KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 05/23/2014 TIME: 11:17 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 OUR LADY OFTHE RESURRECTION (14-0251) {(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		-239,926	80,636	-11,325		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		-1,395	7,276			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		-241,321	87,912	-11,325		200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:

1	STREET: 5645 WEST ADDISON STREET	P.O. BOX:		1
2	CITY: CHICAGO	STATE: IL	ZIP CODE: 60634	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 OUR LADY OFTHE RESURRECTION	14-0251	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	OLRMC SKILLED NURSING FACILITY	14-5548	16974		07/01/1985	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19

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

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

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	4,269	1,766			133	174	24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25

26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	1		26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.	1		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	38

	1	2	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	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)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
	1	2	3	4	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)	3.13			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				66

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

	INPATIENT PSYCHIATRIC FACILITY PPS	1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71

	INPATIENT REHABILITATION FACILITY PPS	1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76

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

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WORKSHEET S-2
PART I

				V	XIX	
TITLE V AND XIX SERVICES				1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	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
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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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS

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

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

141	NAME: PRESENCE HEALTH	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 00131	141
142	STREET: 200 SOUTH WACKER	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.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

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

MULTICAMPUS

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

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)				168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00			169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)		06/02/2013	08/30/2013	170

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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)	N			3

		Y/N	TYPE	DATE	
	FINANCIAL DATA AND REPORTS	1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	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.	Y			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.	N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	04/08/2014	Y	04/08/2014	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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: JOHN	LAST NAME: VILLARREAL	TITLE: REIMBURSMENT MANAGER	41
42	EMPLOYER: PRESENCE HEALTH			42
43	PHONE NUMBER: (847) 813-3737	E-MAIL ADDRESS: JVILLARREAL@PRESENCEHEALTH.ORG		43

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	193	70,445			13,904	5,605	25,504	1
2	HMO AND OTHER (see instructions)						1,792			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)		193	70,445			13,904	5,605	25,504	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34	20	7,300			2,799	737	5,473	11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		213	77,745			16,703	6,342	30,977	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	66	24,090			11,455		13,234	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)		279							27
28	OBSERVATION BED DAYS								678	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					3,365	1,391	7,964	1
2	HMO AND OTHER (see instructions)					367			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)	1.31	818.00			3,365	1,391	7,964	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY		57.00						19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)	1.31	875.00						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	44,771,499		44,771,499	1,449,896.00	30.88	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE		38,296		38,296	255.00	150.18	4
4.01	PHYSICIAN-PART A - TEACHING		46,080		46,080	576.00	80.00	4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)		150,148		150,148	2,440.00	61.54	7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44	2,849,955		2,849,955	106,829.00	26.68	9
10	EXCLUDED AREA SALARIES (see instructions)		19,274		19,274	725.00	26.58	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		2,840,408		2,840,408	99,501.00	28.55	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		7,809,697		7,809,697	161,882.00	48.24	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)		9,746,675		9,746,675			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		667,960		667,960			19
20	NON-PHYSICIAN ANESTHETIST PART A		2,277		2,277			20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE		545		545			22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL		3,383,798	107,780	3,491,578	107,575.00	32.46	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		1,436,916		1,436,916	71,654.00	20.05	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		1,031,882		1,031,882	84,235.00	12.25	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		1,688,917	-690,575	998,342	60,253.00	16.57	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			690,575	690,575	40,516.00	17.04	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,020,312		1,020,312	25,805.00	39.54	38
39	CENTRAL SERVICES AND SUPPLY		321,450		321,450	21,584.00	14.89	39
40	PHARMACY		1,739,186		1,739,186	45,069.00	38.59	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		2,471,288	-107,780	2,363,508	116,728.00	20.25	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		44,575,271		44,575,271	1,446,880.00	30.81	1
2	EXCLUDED AREA SALARIES (see instructions)		2,869,229		2,869,229	107,554.00	26.68	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		41,706,042		41,706,042	1,339,326.00	31.14	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		10,650,105		10,650,105	261,383.00	40.75	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		9,747,220		9,747,220		23.37%	5
6	TOTAL (sum of lines 3 through 5)		62,103,367		62,103,367	1,600,709.00	38.80	6
7	TOTAL OVERHEAD COST (see instructions)		13,093,749		13,093,749	573,419.00	22.83	7

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		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)	2,582,241	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	4,010,779	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	114,491	10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	228,593	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	518,735	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	3,242,704	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	101,616	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	113,847	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	10,913,006	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL	202,230	25

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	2,840,408		1
2	HOSPITAL	2,840,408		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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX	7		7	9
10	RML				10
11	RLX				11
12	RUC	275		275	12
13	RUB	4,047		4,047	13
14	RUA	1,158		1,158	14
15	RVC	195		195	15
16	RVB	3,660		3,660	16
17	RVA	1,310		1,310	17
18	RHC	6		6	18
19	RHB	173		173	19
20	RHA	125		125	20
21	RMC	39		39	21
22	RMB				22
23	RMA	66		66	23
24	RLB	145		145	24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	6		6	28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1	3		3	32
33	HC2	18		18	33
34	HC1	14		14	34
35	HB2				35
36	HB1	28		28	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1	35		35	42
43	LB2				43
44	LB1	6		6	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	1		1	48
49	CC2				49
50	CC1	33		33	50
51	CB2				51
52	CB1	27		27	52
53	CA2				53
54	CA1	61		61	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1	5		5	74
75	PB2				75
76	PB1	8		8	76
77	PA2				77
78	PA1	1		1	78
199	AAA	3		3	199
200	TOTAL	11,455		11,455	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)	11,737,070			207

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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)	0.188958	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	12,124,221	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	5,061,432	5
6	MEDICAID CHARGES	116,854,100	6
7	MEDICAID COST (line 1 times line 6)	22,080,517	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.	4,894,864	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)	4,894,864	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	26,236,741	535,532	26,772,273	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	4,957,642	101,193	5,058,835	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	43,295	1,738,892	1,782,187	22
23	COST OF CHARITY CARE (line 21 minus line 22)	4,914,347	-1,637,699	3,276,648	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?		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)	21,698,663	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,217,452	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	20,481,211	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	3,870,089	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	7,146,737	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	12,041,601	31

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT				4,844,911	4,844,911	-3,131,139	1,713,772	1
2	00200	CAP REL COSTS-MVBLE EQUIP				2,331,574	2,331,574	259,446	2,591,020	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		156,309	156,309		156,309	570,854	727,163	4
5	00500	ADMINISTRATIVE & GENERAL	3,383,798	28,086,416	31,470,214	-7,068,705	24,401,509	-4,751,707	19,649,802	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	1,436,916	3,375,893	4,812,809		4,812,809	-2,539	4,810,270	7
8	00800	LAUNDRY & LINEN SERVICE		702,107	702,107		702,107		702,107	8
9	00900	HOUSEKEEPING	1,031,882	932,716	1,964,598		1,964,598		1,964,598	9
10	01000	DIETARY	1,688,917	1,314,682	3,003,599	-1,219,173	1,784,426		1,784,426	10
11	01100	CAFETERIA				1,219,173	1,219,173	-402,734	816,439	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,020,312	235,817	1,256,129		1,256,129	-21,508	1,234,621	13
14	01400	CENTRAL SERVICES & SUPPLY	321,450	431,979	753,429		753,429	733,256	1,486,685	14
15	01500	PHARMACY	1,739,186	3,879,224	5,618,410	-3,492,382	2,126,028		2,126,028	15
16	01600	MEDICAL RECORDS & LIBRARY	2,471,288	1,284,105	3,755,393	-107,780	3,647,613	-87,596	3,560,017	16
17	01700	SOCIAL SERVICE								17
17.01	01701	HOUSE STAFF PHYSICIANS		1,332,629	1,332,629		1,332,629	-1,332,629		17.01
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				150,148	150,148		150,148	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				20,371	20,371		20,371	22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	11,626,274	3,969,923	15,596,197	-375,267	15,220,930		15,220,930	30
34	03400	SURGICAL INTENSIVE CARE UNIT	1,271,499	388,605	1,660,104	-53,597	1,606,507	41,483	1,647,990	34
44	04400	SKILLED NURSING FACILITY	2,849,955	875,826	3,725,781		3,725,781	-9,035	3,716,746	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	2,437,116	6,260,543	8,697,659	-4,209,928	4,487,731		4,487,731	50
51	05100	RECOVERY ROOM	461,377	103,118	564,495		564,495		564,495	51
53	05300	ANESTHESIOLOGY	65,606	1,175,794	1,241,400	-67,880	1,173,520	-1,075,277	98,243	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,832,684	509,546	2,342,230		2,342,230	-3,233	2,338,997	54
56	05600	RADIOISOTOPE	182,640	214,515	397,155		397,155		397,155	56
57	05700	CT SCAN	548,640	288,662	837,302		837,302		837,302	57
58	05800	MRI	217,068	73,098	290,166		290,166		290,166	58
59	05900	CARDIAC CATHETERIZATION	513,651	1,513,077	2,026,728	-1,462,469	564,259		564,259	59
60	06000	LABORATORY		6,106,507	6,106,507	-412,376	5,694,131	2,284,914	7,979,045	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	1,076,572	461,467	1,538,039	-70,746	1,467,293	-20,889	1,446,404	65
66	06600	PHYSICAL THERAPY	1,795,022	478,138	2,273,160	-94,235	2,178,925		2,178,925	66
67	06700	OCCUPATIONAL THERAPY	707,816	146,690	854,506	-5,161	849,345		849,345	67
68	06800	SPEECH PATHOLOGY	169,965	37,582	207,547		207,547		207,547	68
69	06900	ELECTROCARDIOLOGY	495,922	156,181	652,103	-11,052	641,051		641,051	69
69.01	03160	CARDIAC REHAB	269,428	52,670	322,098	-554	321,544	-9,045	312,499	69.01
70	07000	ELECTROENCEPHALOGRAPHY	51,431	169,536	220,967	-1,310	219,657	-142,906	76,751	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				4,156,328	4,156,328		4,156,328	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				3,518,441	3,518,441		3,518,441	72
73	07300	DRUGS CHARGED TO PATIENTS				3,492,382	3,492,382		3,492,382	73
75.01	07501	ACUTE DIALYSIS	266,475	97,120	363,595		363,595		363,595	75.01
76	03040	AUDIO-VESTIBULAR LAB								76
76.01	03480	ONCOLOGY								76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	998,856	855,358	1,854,214	-310,448	1,543,766	-25,000	1,518,766	90
91	09100	EMERGENCY	3,820,479	4,908,028	8,728,507	-770,265	7,958,242	-2,363,989	5,594,253	91
91.01	09101	LITHOTRIPSY								91.01
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	44,752,225	70,573,861	115,326,086		115,326,086	-9,489,273	105,836,813	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,274	53,062	72,336		72,336		72,336	190
193.01	19301	NON EMPLOYEE DAY CARE								193.01
193.02	19302	RESURRECTION HOME CARE OFFICES								193.02
193.03	19303	OCCUPATIONAL HEALTH NON-REIM								193.03
200		TOTAL (sum of lines 118-199)	44,771,499	70,626,923	115,398,422		115,398,422	-9,489,273	105,909,149	200

