557	37

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T224** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[XX] PPS**
	[XX] TITLE XVIII, PART A	**[ ] IPF**		**[ ] TEFRA**
	[ ] TITLE XIX - I/P	**[XX] IRF**		**[ ] 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)	1,054.01	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	1,914,082	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	1,914,082	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	1,167,851	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	3,081,933	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	178,476	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	57,681	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	236,157	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	2,845,776	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5568** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	5,459	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,459	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	5,459	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	4,057	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)	4,264,970	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	4,264,970	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)	4,264,970	37

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5568** **WORKSHEET D-1 PARTS III & IV**

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	4,264,970	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	781.27	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	3,169,612	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (line 14 x line 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (line 72 + line 73)	3,169,612	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 26, line 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (line 75 ÷ line 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (line 9 x line 76)		77
78	INPATIENT ROUTINE SERVICE COST (line 74 minus line 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (from provider records)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (line 78 minus line 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (line 9 x line 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (see instructions)	3,169,612	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	1,097,033	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	4,266,645	86

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0224** **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		38,945,977		30
31	INTENSIVE CARE UNIT		6,585,860		31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.199727	11,304,741	2,257,862	50
51	RECOVERY ROOM	0.102918	1,738,375	178,910	51
53	ANESTHESIOLOGY	0.036542	2,339,687	85,497	53
54	RADIOLOGY-DIAGNOSTIC	0.191875	6,397,923	1,227,601	54
55	RADIOLOGY-THERAPEUTIC	0.442878	73,284	32,456	55
57	CT SCAN	0.047488	3,855,514	183,091	57
58	MRI	0.050303	1,516,594	76,289	58
59	CARDIAC CATHETERIZATION	0.128191	6,649,493	852,405	59
60	LABORATORY	0.143496	21,392,298	3,069,709	60
63	BLOOD STORING, PROCESSING & TRANS.	0.230345	1,943,671	447,715	63
65	RESPIRATORY THERAPY	0.208865	5,437,574	1,135,719	65
66	PHYSICAL THERAPY	0.394684	1,934,824	763,644	66
69	ELECTROCARDIOLOGY	0.119080	4,003,373	476,722	69
70	ELECTROENCEPHALOGRAPHY	0.076698	246,443	18,902	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.253655	12,260,379	3,109,906	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.374300	5,715,208	2,139,202	72
73	DRUGS CHARGED TO PATIENTS	0.116995	30,457,756	3,563,405	73
74	RENAL DIALYSIS	0.307822	1,103,329	339,629	74
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.97	CARDIAC REHABILITATION	0.427651	760	325	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.412843	79,512	32,826	90
91	EMERGENCY	0.113822	6,178,235	703,219	91
91.01	PARTIAL HOSPITALIZATION	0.477473			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.430854	1,120,005	482,559	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		125,748,978	21,177,593	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		125,748,978		202

(A) Worksheet A line numbers

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T224** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF		3,283,770		41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.199727	14,275	2,851	50
51	RECOVERY ROOM	0.102918			51
53	ANESTHESIOLOGY	0.036542	911	33	53
54	RADIOLOGY-DIAGNOSTIC	0.191875	121,018	23,220	54
55	RADIOLOGY-THERAPEUTIC	0.442878			55
57	CT SCAN	0.047488	72,036	3,421	57
58	MRI	0.050303	8,216	413	58
59	CARDIAC CATHETERIZATION	0.128191			59
60	LABORATORY	0.143496	560,539	80,435	60
63	BLOOD STORING, PROCESSING & TRANS.	0.230345	19,204	4,424	63
65	RESPIRATORY THERAPY	0.208865	273,512	57,127	65
66	PHYSICAL THERAPY	0.394684	1,916,983	756,603	66
69	ELECTROCARDIOLOGY	0.119080	24,306	2,894	69
70	ELECTROENCEPHALOGRAPHY	0.076698	3,044	233	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.253655	297,471	75,455	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.374300			72
73	DRUGS CHARGED TO PATIENTS	0.116995	1,126,288	131,770	73
74	RENAL DIALYSIS	0.307822	94,120	28,972	74
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.97	CARDIAC REHABILITATION	0.427651			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.412843			90
91	EMERGENCY	0.113822			91
91.01	PARTIAL HOSPITALIZATION	0.477473			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.430854			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		4,531,923	1,167,851	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		4,531,923		202