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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	SHARED FOOD COSTS	A	CAFETERIA	11	690,575	528,598	1
500	TOTAL RECLASSIFICATIONS				690,575	528,598	500
	CODE LETTER - A						
1	CHARGEABLE MEDICAL SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71		4,156,328	1
2	CHARGEABLE MEDICAL SUPPLIES	B	IMPL. DEV. CHARGED TO PATIENT	72		3,518,441	2
3	0	B					3
4	CHARGEABLE MEDICAL SUPPLIES	B					4
5	CHARGEABLE MEDICAL SUPPLIES	B					5
6	CHARGEABLE MEDICAL SUPPLIES	B					6
7	CHARGEABLE MEDICAL SUPPLIES	B					7
8	CHARGEABLE MEDICAL SUPPLIES	B					8
9	CHARGEABLE MEDICAL SUPPLIES	B					9
10							10
11	CHARGEABLE MEDICAL SUPPLIES	B					11
12	CHARGEABLE MEDICAL SUPPLIES	B					12
13	CHARGEABLE MEDICAL SUPPLIES	B					13
14	CHARGEABLE MEDICAL SUPPLIES	B					14
15	CHARGEABLE MEDICAL SUPPLIES	B					15
500	TOTAL RECLASSIFICATIONS					7,674,769	500
	CODE LETTER - B						
1	DEPRECIATION	C	CAP REL COSTS-BLDG & FIXT	1		3,813,921	1
2	DEPRECIATION	C	CAP REL COSTS-MVBLE EQUIP	2		2,331,574	2
500	TOTAL RECLASSIFICATIONS					6,145,495	500
	CODE LETTER - C						
1	DRUGS	D	DRUGS CHARGED TO PATIENTS	73		3,492,382	1
500	TOTAL RECLASSIFICATIONS					3,492,382	500
	CODE LETTER - D						
1	RESIDENTS COSTS	E	I&R SERVICES-SALARY & FRINGES	21		150,148	1
500	TOTAL RECLASSIFICATIONS					150,148	500
	CODE LETTER - E						
1	INSURANCE	F	CAP REL COSTS-BLDG & FIXT	1		83,471	1
500	TOTAL RECLASSIFICATIONS					83,471	500
	CODE LETTER - F						
1	TEACHING PHYSICIANS	G	I&R SERVICES-OTHER PRGM COSTS	22	20,371		1
500	TOTAL RECLASSIFICATIONS				20,371		500
	CODE LETTER - G						
1	INTEREST	I	CAP REL COSTS-BLDG & FIXT	1		947,519	1
500	TOTAL RECLASSIFICATIONS					947,519	500
	CODE LETTER - I						
1	RECLASS EHR FROM MED REC TO ADM	J	ADMINISTRATIVE & GENERAL	5	107,780		1
500	TOTAL RECLASSIFICATIONS				107,780		500
	CODE LETTER - J						
	GRAND TOTAL (INCREASES)				818,726	19,022,382	

(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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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	SHARED FOOD COSTS	A	DIETARY	10	690,575	528,598		1
500	TOTAL RECLASSIFICATIONS				690,575	528,598		500
	CODE LETTER - A							
1	CHARGEABLE MEDICAL SUPPLIES	B	ADULTS & PEDIATRICS	30		375,267		1
2	CHARGEABLE MEDICAL SUPPLIES	B	SURGICAL INTENSIVE CARE UNIT	34		53,597		2
3	0	B	OPERATING ROOM	50		4,209,928		3
4	CHARGEABLE MEDICAL SUPPLIES	B	ANESTHESIOLOGY	53		67,880		4
5	CHARGEABLE MEDICAL SUPPLIES	B	CARDIAC CATHETERIZATION	59		1,462,469		5
6	CHARGEABLE MEDICAL SUPPLIES	B	LABORATORY	60		412,376		6
7	CHARGEABLE MEDICAL SUPPLIES	B	RESPIRATORY THERAPY	65		70,746		7
8	CHARGEABLE MEDICAL SUPPLIES	B	PHYSICAL THERAPY	66		94,235		8
9	CHARGEABLE MEDICAL SUPPLIES	B	OCCUPATIONAL THERAPY	67		5,161		9
10								10
11	CHARGEABLE MEDICAL SUPPLIES	B	ELECTROCARDIOLOGY	69		11,052		11
12	CHARGEABLE MEDICAL SUPPLIES	B	CARDIAC REHAB	69.01		554		12
13	CHARGEABLE MEDICAL SUPPLIES	B	ELECTROENCEPHALOGRAPHY	70		1,310		13
14	CHARGEABLE MEDICAL SUPPLIES	B	CLINIC	90		310,448		14
15	CHARGEABLE MEDICAL SUPPLIES	B	EMERGENCY	91		599,746		15
500	TOTAL RECLASSIFICATIONS					7,674,769		500
	CODE LETTER - B							
1	DEPRECIATION	C	ADMINISTRATIVE & GENERAL	5		6,145,495	9	1
2	DEPRECIATION	C					9	2
500	TOTAL RECLASSIFICATIONS					6,145,495		500
	CODE LETTER - C							
1	DRUGS	D	PHARMACY	15		3,492,382		1
500	TOTAL RECLASSIFICATIONS					3,492,382		500
	CODE LETTER - D							
1	RESIDENTS COSTS	E	EMERGENCY	91		150,148		1
500	TOTAL RECLASSIFICATIONS					150,148		500
	CODE LETTER - E							
1	INSURANCE	F	ADMINISTRATIVE & GENERAL	5		83,471	12	1
500	TOTAL RECLASSIFICATIONS					83,471		500
	CODE LETTER - F							
1	TEACHING PHYSICIANS	G	EMERGENCY	91	20,371			1
500	TOTAL RECLASSIFICATIONS				20,371			500
	CODE LETTER - G							
1	INTEREST	I	ADMINISTRATIVE & GENERAL	5		947,519	11	1
500	TOTAL RECLASSIFICATIONS					947,519		500
	CODE LETTER - I							
1	RECLASS EHR FROM MED REC TO ADM	J	MEDICAL RECORDS & LIBRARY	16	107,780			1
500	TOTAL RECLASSIFICATIONS				107,780			500
	CODE LETTER - J							
	GRAND TOTAL (DECREASES)				818,726	19,022,382		

(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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	1,760,349					1,760,349		1
2	LAND IMPROVEMENTS	2,520,848					2,520,848		2
3	BUILDINGS AND FIXTURES	72,590,206					72,590,206		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	46,413,327	1,251,848		1,251,848		47,665,175		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	123,284,730	1,251,848		1,251,848		124,536,578		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	123,284,730	1,251,848		1,251,848		124,536,578		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT								1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)								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	76,871,403		76,871,403	0.617260					1
2	CAP REL COSTS-MVBLE EQU	47,665,175		47,665,175	0.382740					2
3	TOTAL (sum of lines 1-2)	124,536,578		124,536,578	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	3,850,241		-2,219,940	83,471			1,713,772	1
2	CAP REL COSTS-MVBLE EQUIP	2,591,020						2,591,020	2
3	TOTAL (sum of lines 1-2)	6,441,261		-2,219,940	83,471			4,304,792	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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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	A	-3,167,459	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-9,303	ADMINISTRATIVE & GENERAL	5	9	7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-3,907	ADMINISTRATIVE & GENERAL	5	10	8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-4,078,470				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-272,943				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-402,734	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			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	EMPLOYEE DAY CARE REVENUE	B	-81,952	EMPLOYEE BENEFITS DEPARTMENT	4		33
33.03	HOUSE STAFF PHYSICIANS	A	-1,332,629	HOUSE STAFF PHYSICIANS	17.01		33.03
33.20	FITNESS CENTER REVENUE	B	-6,186	EMPLOYEE BENEFITS DEPARTMENT	4		33.20
33.36	PATIENT TRANSPORTATION	B	-5,015	ADMINISTRATIVE & GENERAL	5		33.36
33.42	GIFT SHOP REVENUE AND MISCELLAN	A	-75,027	ADMINISTRATIVE & GENERAL	5		33.42
33.43	CARDIAC REHAB MISC REVENUE	B	-9,045	CARDIAC REHAB	69.01		33.43
33.45	AHA AND MCHC DUES	A	-19,474	ADMINISTRATIVE & GENERAL	5		33.45
34	ER PHYSICAN MISC EXPENSE	A	-1,082	EMERGENCY	91		34
35							35
36	OLR 5K	B	-16,818	NURSING ADMINISTRATION	13		36
37							37
38	EDUCATION	B	-4,690	NURSING ADMINISTRATION	13		38
39							39
40	BIOM-MISCELLANEOUS REVENUE	B	-2,539	OPERATION OF PLANT	7		40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-9,489,273				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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	8,023,026	17,313,048	-9,290,022		1
2	14	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	733,256		733,256		2
3	4	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	658,992		658,992		3
3.01	5	ADMINISTRATIVE & GENERAL	DATA PROCESSING	1,469,814		1,469,814		3.01
3.02	5	ADMINISTRATIVE & GENERAL	PURCHASING	220,259		220,259		3.02
3.03	5	ADMINISTRATIVE & GENERAL	CASHIERING	3,258,995		3,258,995		3.03
3.04	34	SURGICAL INTENSIVE CARE UNIT	ICU	75,083		75,083		3.04
3.05	2	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION	259,446		259,446	9	3.05
3.06	1	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	36,320		36,320	9	3.06
3.07	60	LABORATORY	LAB	2,304,914		2,304,914		3.07
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			17,040,105	17,313,048	-272,943		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			RESURRECTION HEALTH CARE	100.00	SOLE CORPORATE MEMBER	6
7	C			ALVERNO LAB	66.00	RELATED LAB	7
8							8
9							9
10							10

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

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	53	ANESTHESIOLOGY ANESTHESIOLOGY	1,075,277	1,075,277						1
2	44	SKILLED NURSING FACI SKILLED NURSING	17,925		17,925	154,100	120	8,890	445	2
3	65	RESPIRATORY THERAPY RESPIRATORY THE	20,889	20,889						3
4	91	EMERGENCY EMERGENCY	2,408,987	2,362,907	46,080	177,200	576	49,071	2,454	4
5	90	CLINIC CLINIC	25,000	25,000						5
6	60	LABORATORY LABORATORY	20,000	20,000						6
7	34	SURGICAL INTENSIVE C SURGICAL INTENS	33,600	33,600						7
8	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN	3,233	3,233						8
9	5	ADMINISTRATIVE & GEN ADMINISTRATIVE	298,027	298,027						9
10	70	ELECTROENCEPHALOGRAP ELECTROENCEPHAL	142,906	142,906						10
11	16	MEDICAL RECORDS & LI MEDICAL RECORDS	87,596	87,596						11
200		TOTAL	4,133,440	4,069,435	64,005		696	57,961	2,899	200

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	53	ANESTHESIOLOGY ANESTHESIOLOGY							1,075,277	1
2	44	SKILLED NURSING FACI SKILLED NURSING					8,890	9,035	9,035	2
3	65	RESPIRATORY THERAPY RESPIRATORY THE							20,889	3
4	91	EMERGENCY EMERGENCY					49,071		2,362,907	4
5	90	CLINIC CLINIC							25,000	5
6	60	LABORATORY LABORATORY							20,000	6
7	34	SURGICAL INTENSIVE C SURGICAL INTENS							33,600	7
8	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN							3,233	8
9	5	ADMINISTRATIVE & GEN ADMINISTRATIVE							298,027	9
10	70	ELECTROENCEPHALOGRAP ELECTROENCEPHAL							142,906	10
11	16	MEDICAL RECORDS & LI MEDICAL RECORDS							87,596	11
200		TOTAL					57,961	9,035	4,078,470	200

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,713,772	1,713,772					1
2	CAP REL COSTS-MVBLE EQUIP	2,591,020		2,591,020				2
4	EMPLOYEE BENEFITS DEPARTMENT	727,163		2,131	729,294			4
5	ADMINISTRATIVE & GENERAL	19,649,802	577,657	1,271,540	55,119	21,554,118	21,554,118	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	4,810,270	145,333	120,483	23,406	5,099,492	1,303,007	7
8	LAUNDRY & LINEN SERVICE	702,107				702,107	179,400	8
9	HOUSEKEEPING	1,964,598	30,087	2,254	16,808	2,013,747	514,547	9
10	DIETARY	1,784,426	39,998	25,371	27,511	1,877,306	479,684	10
11	CAFETERIA	816,439	39,233			855,672	218,639	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,234,621	12,714	3,112	16,620	1,267,067	323,757	13
14	CENTRAL SERVICES & SUPPLY	1,486,685	38,294	19,476	5,236	1,549,691	395,972	14
15	PHARMACY	2,126,028	13,435	4,085	28,330	2,171,878	554,952	15
16	MEDICAL RECORDS & LIBRARY	3,560,017	33,669	2,434	40,255	3,636,375	929,156	16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	150,148				150,148	38,365	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	20,371				20,371	5,205	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	15,220,930	270,809	32,330	146,972	15,671,041	4,004,190	30
34	SURGICAL INTENSIVE CARE UNIT	1,647,990	36,159	15,197	63,128	1,762,474	450,342	34
44	SKILLED NURSING FACILITY	3,716,746	98,383	1,882	46,423	3,863,434	987,173	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,487,731	93,901	199,147	39,698	4,820,477	1,231,714	50
51	RECOVERY ROOM	564,495	6,937	876	7,515	579,823	148,155	51
53	ANESTHESIOLOGY	98,243	2,861	39,217	1,069	141,390	36,128	53
54	RADIOLOGY-DIAGNOSTIC	2,338,997	49,693	626,884	29,853	3,045,427	778,158	54
56	RADIOISOTOPE	397,155	3,039		2,975	403,169	103,017	56
57	CT SCAN	837,302	5,524		8,937	851,763	217,640	57
58	MRI	290,166	1,477		3,536	295,179	75,423	58
59	CARDIAC CATHETERIZATION	564,259	21,543	69,027	8,367	663,196	169,458	59
60	LABORATORY	7,979,045	47,633	16,962		8,043,640	2,055,287	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,446,404	10,035	26,609	17,536	1,500,584	383,425	65
66	PHYSICAL THERAPY	2,178,925	24,044	5,967	29,239	2,238,175	571,892	66
67	OCCUPATIONAL THERAPY	849,345	6,078	709	11,530	867,662	221,702	67
68	SPEECH PATHOLOGY	207,547	4,002	297	2,769	214,615	54,838	68
69	ELECTROCARDIOLOGY	641,051	7,283	41,309	8,078	697,721	178,280	69
69.01	CARDIAC REHAB	312,499	8,771	4,077	4,389	329,736	84,253	69.01
70	ELECTROENCEPHALOGRAPHY	76,751		1,444	838	79,033	20,194	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,156,328				4,156,328	1,062,012	71
72	IMPL. DEV. CHARGED TO PATIENTS	3,518,441				3,518,441	899,021	72
73	DRUGS CHARGED TO PATIENTS	3,492,382				3,492,382	892,363	73
75.01	ACUTE DIALYSIS	363,595	3,513	8,765	4,341	380,214	97,151	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,518,766	22,551	8,683	16,270	1,566,270	400,209	90
91	EMERGENCY	5,594,253	52,025	40,752	62,232	5,749,262	1,469,034	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	105,836,813	1,706,681	2,591,020	728,980	105,829,408	21,533,743	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,336	7,091		314	79,741	20,375	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	105,909,149	1,713,772	2,591,020	729,294	105,909,149	21,554,118	202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	6,402,499						7
8	LAUNDRY & LINEN SERVICE		881,507					8
9	HOUSEKEEPING	194,422	131	2,722,847				9
10	DIETARY	258,473		113,366	2,728,829			10
11	CAFETERIA	253,524		111,195		1,439,030		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	82,156		36,033		25,593	1,734,606	13
14	CENTRAL SERVICES & SUPPLY	247,457	158	108,534		21,407		14
15	PHARMACY	86,818		38,078		44,699		15
16	MEDICAL RECORDS & LIBRARY	217,571		95,426		116,641		16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,749,983	400,191	767,540	1,762,445	376,289	595,308	30
34	SURGICAL INTENSIVE CARE UNIT	233,663	109,043	102,484	344,589	133,545		34
44	SKILLED NURSING FACILITY	635,757	98,304	278,842	621,795	117,293	185,564	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	606,797	45,600	266,140		82,765	130,939	50
51	RECOVERY ROOM	44,830		19,662		17,843	28,229	51
53	ANESTHESIOLOGY	18,487		8,109		7,338	11,610	53
54	RADIOLOGY-DIAGNOSTIC	321,120	72,279	140,842		72,689	114,998	54
56	RADIOISOTOPE	19,637		8,613		9,887	15,642	56
57	CT SCAN	35,698		15,657		18,600	29,426	57
58	MRI	9,547		4,187		10,103	15,984	58
59	CARDIAC CATHETERIZATION	139,215	3,993	61,059		34,797	55,051	59
60	LABORATORY	307,805		135,002				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	64,850		28,443		46,628	73,768	65
66	PHYSICAL THERAPY	155,371	17,802	68,145		51,799	81,950	66
67	OCCUPATIONAL THERAPY	39,274	1,906	17,225		19,481	30,820	67
68	SPEECH PATHOLOGY	25,863		11,344		4,366	6,907	68
69	ELECTROCARDIOLOGY	47,065	4,669	20,642		25,362	40,124	69
69.01	CARDIAC REHAB	56,676		24,858		8,522	13,483	69.01
70	ELECTROENCEPHALOGRAPHY					2,432	3,847	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75.01	ACUTE DIALYSIS	22,702	1,941	9,957		13,282	21,013	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	145,728	6,084	63,916		42,843	67,779	90
91	EMERGENCY	336,191	119,406	147,452		134,107	212,164	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	6,356,680	881,507	2,702,751	2,728,829	1,438,311	1,734,606	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,819		20,096		719		190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	6,402,499	881,507	2,722,847	2,728,829	1,439,030	1,734,606	202