(A) Worksheet A line numbers

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5568** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.199727	8,840	1,766	50
51	RECOVERY ROOM	0.102918			51
53	ANESTHESIOLOGY	0.036542	3,913	143	53
54	RADIOLOGY-DIAGNOSTIC	0.191875	165,365	31,729	54
55	RADIOLOGY-THERAPEUTIC	0.442878	57,678	25,544	55
57	CT SCAN	0.047488			57
58	MRI	0.050303	9,470	476	58
59	CARDIAC CATHETERIZATION	0.128191			59
60	LABORATORY	0.143496	960,363	137,808	60
63	BLOOD STORING, PROCESSING & TRANS.	0.230345	10,040	2,313	63
65	RESPIRATORY THERAPY	0.208865	334,659	69,899	65
66	PHYSICAL THERAPY	0.394684	2,080,389	821,096	66
69	ELECTROCARDIOLOGY	0.119080	48,607	5,788	69
70	ELECTROENCEPHALOGRAPHY	0.076698	5,459	419	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.253655			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.374300			72
73	DRUGS CHARGED TO PATIENTS	0.116995			73
74	RENAL DIALYSIS	0.307822			74
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.97	CARDIAC REHABILITATION	0.427651			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.412843			90
91	EMERGENCY	0.113822			91
91.01	PARTIAL HOSPITALIZATION	0.477473			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.430854	120	52	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		3,684,903	1,097,033	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		3,684,903		202

(A) Worksheet A line numbers

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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)	21,825,106			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	6,617,223			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)	470,969			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	2,758,877			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	263.27			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)	139.15			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)	22.76			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	0.64			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	-0.89			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	3.50			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)	3.50			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)	121.86			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	107.18			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS	13.39			11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	120.57			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	123.74			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	125.76			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	123.36			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	123.36			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.468568			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.443910			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.443910			21
22	IME PAYMENT ADJUSTMENT (see instructions)	6,756,996			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)	-14.68			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)	6,756,996			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0576			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1924			31
32	SUM OF LINES 30 AND 31	0.2500			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0984			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	2,310,374			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		2,945,868		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		742,521		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	742,521			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	38,723,189			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)	38,723,189			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	3,068,628			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)	5,575,264			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	47,367,081			59
60	PRIMARY PAYER PAYMENTS	33,497			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	47,333,584			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,762,364			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	270,278			63
64	ALLOWABLE BAD DEBTS (see instructions)	1,203,665			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	782,382			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	1,053,081			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	45,083,324			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	84,064			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-54,900			70.94
71	AMOUNT DUE PROVIDER (see instructions)	45,112,488			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	681,199			71.01
72	INTERIM PAYMENTS	44,379,172			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	52,117			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	122,959			75