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	2,323,219						14
15	PHARMACY	80,661	2,977,086					15
16	MEDICAL RECORDS & LIBRARY	9,241		5,004,410				16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				188,513			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					25,576		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	254,381	44	809,410	47,128	6,394	26,444,344	30
34	SURGICAL INTENSIVE CARE UNIT	35,361	30	50,101	47,128	6,394	3,275,154	34
44	SKILLED NURSING FACILITY	56,864	175	103,833			6,949,034	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	871,065	119	276,255			8,331,871	50
51	RECOVERY ROOM	9,262		50,215			898,019	51
53	ANESTHESIOLOGY	38,795	12	69,607			331,476	53
54	RADIOLOGY-DIAGNOSTIC	5,105		234,470			4,785,088	54
56	RADIOISOTOPE	1,975		50,064			612,004	56
57	CT SCAN	47,911	79	325,363			1,542,137	57
58	MRI	947		77,854			489,224	58
59	CARDIAC CATHETERIZATION	138,080	7	143,755			1,408,611	59
60	LABORATORY	216,170		705,062			11,462,966	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	37,108	3,577	150,638			2,289,021	65
66	PHYSICAL THERAPY	49,424		101,812			3,336,370	66
67	OCCUPATIONAL THERAPY	2,710		48,689			1,249,469	67
68	SPEECH PATHOLOGY			8,083			326,016	68
69	ELECTROCARDIOLOGY	7,861		167,712			1,189,436	69
69.01	CARDIAC REHAB	291		5,445			523,264	69.01
70	ELECTROENCEPHALOGRAPHY	687		2,490			108,683	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			167,671			5,386,011	71
72	IMPL. DEV. CHARGED TO PATIENTS			106,450			4,523,912	72
73	DRUGS CHARGED TO PATIENTS		2,965,545	645,545			7,995,835	73
75.01	ACUTE DIALYSIS	16,984	124	18,104			581,472	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	32,672	6,863	97,137			2,429,501	90
91	EMERGENCY	409,664	511	588,645	94,257	12,788	9,273,481	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,323,219	2,977,086	5,004,410	188,513	25,576	105,742,399	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						166,750	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,323,219	2,977,086	5,004,410	188,513	25,576	105,909,149	202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	-53,522	26,390,822					30
34	SURGICAL INTENSIVE CARE UNIT	-53,522	3,221,632					34
44	SKILLED NURSING FACILITY		6,949,034					44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		8,331,871					50
51	RECOVERY ROOM		898,019					51
53	ANESTHESIOLOGY		331,476					53
54	RADIOLOGY-DIAGNOSTIC		4,785,088					54
56	RADIOISOTOPE		612,004					56
57	CT SCAN		1,542,137					57
58	MRI		489,224					58
59	CARDIAC CATHETERIZATION		1,408,611					59
60	LABORATORY		11,462,966					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		2,289,021					65
66	PHYSICAL THERAPY		3,336,370					66
67	OCCUPATIONAL THERAPY		1,249,469					67
68	SPEECH PATHOLOGY		326,016					68
69	ELECTROCARDIOLOGY		1,189,436					69
69.01	CARDIAC REHAB		523,264					69.01
70	ELECTROENCEPHALOGRAPHY		108,683					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		5,386,011					71
72	IMPL. DEV. CHARGED TO PATIENTS		4,523,912					72
73	DRUGS CHARGED TO PATIENTS		7,995,835					73
75.01	ACUTE DIALYSIS		581,472					75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		2,429,501					90
91	EMERGENCY	-107,045	9,166,436					91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	-214,089	105,528,310					118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		166,750					190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	-214,089	105,695,060					202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT	969		2,131	3,100	3,100		4
5	ADMINISTRATIVE & GENERAL		577,657	1,271,540	1,849,197	233	1,849,430	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	5,686	145,333	120,483	271,502	99	111,801	7
8	LAUNDRY & LINEN SERVICE						15,393	8
9	HOUSEKEEPING	431	30,087	2,254	32,772	71	44,149	9
10	DIETARY	2,283	39,998	25,371	67,652	117	41,158	10
11	CAFETERIA		39,233		39,233		18,760	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,838	12,714	3,112	17,664	70	27,779	13
14	CENTRAL SERVICES & SUPPLY	60,348	38,294	19,476	118,118	22	33,975	14
15	PHARMACY	455	13,435	4,085	17,975	120	47,616	15
16	MEDICAL RECORDS & LIBRARY	3,217	33,669	2,434	39,320	171	79,724	16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD						3,292	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						447	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,782	270,809	32,330	304,921	633	343,602	30
34	SURGICAL INTENSIVE CARE UNIT	857	36,159	15,197	52,213	267	38,640	34
44	SKILLED NURSING FACILITY	1,183	98,383	1,882	101,448	197	84,702	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	79,809	93,901	199,147	372,857	168	105,684	50
51	RECOVERY ROOM		6,937	876	7,813	32	12,712	51
53	ANESTHESIOLOGY		2,861	39,217	42,078	5	3,100	53
54	RADIOLOGY-DIAGNOSTIC	1,542	49,693	626,884	678,119	126	66,768	54
56	RADIOISOTOPE		3,039		3,039	13	8,839	56
57	CT SCAN		5,524		5,524	38	18,674	57
58	MRI		1,477		1,477	15	6,472	58
59	CARDIAC CATHETERIZATION	1,937	21,543	69,027	92,507	35	14,540	59
60	LABORATORY	407	47,633	16,962	65,002		176,349	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,888	10,035	26,609	38,532	74	32,899	65
66	PHYSICAL THERAPY	2,873	24,044	5,967	32,884	124	49,070	66
67	OCCUPATIONAL THERAPY		6,078	709	6,787	49	19,023	67
68	SPEECH PATHOLOGY		4,002	297	4,299	12	4,705	68
69	ELECTROCARDIOLOGY	4,255	7,283	41,309	52,847	34	15,297	69
69.01	CARDIAC REHAB		8,771	4,077	12,848	19	7,229	69.01
70	ELECTROENCEPHALOGRAPHY			1,444	1,444	4	1,733	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						91,123	71
72	IMPL. DEV. CHARGED TO PATIENTS						77,138	72
73	DRUGS CHARGED TO PATIENTS						76,567	73
75.01	ACUTE DIALYSIS		3,513	8,765	12,278	18	8,336	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,906	22,551	8,683	34,140	69	34,339	90
91	EMERGENCY	1,761	52,025	40,752	94,538	264	126,047	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	176,427	1,706,681	2,591,020	4,474,128	3,099	1,847,682	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,091		7,091	1	1,748	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	176,427	1,713,772	2,591,020	4,481,219	3,100	1,849,430	202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	383,402						7
8	LAUNDRY & LINEN SERVICE		15,393					8
9	HOUSEKEEPING	11,643	2	88,637				9
10	DIETARY	15,478		3,690	128,095			10
11	CAFETERIA	15,182		3,620		76,795		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	4,920		1,173		1,366	52,972	13
14	CENTRAL SERVICES & SUPPLY	14,819	3	3,533		1,142		14
15	PHARMACY	5,199		1,240		2,385		15
16	MEDICAL RECORDS & LIBRARY	13,029		3,106		6,225		16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	104,792	6,988	24,986	82,731	20,081	18,178	30
34	SURGICAL INTENSIVE CARE UNIT	13,993	1,904	3,336	16,176	7,127		34
44	SKILLED NURSING FACILITY	38,071	1,717	9,077	29,188	6,259	5,667	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	36,337	796	8,664		4,417	3,999	50
51	RECOVERY ROOM	2,685		640		952	862	51
53	ANESTHESIOLOGY	1,107		264		392	355	53
54	RADIOLOGY-DIAGNOSTIC	19,230	1,262	4,585		3,879	3,512	54
56	RADIOISOTOPE	1,176		280		528	478	56
57	CT SCAN	2,138		510		993	899	57
58	MRI	572		136		539	488	58
59	CARDIAC CATHETERIZATION	8,337	70	1,988		1,857	1,681	59
60	LABORATORY	18,432		4,395				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,883		926		2,488	2,253	65
66	PHYSICAL THERAPY	9,304	311	2,218		2,764	2,503	66
67	OCCUPATIONAL THERAPY	2,352	33	561		1,040	941	67
68	SPEECH PATHOLOGY	1,549		369		233	211	68
69	ELECTROCARDIOLOGY	2,818	82	672		1,353	1,225	69
69.01	CARDIAC REHAB	3,394		809		455	412	69.01
70	ELECTROENCEPHALOGRAPHY					130	117	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75.01	ACUTE DIALYSIS	1,359	34	324		709	642	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	8,727	106	2,081		2,286	2,070	90
91	EMERGENCY	20,132	2,085	4,800		7,157	6,479	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	380,658	15,393	87,983	128,095	76,757	52,972	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,744		654		38		190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	383,402	15,393	88,637	128,095	76,795	52,972	202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	171,612						14
15	PHARMACY	5,958	80,493					15
16	MEDICAL RECORDS & LIBRARY	683		142,258				16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				3,292			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					447		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	18,790	1	23,147			948,850	30
34	SURGICAL INTENSIVE CARE UNIT	2,612	1	1,423			137,692	34
44	SKILLED NURSING FACILITY	4,200	5	2,948			283,479	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	64,345	3	7,844			605,114	50
51	RECOVERY ROOM	684		1,426			27,806	51
53	ANESTHESIOLOGY	2,866		1,976			52,143	53
54	RADIOLOGY-DIAGNOSTIC	377		6,657			784,515	54
56	RADIOISOTOPE	146		1,421			15,920	56
57	CT SCAN	3,539	2	9,238			41,555	57
58	MRI	70		2,211			11,980	58
59	CARDIAC CATHETERIZATION	10,200		4,082			135,297	59
60	LABORATORY	15,968		20,019			300,165	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,741	97	4,277			88,170	65
66	PHYSICAL THERAPY	3,651		2,891			105,720	66
67	OCCUPATIONAL THERAPY	200		1,382			32,368	67
68	SPEECH PATHOLOGY			230			11,608	68
69	ELECTROCARDIOLOGY	581		4,762			79,671	69
69.01	CARDIAC REHAB	21		155			25,342	69.01
70	ELECTROENCEPHALOGRAPHY	51		71			3,550	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			4,761			95,884	71
72	IMPL. DEV. CHARGED TO PATIENTS			3,022			80,160	72
73	DRUGS CHARGED TO PATIENTS		80,181	18,329			175,077	73
75.01	ACUTE DIALYSIS	1,255	3	514			25,472	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,413	186	2,758			89,175	90
91	EMERGENCY	30,261	14	16,714			308,491	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	171,612	80,493	142,258			4,465,204	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						12,276	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS				3,292	447	3,739	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	171,612	80,493	142,258	3,292	447	4,481,219	202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		948,850					30
34	SURGICAL INTENSIVE CARE UNIT		137,692					34
44	SKILLED NURSING FACILITY		283,479					44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		605,114					50
51	RECOVERY ROOM		27,806					51
53	ANESTHESIOLOGY		52,143					53
54	RADIOLOGY-DIAGNOSTIC		784,515					54
56	RADIOISOTOPE		15,920					56
57	CT SCAN		41,555					57
58	MRI		11,980					58
59	CARDIAC CATHETERIZATION		135,297					59
60	LABORATORY		300,165					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		88,170					65
66	PHYSICAL THERAPY		105,720					66
67	OCCUPATIONAL THERAPY		32,368					67
68	SPEECH PATHOLOGY		11,608					68
69	ELECTROCARDIOLOGY		79,671					69
69.01	CARDIAC REHAB		25,342					69.01
70	ELECTROENCEPHALOGRAPHY		3,550					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		95,884					71
72	IMPL. DEV. CHARGED TO PATIENTS		80,160					72
73	DRUGS CHARGED TO PATIENTS		175,077					73
75.01	ACUTE DIALYSIS		25,472					75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		89,175					90
91	EMERGENCY		308,491					91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		4,465,204					118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		12,276					190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS		3,739					200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		4,481,219					202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT DOLLAR VALUE)	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	346,838						1
2	CAP REL COSTS-MVBLE EQUIP		3,559,297					2
4	EMPLOYEE BENEFITS DEPARTMENT		2,928	44,771,504				4
5	ADMINISTRATIVE & GENERAL	116,908	1,746,719	3,383,797	-21,554,118	84,355,031		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	29,413	165,508	1,436,917		5,099,492	200,517	7
8	LAUNDRY & LINEN SERVICE					702,107		8
9	HOUSEKEEPING	6,089	3,097	1,031,882		2,013,747	6,089	9
10	DIETARY	8,095	34,852	1,688,917		1,877,306	8,095	10
11	CAFETERIA	7,940				855,672	7,940	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,573	4,275	1,020,313		1,267,067	2,573	13
14	CENTRAL SERVICES & SUPPLY	7,750	26,754	321,450		1,549,691	7,750	14
15	PHARMACY	2,719	5,612	1,739,186		2,171,878	2,719	15
16	MEDICAL RECORDS & LIBRARY	6,814	3,344	2,471,289		3,636,375	6,814	16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD					150,148		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					20,371		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	54,807	44,412	9,022,281		15,671,041	54,807	30
34	SURGICAL INTENSIVE CARE UNIT	7,318	20,876	3,875,492		1,762,474	7,318	34
44	SKILLED NURSING FACILITY	19,911	2,586	2,849,955		3,863,434	19,911	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	19,004	273,569	2,437,116		4,820,477	19,004	50
51	RECOVERY ROOM	1,404	1,203	461,377		579,823	1,404	51
53	ANESTHESIOLOGY	579	53,873	65,607		141,390	579	53
54	RADIOLOGY-DIAGNOSTIC	10,057	861,154	1,832,685		3,045,427	10,057	54
56	RADIOISOTOPE	615		182,641		403,169	615	56
57	CT SCAN	1,118		548,639		851,763	1,118	57
58	MRI	299		217,068		295,179	299	58
59	CARDIAC CATHETERIZATION	4,360	94,823	513,651		663,196	4,360	59
60	LABORATORY	9,640	23,301			8,043,640	9,640	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,031	36,553	1,076,572		1,500,584	2,031	65
66	PHYSICAL THERAPY	4,866	8,197	1,795,022		2,238,175	4,866	66
67	OCCUPATIONAL THERAPY	1,230	974	707,816		867,662	1,230	67
68	SPEECH PATHOLOGY	810	408	169,967		214,615	810	68
69	ELECTROCARDIOLOGY	1,474	56,747	495,921		697,721	1,474	69
69.01	CARDIAC REHAB	1,775	5,600	269,429		329,736	1,775	69.01
70	ELECTROENCEPHALOGRAPHY		1,983	51,430		79,033		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					4,156,328		71
72	IMPL. DEV. CHARGED TO PATIENTS					3,518,441		72
73	DRUGS CHARGED TO PATIENTS					3,492,382		73
75.01	ACUTE DIALYSIS	711	12,040	266,475		380,214	711	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	4,564	11,928	998,856		1,566,270	4,564	90
91	EMERGENCY	10,529	55,981	3,820,479		5,749,262	10,529	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	345,403	3,559,297	44,752,230	-21,554,118	84,275,290	199,082	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,435		19,274		79,741	1,435	190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,713,772	2,591,020	729,294		21,554,118	6,402,499	202
203	UNIT COST MULT-WS B PT I	4.941131	0.727958	0.016289		0.255517	31.929956	203
204	COST TO BE ALLOC PER B PT II			3,100		1,849,430	383,402	204
205	UNIT COST MULT-WS B PT II			0.000069		0.021924	1.912067	205