TO BE COMPLETED BY CONTRACTOR

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0224** **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)	25,263			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	12,063,232			2
3	PPS PAYMENTS	10,014,782			3
4	OUTLIER PAYMENT (see instructions)	100,122			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)	25,263			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	72,492			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)	72,492			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)	72,492			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	47,229			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)	25,263			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)	10,114,904			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	13,803			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	2,351,196			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	7,775,168			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	1,347,528			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	9,122,696			30
31	PRIMARY PAYER PAYMENTS	1,511			31
32	SUBTOTAL (line 30 minus line 31)	9,121,185			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)	705,640			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	458,666			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	623,154			36
37	SUBTOTAL (see instructions)	9,579,851			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	9,579,851			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	144,656			40.01
41	INTERIM PAYMENTS	9,040,188			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	395,007			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T224** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	830			2
3	PPS PAYMENTS	930			3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	930			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	247			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	683			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)	683			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	683			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)	683			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	683			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	10			40.01
41	INTERIM PAYMENTS	669			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	4			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5568** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	16			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)	16			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	135			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)	135			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)	135			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	119			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)	16			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	16			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)	16			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	16			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)	16			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	16			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS	34			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-18			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0224** **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				39,082,813		7,641,741	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				5,324,153		1,292,864	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	09/09/2013	650,351	09/09/2013	271,677	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	01/25/2013	678,145	01/25/2013	166,094	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		-27,794		105,583	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)				44,379,172		9,040,188	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		733,316		539,663	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				45,112,488		9,579,851	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-T224** **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				3,022,816		669	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	01/25/2013	30,660			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	09/09/2013	46,181			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		-15,521			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)				3,007,295		669	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		12,503		14	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				3,019,798		683	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-5568** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,611,994		34	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,611,994		34	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		25,186			6.01
	BASED ON THE COST REPORT (1)		.02				-18	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,637,180		16	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	10,372	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	19,875	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,880	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	50,131	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	717,149,449	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	8,707,889	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)	1,688,933	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,702,959	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-14,026	32

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T224** **WORKSHEET E-3 PART III**

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	2,170,531	744,802	1
2	MEDICARE SSI RATIO (see instructions)	0.019000		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	108,092	25,323	3
4	OUTLIER PAYMENTS	12,871		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)	7.079452		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	3,061,619		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)	3,061,619		17
18	PRIMARY PAYER PAYMENTS	86		18
19	SUBTOTAL (line 17 less line 18)	3,061,533		19
20	DEDUCTIBLES	34,336		20
21	SUBTOTAL (line 19 minus line 20)	3,027,197		21
22	COINSURANCE	14,914		22
23	SUBTOTAL (line 21 minus line 22)	3,012,283		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	11,562		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	7,515		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	7,915		26
27	SUBTOTAL (sum of lines 23 and 25)	3,019,798		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	3,019,798		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	45,599		32.01
33	INTERIM PAYMENTS	3,007,295		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	-33,096		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	6,518		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (see instructions)	800		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)			51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)			52
53	TIME VALUE OF MONEY (see instructions)			53

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	1,675,304	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (sum of lines 1-3)	1,675,304	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	DO NOT USE THIS LINE		5
6	DEDUCTIBLES		6
7	COINSURANCE	38,628	7
8	ALLOWABLE BAD DEBTS (see instructions)	775	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	504	10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	1,637,180	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		14
15	SUBTOTAL (line 12 minus 13 ± line 14)	1,637,180	15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	24,721	15.01
16	INTERIM PAYMENTS	1,611,994	16
17	TENTATIVE SETTLEMENT (for contractor use only)		17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)	465	18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			142.44	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			23.61	3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			1.79	3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))			-3.75	4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011			7.00	4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			120.29	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			107.29	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			107.29	7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	93.91	12.92	106.83	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	93.91	12.92	106.83	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		11.66		10
11	TOTAL WEIGHTED FTE COUNT	93.91	24.58		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	97.10	18.14		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	98.26	24.88		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	96.42	22.53		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	96.42	22.53		17
18	PER RESIDENT AMOUNT	132,549.00	127,762.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	12,780,375	2,878,478	15,658,853	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			15,658,853	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	21,691	1,880		26
27	TOTAL INPATIENT DAYS (see instructions)	52,715	52,715		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.411477	0.035663		28
29	PROGRAM DIRECT GME AMOUNT	6,443,258	558,442		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		78,908		30
31	NET PROGRAM DIRECT GME AMOUNT			6,922,792	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			1,716,164	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			50,045,911	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)			33,583	40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			50,012,328	41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			12,089,341	42
43	PRIMARY PAYER PAYMENTS (see instructions)			1,511	43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			12,087,830	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			62,100,158	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.805349	46

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

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

47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)	0.194651	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	TOTAL PROGRAM GME PAYMENT (line 31)	6,922,792	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)	5,575,264	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)	1,347,528	50

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	85,998				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	41,341,115				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-12,340,006				6
7	INVENTORY	3,954,566				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	658,278				9
10	DUE FROM OTHER FUNDS	9,972,905				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	43,672,856				11
	FIXED ASSETS					
12	LAND	7,327,666				12
13	LAND IMPROVEMENTS	11,980,239				13
14	ACCUMULATED DEPRECIATION	-3,877,329				14
15	BUILDINGS	65,594,665				15
16	ACCUMULATED DEPRECIATION	-33,701,676				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	54,218,343				23
24	ACCUMULATED DEPRECIATION	-30,643,185				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)	70,898,723				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	2,821,375				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	2,821,375				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	117,392,954				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	1,382,607				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	1,593,928				43
44	OTHER CURRENT LIABILITIES	32,719,927				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	35,696,462				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	22,597,874				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	22,597,874				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	58,294,336				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	59,098,618				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	59,098,618				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	117,392,954				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		59,611,536			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-1,010,324			2
3	TOTAL (sun of line 1 and line 2)		58,601,212			3
4	ADDITIONS (credit adjustments)					4
5						5
6	TRANSFER FROM AFFILIATE	497,406				6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		497,406			10
11	SUBTOTAL (line 3 plus line 10)		59,098,618			11
12	DEDUCTIONS (debit adjustments)					12
13						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)		59,098,618			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	TRANSFER FROM AFFILIATE					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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	135,691,895		135,691,895	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	4,698,743		4,698,743	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	4,813,542		4,813,542	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	145,204,180		145,204,180	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	12,966,085		12,966,085	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)	12,966,085		12,966,085	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	158,170,265		158,170,265	17
18	ANCILLARY SERVICES	295,740,870		295,740,870	18
19	OUTPATIENT SERVICES		276,601,433	276,601,433	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)	453,911,135	276,601,433	730,512,568	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		204,535,426	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39	RECONCILING ITEM			39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		204,535,426	43

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 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)	730,512,568	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	534,594,082	2
3	NET PATIENT REVENUES (line 1 minus line 2)	195,918,486	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	204,535,426	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-8,616,940	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	73,771	6
7	INCOME FROM INVESTMENTS	264,901	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 (REVENUE FROM OTHER SOURCES)	7,180,663	24
24.01	OTHER (NET ASSETS RELEASED FROM RESTRICTION)	87,281	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	7,606,616	25
26	TOTAL (line 5 plus line 25)	-1,010,324	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-1,010,324	29

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0224** **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	2,264,425	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	33,392	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)	137.35	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	123.36	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	28.85	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	653,287	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0576	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1924	8
9	SUM OF LINES 7 AND 8	0.2500	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0519	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	117,524	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	3,068,628	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES **WORKSHEET L-1**
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING,RECEIVING&STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCTS RECEIVABLE							5.05
5.06	ADMINISTRATION & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
41	SUBPROVIDER - IRF							41
43	NURSERY							43
44	SKILLED NURSING FACILITY							44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
91.01	PARTIAL HOSPITALIZATION							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
194	OTHER							194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	35.26		11.82				47.08	30
31	INTENSIVE CARE UNIT	56.90		9.13				66.03	31
43	NURSERY			60.26				60.26	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	12.04	13.26					25.30	50
51	RECOVERY ROOM	12.81	9.31					22.12	51
53	ANESTHESIOLOGY	11.71	12.06					23.77	53
54	RADIOLOGY-DIAGNOSTIC	15.40	17.30					32.70	54
55	RADIOLOGY-THERAPEUTIC	0.86	34.33					35.19	55
57	CT SCAN	17.26	22.40					39.66	57
58	MRI	10.62	19.00					29.62	58
59	CARDIAC CATHETERIZATION	38.49	21.57					60.06	59
60	LABORATORY	28.01	2.13					30.14	60
63	BLOOD STORING, PROCESSING & TRA	44.53	3.66					48.19	63
65	RESPIRATORY THERAPY	49.57	2.84					52.41	65
66	PHYSICAL THERAPY	12.65	1.97					14.62	66
69	ELECTROCARDIOLOGY	22.16	20.76					42.92	69
70	ELECTROENCEPHALOGRAPHY	16.48	23.19					39.67	70
71	MEDICAL SUPPLIES CHARGED TO PAT	28.32	8.44					36.76	71
72	IMPL. DEV. CHARGED TO PATIENTS	29.63	12.06					41.69	72
73	DRUGS CHARGED TO PATIENTS	28.95	7.03					35.98	73
74	RENAL DIALYSIS	64.29	5.78					70.07	74
76.97	CARDIAC REHABILITATION	0.32	52.06					52.38	76.97
90	CLINIC	2.99	14.94					17.93	90
91	EMERGENCY	19.25	15.26					34.51	91
91.01	PARTIAL HOSPITALIZATION		11.29					11.29	91.01
92	OBSERVATION BEDS (NON-DISTINCT	11.64	34.08					45.72	92
200	TOTAL CHARGES	21.94	11.59					33.53	200