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED)	CAFETERIA FTES SERVED	NURSING ADMINIS-TRATION FTES SERVED	CENTRAL SERVICES & SUPPLY COSTED REQUIS)	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	1,174,704						8
9	HOUSEKEEPING	174	194,428					9
10	DIETARY		8,095	78,969				10
11	CAFETERIA		7,940		1,450,935			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,573		25,805	1,105,496		13
14	CENTRAL SERVICES & SUPPLY	210	7,750		21,584		4,429,902	14
15	PHARMACY		2,719		45,069		153,805	15
16	MEDICAL RECORDS & LIBRARY		6,814		117,606		17,621	16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	533,299	54,807	51,003	379,400	379,400	485,053	30
34	SURGICAL INTENSIVE CARE UNIT	145,312	7,318	9,972	134,650		67,427	34
44	SKILLED NURSING FACILITY	131,001	19,911	17,994	118,263	118,263	108,428	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	60,767	19,004		83,450	83,450	1,660,937	50
51	RECOVERY ROOM		1,404		17,991	17,991	17,660	51
53	ANESTHESIOLOGY		579		7,399	7,399	73,974	53
54	RADIOLOGY-DIAGNOSTIC	96,319	10,057		73,290	73,290	9,734	54
56	RADIOISOTOPE		615		9,969	9,969	3,766	56
57	CT SCAN		1,118		18,754	18,754	91,357	57
58	MRI		299		10,187	10,187	1,806	58
59	CARDIAC CATHETERIZATION	5,321	4,360		35,085	35,085	263,291	59
60	LABORATORY		9,640				412,193	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		2,031		47,014	47,014	70,758	65
66	PHYSICAL THERAPY	23,723	4,866		52,228	52,228	94,242	66
67	OCCUPATIONAL THERAPY	2,540	1,230		19,642	19,642	5,167	67
68	SPEECH PATHOLOGY		810		4,402	4,402		68
69	ELECTROCARDIOLOGY	6,222	1,474		25,572	25,572	14,989	69
69.01	CARDIAC REHAB		1,775		8,593	8,593	554	69.01
70	ELECTROENCEPHALOGRAPHY				2,452	2,452	1,310	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75.01	ACUTE DIALYSIS	2,587	711		13,392	13,392	32,385	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	8,107	4,564		43,197	43,197	62,299	90
91	EMERGENCY	159,122	10,529		135,216	135,216	781,146	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,174,704	192,993	78,969	1,450,210	1,105,496	4,429,902	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,435		725			190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	881,507	2,722,847	2,728,829	1,439,030	1,734,606	2,323,219	202
203	UNIT COST MULT-WS B PT I	0.750408	14.004398	34.555699	0.991795	1.569075	0.524440	203
204	COST TO BE ALLOC PER B PT II	15,393	88,637	128,095	76,795	52,972	171,612	204
205	UNIT COST MULT-WS B PT II	0.013104	0.455886	1.622092	0.052928	0.047917	0.038739	205

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS)	MEDICAL RECORDS & LIBRARY TIME SPENT)	I&R SALARY & FRINGES ASSIGNED TIME)	I&R PROGRAM COSTS ASSIGNED TIME)			
		15	16	21	22			
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	3,365,554						15
16	MEDICAL RECORDS & LIBRARY		557,217,922					16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			200				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				200			22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	50	90,120,724	50	50			30
34	SURGICAL INTENSIVE CARE UNIT	34	5,578,571	50	50			34
44	SKILLED NURSING FACILITY	198	11,561,391					44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	134	30,759,951					50
51	RECOVERY ROOM		5,591,218					51
53	ANESTHESIOLOGY	14	7,750,470					53
54	RADIOLOGY-DIAGNOSTIC		26,107,297					54
56	RADIOISOTOPE		5,574,463					56
57	CT SCAN	89	36,227,941					57
58	MRI		8,668,741					58
59	CARDIAC CATHETERIZATION	8	16,006,514					59
60	LABORATORY		78,505,973					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,044	16,772,918					65
66	PHYSICAL THERAPY		11,336,384					66
67	OCCUPATIONAL THERAPY		5,421,374					67
68	SPEECH PATHOLOGY		900,015					68
69	ELECTROCARDIOLOGY		18,674,141					69
69.01	CARDIAC REHAB		606,241					69.01
70	ELECTROENCEPHALOGRAPHY		277,239					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		18,669,537					71
72	IMPL. DEV. CHARGED TO PATIENTS		11,852,759					72
73	DRUGS CHARGED TO PATIENTS	3,352,507	71,879,021					73
75.01	ACUTE DIALYSIS	140	2,015,851					75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	7,758	10,815,803					90
91	EMERGENCY	578	65,543,385	100	100			91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,365,554	557,217,922	200	200			118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,977,086	5,004,410	188,513	25,576			202
203	UNIT COST MULT-WS B PT I	0.884575	0.008981	942.565000	127.880000			203
204	COST TO BE ALLOC PER B PT II	80,493	142,258	3,292	447			204

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY TIME SPENT)	I&R SALARY & FRINGES ASSIGNED T IME)	I&R PROGRAM COSTS ASSIGNED T IME)			
		15	16	21	22			
205	UNIT COST MULT-WS B PT II	0.023917	0.000255	16.460000	2.235000			205