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REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IRF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
41	SUBPROVIDER - IRF	70.28		9.25				79.53	41
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	0.02						0.02	50
54	RADIOLOGY-DIAGNOSTIC	0.29						0.29	54
57	CT SCAN	0.32	0.01					0.33	57
58	MRI	0.06						0.06	58
60	LABORATORY	0.73						0.73	60
63	BLOOD STORING, PROCESSING & TRA	0.44						0.44	63
65	RESPIRATORY THERAPY	2.49						2.49	65
66	PHYSICAL THERAPY	12.53						12.53	66
69	ELECTROCARDIOLOGY	0.13	0.02					0.15	69
70	ELECTROENCEPHALOGRAPHY	0.20						0.20	70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.69						0.69	71
73	DRUGS CHARGED TO PATIENTS	1.07						1.07	73
74	RENAL DIALYSIS	5.48						5.48	74
200	TOTAL CHARGES	0.79						0.79	200

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

REPORT 97 - UTILIZATION STATISTICS - SNF / NF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
44	SKILLED NURSING FACILITY	74.32						74.32	44
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	0.01						0.01	50
53	ANESTHESIOLOGY	0.02						0.02	53
54	RADIOLOGY-DIAGNOSTIC	0.40						0.40	54
55	RADIOLOGY-THERAPEUTIC	0.68						0.68	55
58	MRI	0.07						0.07	58
60	LABORATORY	1.26						1.26	60
63	BLOOD STORING, PROCESSING & TRA	0.23						0.23	63
65	RESPIRATORY THERAPY	3.05						3.05	65
66	PHYSICAL THERAPY	13.60						13.60	66
69	ELECTROCARDIOLOGY	0.27						0.27	69
70	ELECTROENCEPHALOGRAPHY	0.37						0.37	70
200	TOTAL CHARGES	0.64						0.64	200

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	954,643	0.50	-954,643	-0.88			1
2	CAP REL COSTS-MVBLE EQUIP	12,520,264	6.55	-12,520,264	-11.55			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	15,737,095	8.23	-15,737,095	-14.52			4
5.01	NONPATIENT TELEPHONES	229,396	0.12	-229,396	-0.21			5.01
5.02	DATA PROCESSING	2,889,331	1.51	-2,889,331	-2.67			5.02
5.03	PURCHASING,RECEIVING&STORES	283,261	0.15	-283,261	-0.26			5.03
5.04	ADMITTING	676,726	0.35	-676,726	-0.62			5.04
5.05	CASHIERING/ACCTS RECEIVABLE	4,543,603	2.38	-4,543,603	-4.19			5.05
5.06	ADMINISTRATION & GENERAL	37,799,676	19.77	-37,799,676	-34.88			5.06
6	MAINTENANCE & REPAIRS	1,348,280	0.71	-1,348,280	-1.24			6
7	OPERATION OF PLANT	5,572,953	2.92	-5,572,953	-5.14			7
8	LAUNDRY & LINEN SERVICE	1,126,629	0.59	-1,126,629	-1.04			8
9	HOUSEKEEPING	2,248,376	1.18	-2,248,376	-2.07			9
10	DIETARY	1,774,398	0.93	-1,774,398	-1.64			10
11	CAFETERIA	209,179	0.11	-209,179	-0.19			11
13	NURSING ADMINISTRATION	1,865,071	0.98	-1,865,071	-1.72			13
14	CENTRAL SERVICES & SUPPLY	312,362	0.16	-312,362	-0.29			14
15	PHARMACY	1,025,773	0.54	-1,025,773	-0.95			15
16	MEDICAL RECORDS & LIBRARY	1,363,622	0.71	-1,363,622	-1.26			16
17	SOCIAL SERVICE	1,921,448	1.01	-1,921,448	-1.77			17
19	NONPHYSICIAN ANESTHETISTS							19
21	I&R SERVICES-SALARY & FRINGES APPRVD	7,347,288	3.84	-7,347,288	-6.78			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	6,630,290	3.47	-6,630,290	-6.12			22
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	ADULTS & PEDIATRICS	20,246,201	10.59	44,841,179	41.37	65,087,380	34.04	30
31	INTENSIVE CARE UNIT	2,700,532	1.41	7,063,492	6.52	9,764,024	5.11	31
41	SUBPROVIDER - IRF	1,107,705	0.58	1,615,852	1.49	2,723,557	1.42	41
43	NURSERY	1,975,054	1.03	1,661,982	1.53	3,637,036	1.90	43
44	SKILLED NURSING FACILITY	1,431,392	0.75	2,833,578	2.61	4,264,970	2.23	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	9,528,972	4.98	10,123,520	9.34	19,652,492	10.28	50
51	RECOVERY ROOM	627,097	0.33	769,104	0.71	1,396,201	0.73	51
53	ANESTHESIOLOGY	291,133	0.15	439,291	0.41	730,424	0.38	53
54	RADIOLOGY-DIAGNOSTIC	3,437,886	1.80	5,022,629	4.63	8,460,515	4.43	54
55	RADIOLOGY-THERAPEUTIC	2,004,592	1.05	1,751,183	1.62	3,755,775	1.96	55
57	CT SCAN	469,015	0.25	591,748	0.55	1,060,763	0.55	57
58	MRI	334,482	0.17	383,976	0.35	718,458	0.38	58
59	CARDIAC CATHETERIZATION	1,209,412	0.63	1,005,467	0.93	2,214,879	1.16	59
60	LABORATORY	6,931,399	3.63	4,225,548	3.90	11,156,947	5.84	60
63	BLOOD STORING, PROCESSING & TRANS.	716,713	0.37	288,761	0.27	1,005,474	0.53	63
65	RESPIRATORY THERAPY	1,156,292	0.60	1,524,737	1.41	2,681,029	1.40	65
66	PHYSICAL THERAPY	3,443,865	1.80	2,983,600	2.75	6,427,465	3.36	66
69	ELECTROCARDIOLOGY	786,350	0.41	1,365,094	1.26	2,151,444	1.13	69
70	ELECTROENCEPHALOGRAPHY	48,493	0.03	965,124	0.89	1,013,617	0.53	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,914,211	3.62	4,066,521	3.75	10,980,732	5.74	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,763,438	2.49	2,455,640	2.27	7,219,078	3.78	72
73	DRUGS CHARGED TO PATIENTS	6,521,847	3.41	5,789,054	5.34	12,310,901	6.44	73
74	RENAL DIALYSIS	381,033	0.20	147,240	0.14	528,273	0.28	74
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.97	CARDIAC REHABILITATION	59,274	0.03	41,123	0.04	100,397	0.05	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
90	CLINIC	346,579	0.18	751,629	0.69	1,098,208	0.57	90
91	EMERGENCY	1,903,833	1.00	1,749,711	1.61	3,653,544	1.91	91
91.01	PARTIAL HOSPITALIZATION	212,348	0.11	281,474	0.26	493,822	0.26	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
194	OTHER	3,252,919	1.70	3,641,407	3.36	6,894,326	3.61	194
194.01	LAKESHORE GUEST UNIT							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	191,181,731	100.00			191,181,731	100.00	202