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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	26,390,822		26,390,822		26,390,822	30
34	SURGICAL INTENSIVE CARE UNIT	3,221,632		3,221,632		3,221,632	34
44	SKILLED NURSING FACILITY	6,949,034		6,949,034	9,035	6,958,069	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,331,871		8,331,871		8,331,871	50
51	RECOVERY ROOM	898,019		898,019		898,019	51
53	ANESTHESIOLOGY	331,476		331,476		331,476	53
54	RADIOLOGY-DIAGNOSTIC	4,785,088		4,785,088		4,785,088	54
56	RADIOISOTOPE	612,004		612,004		612,004	56
57	CT SCAN	1,542,137		1,542,137		1,542,137	57
58	MRI	489,224		489,224		489,224	58
59	CARDIAC CATHETERIZATION	1,408,611		1,408,611		1,408,611	59
60	LABORATORY	11,462,966		11,462,966		11,462,966	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,289,021		2,289,021		2,289,021	65
66	PHYSICAL THERAPY	3,336,370		3,336,370		3,336,370	66
67	OCCUPATIONAL THERAPY	1,249,469		1,249,469		1,249,469	67
68	SPEECH PATHOLOGY	326,016		326,016		326,016	68
69	ELECTROCARDIOLOGY	1,189,436		1,189,436		1,189,436	69
69.01	CARDIAC REHAB	523,264		523,264		523,264	69.01
70	ELECTROENCEPHALOGRAPHY	108,683		108,683		108,683	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,386,011		5,386,011		5,386,011	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,523,912		4,523,912		4,523,912	72
73	DRUGS CHARGED TO PATIENTS	7,995,835		7,995,835		7,995,835	73
75.01	ACUTE DIALYSIS	581,472		581,472		581,472	75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	2,429,501		2,429,501		2,429,501	90
91	EMERGENCY	9,166,436		9,166,436		9,166,436	91
91.01	LITHOTRIPSY						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	683,410		683,410		683,410	92
	OTHER REIMBURSABLE COST CENTERS						
200	SUBTOTAL (SEE INSTRUCTIONS)	106,211,720		106,211,720	9,035	106,220,755	200
201	LESS OBSERVATION BEDS	683,410		683,410		683,410	201
202	TOTAL (SEE INSTRUCTIONS)	105,528,310		105,528,310		105,537,345	202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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	75,246,994		75,246,994				30
34	SURGICAL INTENSIVE CARE UNIT	20,452,301		20,452,301				34
44	SKILLED NURSING FACILITY	11,561,391		11,561,391				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	15,489,764	15,270,188	30,759,952	0.270867	0.270867	0.270867	50
51	RECOVERY ROOM	3,099,329	2,491,889	5,591,218	0.160612	0.160612	0.160612	51
53	ANESTHESIOLOGY	4,044,817	3,705,653	7,750,470	0.042769	0.042769	0.042769	53
54	RADIOLOGY-DIAGNOSTIC	9,818,396	16,288,901	26,107,297	0.183285	0.183285	0.183285	54
56	RADIOISOTOPE	1,770,254	3,804,209	5,574,463	0.109787	0.109787	0.109787	56
57	CT SCAN	12,360,649	23,867,292	36,227,941	0.042568	0.042568	0.042568	57
58	MRI	2,933,866	5,734,875	8,668,741	0.056435	0.056435	0.056435	58
59	CARDIAC CATHETERIZATION	10,487,516	5,518,997	16,006,513	0.088002	0.088002	0.088002	59
60	LABORATORY	42,087,727	36,418,246	78,505,973	0.146014	0.146014	0.146014	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	15,923,075	849,843	16,772,918	0.136471	0.136471	0.136471	65
66	PHYSICAL THERAPY	7,954,814	3,381,570	11,336,384	0.294306	0.294306	0.294306	66
67	OCCUPATIONAL THERAPY	4,367,737	1,053,637	5,421,374	0.230471	0.230471	0.230471	67
68	SPEECH PATHOLOGY	807,907	92,108	900,015	0.362234	0.362234	0.362234	68
69	ELECTROCARDIOLOGY	9,964,356	8,709,785	18,674,141	0.063694	0.063694	0.063694	69
69.01	CARDIAC REHAB	309,525	296,716	606,241	0.863129	0.863129	0.863129	69.01
70	ELECTROENCEPHALOGRAPHY	209,337	67,902	277,239	0.392019	0.392019	0.392019	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,146,718	4,522,819	18,669,537	0.288492	0.288492	0.288492	71
72	IMPL. DEV. CHARGED TO PATIENTS	6,752,371	5,100,388	11,852,759	0.381676	0.381676	0.381676	72
73	DRUGS CHARGED TO PATIENTS	60,034,544	11,844,477	71,879,021	0.111240	0.111240	0.111240	73
75.01	ACUTE DIALYSIS	1,823,177	192,674	2,015,851	0.288450	0.288450	0.288450	75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,428,614	8,387,189	10,815,803	0.224625	0.224625	0.224625	90
91	EMERGENCY	18,950,214	46,593,171	65,543,385	0.139853	0.139853	0.139853	91
91.01	LITHOTRIPSY							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		1,255,858	1,255,858	0.544178	0.544178	0.544178	92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	353,025,393	205,448,387	558,473,780				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	353,025,393	205,448,387	558,473,780				202

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	948,850		948,850	26,182	36.24	13,904	503,881	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT	137,692		137,692	5,473	25.16	2,799	70,423	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	283,479		283,479	13,234	21.42	11,455	245,366	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,370,021		1,370,021	44,889		28,158	819,670	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0251** **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	605,114	30,759,952	0.019672	10,410,248	204,790	50
51	RECOVERY ROOM	27,806	5,591,218	0.004973	1,260,705	6,269	51
53	ANESTHESIOLOGY	52,143	7,750,470	0.006728	1,909,422	12,847	53
54	RADIOLOGY-DIAGNOSTIC	784,515	26,107,297	0.030050	5,464,026	164,194	54
56	RADIOISOTOPE	15,920	5,574,463	0.002856	952,271	2,720	56
57	CT SCAN	41,555	36,227,941	0.001147	6,223,525	7,138	57
58	MRI	11,980	8,668,741	0.001382	1,317,301	1,821	58
59	CARDIAC CATHETERIZATION	135,297	16,006,513	0.008453	6,112,543	51,669	59
60	LABORATORY	300,165	78,505,973	0.003823	21,289,138	81,388	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	88,170	16,772,918	0.005257	12,212,188	64,199	65
66	PHYSICAL THERAPY	105,720	11,336,384	0.009326	1,209,139	11,276	66
67	OCCUPATIONAL THERAPY	32,368	5,421,374	0.005970	301,921	1,802	67
68	SPEECH PATHOLOGY	11,608	900,015	0.012898	398,082	5,134	68
69	ELECTROCARDIOLOGY	79,671	18,674,141	0.004266	6,060,925	25,856	69
69.01	CARDIAC REHAB	25,342	606,241	0.041802	157,665	6,591	69.01
70	ELECTROENCEPHALOGRAPHY	3,550	277,239	0.012805	126,737	1,623	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,884	18,669,537	0.005136	4,259,971	21,879	71
72	IMPL. DEV. CHARGED TO PATIENTS	80,160	11,852,759	0.006763			72
73	DRUGS CHARGED TO PATIENTS	175,077	71,879,021	0.002436	23,228,862	56,586	73
75.01	ACUTE DIALYSIS	25,472	2,015,851	0.012636	932,600	11,784	75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	89,175	10,815,803	0.008245	1,531,579	12,628	90
91	EMERGENCY	308,491	65,543,385	0.004707	9,013,965	42,429	91
91.01	LITHOTRIPSY						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	24,571	1,255,858	0.019565			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	3,119,754	451,213,094		114,372,813	794,623	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

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

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	26,182		13,904		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT	5,473		2,799		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	13,234		11,455		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	44,889		28,158		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0251** **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	CARDIAC REHAB							69.01
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
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	LITHOTRIPSY							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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0251** **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	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	30,759,952			10,410,248		8,677,056		50
51	RECOVERY ROOM	5,591,218			1,260,705		682,173		51
53	ANESTHESIOLOGY	7,750,470			1,909,422		1,437,812		53
54	RADIOLOGY-DIAGNOSTIC	26,107,297			5,464,026		3,810,361		54
56	RADIOISOTOPE	5,574,463			952,271		1,729,047		56
57	CT SCAN	36,227,941			6,223,525		6,603,658		57
58	MRI	8,668,741			1,317,301		2,230,340		58
59	CARDIAC CATHETERIZATION	16,006,513			6,112,543		3,091,393		59
60	LABORATORY	78,505,973			21,289,138		1,319,346		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	16,772,918			12,212,188		471,003		65
66	PHYSICAL THERAPY	11,336,384			1,209,139		10,311		66
67	OCCUPATIONAL THERAPY	5,421,374			301,921		3,856		67
68	SPEECH PATHOLOGY	900,015			398,082		632		68
69	ELECTROCARDIOLOGY	18,674,141			6,060,925		3,634,719		69
69.01	CARDIAC REHAB	606,241			157,665		181,815		69.01
70	ELECTROENCEPHALOGRAPHY	277,239			126,737		26,623		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,669,537			4,259,971		368,155		71
72	IMPL. DEV. CHARGED TO PATIENTS	11,852,759							72
73	DRUGS CHARGED TO PATIENTS	71,879,021			23,228,862		3,898,996		73
75.01	ACUTE DIALYSIS	2,015,851			932,600		114,976		75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	10,815,803			1,531,579		3,956,450		90
91	EMERGENCY	65,543,385			9,013,965		8,372,348		91
91.01	LITHOTRIPSY								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,255,858							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	451,213,094			114,372,813		50,621,070		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0251** **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	0.270867	8,677,056			2,350,328			50
51	RECOVERY ROOM	0.160612	682,173			109,565			51
53	ANESTHESIOLOGY	0.042769	1,437,812			61,494			53
54	RADIOLOGY-DIAGNOSTIC	0.183285	3,810,361			698,382			54
56	RADIOISOTOPE	0.109787	1,729,047			189,827			56
57	CT SCAN	0.042568	6,603,658			281,105			57
58	MRI	0.056435	2,230,340			125,869			58
59	CARDIAC CATHETERIZATION	0.088002	3,091,393			272,049			59
60	LABORATORY	0.146014	1,319,346			192,643			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.136471	471,003			64,278			65
66	PHYSICAL THERAPY	0.294306	10,311			3,035			66
67	OCCUPATIONAL THERAPY	0.230471	3,856			889			67
68	SPEECH PATHOLOGY	0.362234	632			229			68
69	ELECTROCARDIOLOGY	0.063694	3,634,719			231,510			69
69.01	CARDIAC REHAB	0.863129	181,815			156,930			69.01
70	ELECTROENCEPHALOGRAPHY	0.392019	26,623			10,437			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.288492	368,155			106,210			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.381676							72
73	DRUGS CHARGED TO PATIENTS	0.111240	3,898,996		190,584	433,724		21,201	73
75.01	ACUTE DIALYSIS	0.288450	114,976			33,165			75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.224625	3,956,450			888,718			90
91	EMERGENCY	0.139853	8,372,348			1,170,898			91
91.01	LITHOTRIPSY								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.544178							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		50,621,070		190,584	7,381,285		21,201	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		50,621,070		190,584	7,381,285		21,201	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5548** **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