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

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,500,223	93,896,171	0.015977	11,304,741	180,616	50
51	RECOVERY ROOM	89,562	13,566,148	0.006602	1,738,375	11,477	51
53	ANESTHESIOLOGY	44,048	19,988,761	0.002204	2,339,687	5,157	53
54	RADIOLOGY-DIAGNOSTIC	883,275	41,552,062	0.021257	6,397,923	136,001	54
55	RADIOLOGY-THERAPEUTIC	327,257	8,480,375	0.038590	73,284	2,828	55
57	CT SCAN	29,943	22,337,731	0.001340	3,855,514	5,166	57
58	MRI	19,846	14,282,735	0.001390	1,516,594	2,108	58
59	CARDIAC CATHETERIZATION	54,635	17,277,945	0.003162	6,649,493	21,026	59
60	LABORATORY	538,557	76,384,829	0.007051	21,392,298	150,837	60
63	BLOOD STORING, PROCESSING & TRA	22,437	4,365,082	0.005140	1,943,671	9,990	63
65	RESPIRATORY THERAPY	138,447	10,970,400	0.012620	5,437,574	68,622	65
66	PHYSICAL THERAPY	307,122	15,297,722	0.020076	1,934,824	38,844	66
69	ELECTROCARDIOLOGY	309,621	18,067,247	0.017137	4,003,373	68,606	69
70	ELECTROENCEPHALOGRAPHY	4,069	1,495,242	0.002721	246,443	671	70
71	MEDICAL SUPPLIES CHARGED TO PAT	517,532	43,290,105	0.011955	12,260,379	146,573	71
72	IMPL. DEV. CHARGED TO PATIENTS	346,298	19,286,856	0.017955	5,715,208	102,617	72
73	DRUGS CHARGED TO PATIENTS	389,012	105,225,880	0.003697	30,457,756	112,602	73
74	RENAL DIALYSIS	11,627	1,716,164	0.006775	1,103,329	7,475	74
76	OTHER ANCILLARY SERVICE COST CE						76
76.97	CARDIAC REHABILITATION	2,283	234,764	0.009725	760	7	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	202,774	2,660,108	0.076228	79,512	6,061	90
91	EMERGENCY	92,289	32,098,722	0.002875	6,178,235	17,762	91
91.01	PARTIAL HOSPITALIZATION	62,049	1,034,240	0.059995			91.01
92	OBSERVATION BEDS (NON-DISTINCT	394,039	9,623,524	0.040945	1,120,005	45,859	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	6,286,945	573,132,813		125,748,978	1,140,905	200

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

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

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	4,715,841		4,715,841	51,223	92.06	18,061	1,662,696	30
31	INTENSIVE CARE UNIT	540,410		540,410	3,188	169.51	1,814	307,491	31
200	TOTAL	5,256,251		5,256,251	54,411		19,875	1,970,187	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	1,970,187
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	1,140,905
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	3,111,092
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	3,639
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	19,875
PER DISCHARGE CAPITAL COSTS	854.93

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PRESENCE SAINT JOSEPH HOSP-CHICAGO Provider CCN: 14-0224	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 22:06 Version: 2014.03

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	39,007,970
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	171,280,815
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.228

COST TO CHARGE RATIO FOR REHAB SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 41 + Worksheet D, Part IV, column 11, line 200))	3,081,933
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 41, column 2 plus Worksheet D-3, line 202, column 2)	7,815,693
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.394

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	3,111,092
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.018

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	11,913,979
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	65,982,050
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.181