		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
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	CARDIAC REHAB							69.01
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
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	LITHOTRIPSY							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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-5548** | **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	30,759,952							50
51	RECOVERY ROOM	5,591,218							51
53	ANESTHESIOLOGY	7,750,470							53
54	RADIOLOGY-DIAGNOSTIC	26,107,297			264,734				54
56	RADIOISOTOPE	5,574,463			15,690				56
57	CT SCAN	36,227,941			13,097				57
58	MRI	8,668,741							58
59	CARDIAC CATHETERIZATION	16,006,513			142,900				59
60	LABORATORY	78,505,973			2,584,514				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	16,772,918			3,200,415				65
66	PHYSICAL THERAPY	11,336,384			5,027,278				66
67	OCCUPATIONAL THERAPY	5,421,374			3,358,594				67
68	SPEECH PATHOLOGY	900,015			159,344				68
69	ELECTROCARDIOLOGY	18,674,141			76,643				69
69.01	CARDIAC REHAB	606,241			5,161				69.01
70	ELECTROENCEPHALOGRAPHY	277,239							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,669,537			420,198				71
72	IMPL. DEV. CHARGED TO PATIENTS	11,852,759							72
73	DRUGS CHARGED TO PATIENTS	71,879,021			6,032,550				73
75.01	ACUTE DIALYSIS	2,015,851							75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	10,815,803			6,874				90
91	EMERGENCY	65,543,385							91
91.01	LITHOTRIPSY								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,255,858							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	451,213,094			21,307,992				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5548** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.270867							50
51	RECOVERY ROOM	0.160612							51
53	ANESTHESIOLOGY	0.042769							53
54	RADIOLOGY-DIAGNOSTIC	0.183285							54
56	RADIOISOTOPE	0.109787							56
57	CT SCAN	0.042568							57
58	MRI	0.056435							58
59	CARDIAC CATHETERIZATION	0.088002							59
60	LABORATORY	0.146014							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.136471							65
66	PHYSICAL THERAPY	0.294306							66
67	OCCUPATIONAL THERAPY	0.230471							67
68	SPEECH PATHOLOGY	0.362234							68
69	ELECTROCARDIOLOGY	0.063694							69
69.01	CARDIAC REHAB	0.863129							69.01
70	ELECTROENCEPHALOGRAPHY	0.392019							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.288492							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.381676							72
73	DRUGS CHARGED TO PATIENTS	0.111240			1,111			124	73
75.01	ACUTE DIALYSIS	0.288450							75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.224625							90
91	EMERGENCY	0.139853							91
91.01	LITHOTRIPSY								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.544178							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)				1,111			124	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)				1,111			124	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

(A)		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)	
	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	948,850		948,850	26,182	36.24	5,605	203,125	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT	137,692		137,692	5,473	25.16	737	18,543	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	283,479		283,479	13,234	21.42			44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,370,021		1,370,021	44,889		6,342	221,668	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0251** **WORKSHEET D PART II**

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

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	605,114	30,759,952	0.019672			50
51	RECOVERY ROOM	27,806	5,591,218	0.004973			51
53	ANESTHESIOLOGY	52,143	7,750,470	0.006728			53
54	RADIOLOGY-DIAGNOSTIC	784,515	26,107,297	0.030050			54
56	RADIOISOTOPE	15,920	5,574,463	0.002856			56
57	CT SCAN	41,555	36,227,941	0.001147			57
58	MRI	11,980	8,668,741	0.001382			58
59	CARDIAC CATHETERIZATION	135,297	16,006,513	0.008453			59
60	LABORATORY	300,165	78,505,973	0.003823			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	88,170	16,772,918	0.005257			65
66	PHYSICAL THERAPY	105,720	11,336,384	0.009326			66
67	OCCUPATIONAL THERAPY	32,368	5,421,374	0.005970			67
68	SPEECH PATHOLOGY	11,608	900,015	0.012898			68
69	ELECTROCARDIOLOGY	79,671	18,674,141	0.004266			69
69.01	CARDIAC REHAB	25,342	606,241	0.041802			69.01
70	ELECTROENCEPHALOGRAPHY	3,550	277,239	0.012805			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,884	18,669,537	0.005136			71
72	IMPL. DEV. CHARGED TO PATIENTS	80,160	11,852,759	0.006763			72
73	DRUGS CHARGED TO PATIENTS	175,077	71,879,021	0.002436			73
75.01	ACUTE DIALYSIS	25,472	2,015,851	0.012636			75.01
76	AUDIO-VESTIBULAR LAB						76
76.01	ONCOLOGY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	89,175	10,815,803	0.008245			90
91	EMERGENCY	308,491	65,543,385	0.004707			91
91.01	LITHOTRIPSY						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	24,571	1,255,858	0.019565			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	3,119,754	451,213,094				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	26,182		5,605		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT	5,473		737		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	13,234				44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	44,889		6,342		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0251** **WORKSHEET D PART IV**

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

		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
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	CARDIAC REHAB							69.01
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
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	LITHOTRIPSY							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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0251** **WORKSHEET D PART IV**

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

(A)	COST CENTER DESCRIPTION	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	30,759,952							50
51	RECOVERY ROOM	5,591,218							51
53	ANESTHESIOLOGY	7,750,470							53
54	RADIOLOGY-DIAGNOSTIC	26,107,297							54
56	RADIOISOTOPE	5,574,463							56
57	CT SCAN	36,227,941							57
58	MRI	8,668,741							58
59	CARDIAC CATHETERIZATION	16,006,513							59
60	LABORATORY	78,505,973							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	16,772,918							65
66	PHYSICAL THERAPY	11,336,384							66
67	OCCUPATIONAL THERAPY	5,421,374							67
68	SPEECH PATHOLOGY	900,015							68
69	ELECTROCARDIOLOGY	18,674,141							69
69.01	CARDIAC REHAB	606,241							69.01
70	ELECTROENCEPHALOGRAPHY	277,239							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,669,537							71
72	IMPL. DEV. CHARGED TO PATIENTS	11,852,759							72
73	DRUGS CHARGED TO PATIENTS	71,879,021							73
75.01	ACUTE DIALYSIS	2,015,851							75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	10,815,803							90
91	EMERGENCY	65,543,385							91
91.01	LITHOTRIPSY								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,255,858							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	451,213,094							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0251** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/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	0.270867							50
51	RECOVERY ROOM	0.160612							51
53	ANESTHESIOLOGY	0.042769							53
54	RADIOLOGY-DIAGNOSTIC	0.183285							54
56	RADIOISOTOPE	0.109787							56
57	CT SCAN	0.042568							57
58	MRI	0.056435							58
59	CARDIAC CATHETERIZATION	0.088002							59
60	LABORATORY	0.146014							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.136471							65
66	PHYSICAL THERAPY	0.294306							66
67	OCCUPATIONAL THERAPY	0.230471							67
68	SPEECH PATHOLOGY	0.362234							68
69	ELECTROCARDIOLOGY	0.063694							69
69.01	CARDIAC REHAB	0.863129							69.01
70	ELECTROENCEPHALOGRAPHY	0.392019							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.288492							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.381676							72
73	DRUGS CHARGED TO PATIENTS	0.111240							73
75.01	ACUTE DIALYSIS	0.288450							75.01
76	AUDIO-VESTIBULAR LAB								76
76.01	ONCOLOGY								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.224625							90
91	EMERGENCY	0.139853							91
91.01	LITHOTRIPSY								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.544178							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0251** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	26,182	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	26,182	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)	25,504	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)	13,904	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)	26,390,822	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	26,390,822	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)	26,390,822	37

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0251** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,007.98	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	14,014,954	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)	14,014,954	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						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT	3,221,632	5,473	588.64	2,799	1,647,603	46
47	OTHER SPECIAL CARE (SPECIFY)						47

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	16,690,334	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	32,352,891	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	574,304	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	794,623	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	1,368,927	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	30,983,964	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0251** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					678	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,007.98	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					683,410	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	948,850	26,390,822	0.035954	683,410	24,571	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5548** **WORKSHEET D-1 PART I**

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 I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	13,234	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	13,234	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	13,234	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,455	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)	6,958,069	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	6,958,069	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)	6,958,069	37

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5548** **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)	6,958,069	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	525.77	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	6,022,695	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)	6,022,695	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)	6,022,695	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	3,992,020	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	10,014,715	86

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0251** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	26,182	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	26,182	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)	25,504	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)	5,605	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)	26,390,822	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	26,390,822	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)	26,390,822	37

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0251** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,007.98	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					5,649,728	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)					5,649,728	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						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT	3,221,632	5,473	588.64	737	433,828	46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					6,083,556	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	221,668	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	221,668	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0251** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					678	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0251** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		35,480,542		30
34	SURGICAL INTENSIVE CARE UNIT		10,262,406		34
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.270867	10,410,248	2,819,793	50
51	RECOVERY ROOM	0.160612	1,260,705	202,484	51
53	ANESTHESIOLOGY	0.042769	1,909,422	81,664	53
54	RADIOLOGY-DIAGNOSTIC	0.183285	5,464,026	1,001,474	54
56	RADIOISOTOPE	0.109787	952,271	104,547	56
57	CT SCAN	0.042568	6,223,525	264,923	57
58	MRI	0.056435	1,317,301	74,342	58
59	CARDIAC CATHETERIZATION	0.088002	6,112,543	537,916	59
60	LABORATORY	0.146014	21,289,138	3,108,512	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.136471	12,212,188	1,666,610	65
66	PHYSICAL THERAPY	0.294306	1,209,139	355,857	66
67	OCCUPATIONAL THERAPY	0.230471	301,921	69,584	67
68	SPEECH PATHOLOGY	0.362234	398,082	144,199	68
69	ELECTROCARDIOLOGY	0.063694	6,060,925	386,045	69
69.01	CARDIAC REHAB	0.863129	157,665	136,085	69.01
70	ELECTROENCEPHALOGRAPHY	0.392019	126,737	49,683	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.288492	4,259,971	1,228,968	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.381676			72
73	DRUGS CHARGED TO PATIENTS	0.111240	23,228,862	2,583,979	73
75.01	ACUTE DIALYSIS	0.288450	932,600	269,008	75.01
76	AUDIO-VESTIBULAR LAB				76
76.01	ONCOLOGY				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.224625	1,531,579	344,031	90
91	EMERGENCY	0.139853	9,013,965	1,260,630	91
91.01	LITHOTRIPSY				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.544178			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		114,372,813	16,690,334	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		114,372,813		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5548** **WORKSHEET D-3**

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 | [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
34	SURGICAL INTENSIVE CARE UNIT				34
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.270867			50
51	RECOVERY ROOM	0.160612			51
53	ANESTHESIOLOGY	0.042769			53
54	RADIOLOGY-DIAGNOSTIC	0.183285	264,734	48,522	54
56	RADIOISOTOPE	0.109787	15,690	1,723	56
57	CT SCAN	0.042568	13,097	558	57
58	MRI	0.056435			58
59	CARDIAC CATHETERIZATION	0.088002	142,900	12,575	59
60	LABORATORY	0.146014	2,584,514	377,375	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.136471	3,200,415	436,764	65
66	PHYSICAL THERAPY	0.294306	5,027,278	1,479,558	66
67	OCCUPATIONAL THERAPY	0.230471	3,358,594	774,059	67
68	SPEECH PATHOLOGY	0.362234	159,344	57,720	68
69	ELECTROCARDIOLOGY	0.063694	76,643	4,882	69
69.01	CARDIAC REHAB	0.863129	5,161	4,455	69.01
70	ELECTROENCEPHALOGRAPHY	0.392019			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.288492	420,198	121,224	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.381676			72
73	DRUGS CHARGED TO PATIENTS	0.111240	6,032,550	671,061	73
75.01	ACUTE DIALYSIS	0.288450			75.01
76	AUDIO-VESTIBULAR LAB				76
76.01	ONCOLOGY				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.224625	6,874	1,544	90
91	EMERGENCY	0.139853			91
91.01	LITHOTRIPSY				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.544178			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		21,307,992	3,992,020	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		21,307,992		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0251** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
34	SURGICAL INTENSIVE CARE UNIT				34
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.270867			50
51	RECOVERY ROOM	0.160612			51
53	ANESTHESIOLOGY	0.042769			53
54	RADIOLOGY-DIAGNOSTIC	0.183285			54
56	RADIOISOTOPE	0.109787			56
57	CT SCAN	0.042568			57
58	MRI	0.056435			58
59	CARDIAC CATHETERIZATION	0.088002			59
60	LABORATORY	0.146014			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.136471			65
66	PHYSICAL THERAPY	0.294306			66
67	OCCUPATIONAL THERAPY	0.230471			67
68	SPEECH PATHOLOGY	0.362234			68
69	ELECTROCARDIOLOGY	0.063694			69
69.01	CARDIAC REHAB	0.863129			69.01
70	ELECTROENCEPHALOGRAPHY	0.392019			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.288492			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.381676			72
73	DRUGS CHARGED TO PATIENTS	0.111240			73
75.01	ACUTE DIALYSIS	0.288450			75.01
76	AUDIO-VESTIBULAR LAB				76
76.01	ONCOLOGY				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.224625			90
91	EMERGENCY	0.139853			91
91.01	LITHOTRIPSY				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.544178			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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)	21,750,660			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	6,414,538			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)	280,391			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	2,986,621			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	211.14			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)	1.56			6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS	0.13			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	1.68			8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)	3.11			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	3.26			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	3.11			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	3.15			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	3.00			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	3.09			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	3.09			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.014635			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.016357			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.014635			21
22	IME PAYMENT ADJUSTMENT (see instructions)	248,218			22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)	0.15			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)	248,218			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0871			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2047			31
32	SUM OF LINES 30 AND 31	0.2918			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1260			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	2,942,641			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		2,357,588		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		594,242		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	594,242			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	32,230,690			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)	32,230,690			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	2,420,708			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)	149,177			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)	34,800,575			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	34,800,575			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,699,444			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	126,040			63
64	ALLOWABLE BAD DEBTS (see instructions)	1,164,044			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	756,629			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	966,221			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	32,731,720			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)	57,865			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-265,615			70.94
71	AMOUNT DUE PROVIDER (see instructions)	32,523,970			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	491,112			71.01
72	INTERIM PAYMENTS	32,272,784			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-239,926			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	153,327			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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0251** **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)	21,201			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	7,381,285			2
3	PPS PAYMENTS	8,989,368			3
4	OUTLIER PAYMENT (see instructions)	27,672			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)	21,201			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	190,584			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)	190,584			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)	190,584			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	169,383			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)	21,201			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)	9,017,040			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	113,707			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,935,368			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	6,989,166			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	25,052			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	7,014,218			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	7,014,218			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)	697,783			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	453,559			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	602,474			36
37	SUBTOTAL (see instructions)	7,467,777			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	1,808			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	7,465,969			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	112,736			40.01
41	INTERIM PAYMENTS	7,272,597			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	80,636			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP COMPU-MAX

PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5548** **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)	124			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)	124			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	1,111			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)	1,111			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)	1,111			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	987			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)	124			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)	124			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)	124			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	124			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)	11,176			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	7,264			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	7,388			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	7,388			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	112			40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	7,276			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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0251** **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				32,272,784		7,272,597	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)				32,272,784		7,272,597	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		251,186		193,372	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				32,523,970		7,465,969	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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-5548** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				5,458,276			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)				5,458,276			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		82,267		7,388	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				5,540,543		7,388	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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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	7,964	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	16,703	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,792	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	30,977	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	558,473,780	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	26,772,273	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)	2,108,937	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	42,179	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	2,066,758	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	2,078,083	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-11,325	32

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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	5,704,017	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (sum of lines 1-3)	5,704,017	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	DO NOT USE THIS LINE		5
6	DEDUCTIBLES		6
7	COINSURANCE	163,474	7
8	ALLOWABLE BAD DEBTS (see instructions)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	5,540,543	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		14
15	SUBTOTAL (line 12 minus 13 ± line 14)	5,540,543	15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	83,662	15.01
16	INTERIM PAYMENTS	5,458,276	16
17	TENTATIVE SETTLEMENT (for contractor use only)		17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)	-1,395	18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0251** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[ ] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[XX] OTHER**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	6,083,556		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	6,083,556		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	6,083,556		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	6,083,556		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)			1.56	2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			0.11	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))			1.66	4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			3.11	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			3.26	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			3.11	7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	3.26	3.26	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	3.11	3.11	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.00	3.11		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	3.15		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	3.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	3.09		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	3.09		17
18	PER RESIDENT AMOUNT	95,749.00	95,749.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS		295,864	295,864	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			0.02	20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)			0.15	21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)			0.02	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)			295,864	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	16,703	1,792		26
27	TOTAL INPATIENT DAYS (see instructions)	30,977	30,977		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.539207	0.057849		28
29	PROGRAM DIRECT GME AMOUNT	159,532	17,115		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		2,418		30
31	NET PROGRAM DIRECT GME AMOUNT			174,229	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			44,079,603	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			44,079,603	41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			7,402,610	42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			7,402,610	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			51,482,213	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.856210	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			0.143790	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)			174,229	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			149,177	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			25,052	50

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	0.00	0.00	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00		17
18	PER RESIDENT AMOUNT	0.00	0.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	6,342			26
27	TOTAL INPATIENT DAYS (see instructions)	30,977			27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.204733	0.000000		28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)				37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)				42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)				44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)				46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)				48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)				49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)				50

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	36,110				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE	91,772,998				3
4	ACCOUNTS RECEIVABLE					4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-70,668,688				6
7	INVENTORY	1,743,016				7
8	PREPAID EXPENSES	1,154,292				8
9	OTHER CURRENT ASSETS	1,281,279				9
10	DUE FROM OTHER FUNDS	10,277,918				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	35,596,925				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS					15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	125,905,089				19
20	ACCUMULATED DEPRECIATION	-101,275,455				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	24,629,634				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS					34
35	TOTAL OTHER ASSETS (sum of lines 31-34)					35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	60,226,559				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	1,207,706				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	620,086				43
44	OTHER CURRENT LIABILITIES	7,735,856				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	9,563,648				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	16,456,278				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	16,456,278				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	26,019,926				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	34,206,633				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	34,206,633				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	60,226,559				60

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		34,707,636			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-501,003			2
3	TOTAL (sun of line 1 and line 2)		34,206,633			3
4	ADDITIONS (credit adjustments)					4
5						5
6	RECONCILIATION					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		34,206,633			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)		34,206,633			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	RECONCILIATION					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 OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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	100,237,947		100,237,947	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	11,737,070		11,737,070	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	111,975,017		111,975,017	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				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)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	111,975,017		111,975,017	17
18	ANCILLARY SERVICES	239,849,830	206,737,144	446,586,974	18
19	OUTPATIENT SERVICES	2,700,774	8,875,549	11,576,323	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		6,361	6,361	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	354,525,621	215,619,054	570,144,675	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		115,398,422	29
30	RECONCILATION			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				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)		115,398,422	43

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 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)	570,144,675	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	462,463,135	2
3	NET PATIENT REVENUES (line 1 minus line 2)	107,681,540	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	115,398,422	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-7,716,882	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1,275	6
7	INCOME FROM INVESTMENTS	2,219,940	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	951,191	23
24	OTHER (REVENUE FROM OTHER SERVICES)	3,808,503	24
24.01	OTHER (NET ASSETS RELASED FROM RESTRICTIONS)	234,971	24.01
24.02	OTHER (RECONCILIATION)		24.02
25	TOTAL OTHER INCOME (sum of lines 6-24)	7,215,880	25
26	TOTAL (line 5 plus line 25)	-501,002	26
27	OTHER EXPENSES (SPECIFY):	1	27
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	1	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-501,003	29

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0251** **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	2,242,307	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	18,749	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)	84.87	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	3.09	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	1.03	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	23,096	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0871	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.2047	8
9	SUM OF LINES 7 AND 8	0.2918	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0609	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	136,556	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	2,420,708	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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PRESENCE OUR LADY OFTHE RESURRECTION Provider CCN: 14-0251	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 11:17 Version: 2014.03

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
17.01	HOUSE STAFF PHYSICIANS							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
34	SURGICAL INTENSIVE CARE UNIT							34
44	SKILLED NURSING FACILITY							44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	CARDIAC REHAB							69.01
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
75.01	ACUTE DIALYSIS							75.01
76	AUDIO-VESTIBULAR LAB							76
76.01	ONCOLOGY							76.01
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	LITHOTRIPSY							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							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
193.01	NON EMPLOYEE DAY CARE							193.01
193.02	RESURRECTION HOME CARE OFFICES							193.02
193.03	OCCUPATIONAL HEALTH NON-REIM							193.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202