



PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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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. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT DATE: 05/27/2014 TIME: 15:57 2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT 3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> 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. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN 9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ____ 12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY PRESENCE ST. JOSEPH MEDICAL CENTER (14-0007) {(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 XIX	
		TITLE V	PART A	PART B	HIT		
		1	2	3	4	5	
1	HOSPITAL		1,370,374	839,119	132,757		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		43,338				3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		1,413,712	839,119	132,757		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 OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS



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

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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:												
1	STREET: 333 NORTH MADISON STREET	P.O. BOX:								1		
2	CITY: JOLIET	STATE: IL	ZIP CODE: 60435	COUNTY: CHAMPAIGN				2				
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:												
										PAYMENT SYSTEM (P, T, O, OR N)		
COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV- IDER TYPE	DATE CERTIFIED	V	XVIII	XIX				
0	1	2	3	4	5	6	7	8				
3	HOSPITAL	PRESENCE ST. JOSEPH MEDICAL CENTER	14-0007	16974	1	07/01/1966	N	P	O	3		
4	SUBPROVIDER - IPF									4		
5	SUBPROVIDER - IRF	SJMC PHYSICAL MED & REHAB	14-T007	16974	5	09/07/1987	N	P	O	5		
6	SUBPROVIDER - (OTHER)									6		
7	SWING BEDS - SNF									7		
8	SWING BEDS - NF									8		
9	HOSPITAL-BASED SNF									9		
10	HOSPITAL-BASED NF									10		
11	HOSPITAL-BASED OLTC									11		
12	HOSPITAL-BASED HHA									12		
13	SEPARATELY CERTIFIED ASC									13		
14	HOSPITAL-BASED HOSPICE									14		
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15		
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16		
17	HOSPITAL-BASED (CMHC)									17		
18	RENAL DIALYSIS									18		
19	OTHER									19		
20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013								20	
21	TYPE OF CONTROL (see instructions)	1								21		
INPATIENT PPS INFORMATION										1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY 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 IPHS 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.	10,729	3,709			615	506		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.	181							25			
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1					26		
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				1					27		



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.				35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.				37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:		38
				1	2
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)			N	N



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		V	XVIII	XIX	
		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)	Y			60
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.(see instructions)	Y/N	IME	DIRECT GME	61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA. (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT
		1	2	3	4
OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63



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**WORKSHEET S-2
PART I**

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						66
ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
INPATIENT PSYCHIATRIC FACILITY PPS				1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						71
INPATIENT REHABILITATION FACILITY PPS				1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N	N		76



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**WORKSHEET S-2
PART I**

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



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**WORKSHEET S-2
PART I**

TITLE V AND XIX SERVICES		V	XIX		
		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	
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	109	
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY
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:		10,668,562		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N			118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N		120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			121
TRANSPLANT CENTER INFORMATION					
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.	N			125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				132



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS						
		1	2			
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	148003		140	
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.						
141	NAME: PRESENCE HEALTH	CONTRACTOR'S NAME: NGS		CONTRACTOR'S NUMBER: 131		
142	STREET: 200 SOUTH WACKER DR	P.O. BOX:				
143	CITY: CHICAGO	STATE: IL	ZIP CODE: 60606			
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y			144	
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y			145	
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N			146	
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			147	
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			148	
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			149	
DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)						
		TITLE XVIII		TITLE V	TITLE XIX	
		PART A	PART B	2	3	
			1			
155	HOSPITAL	N	N		N	
156	SUBPROVIDER - IPF	N	N			
157	SUBPROVIDER - IRF	N	N		N	
158	SUBPROVIDER - (OTHER)					
159	SNF	N	N			
160	HHA	N	N			
161	CMHC		N			
161.10	CORF					
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				
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.					
	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				
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)					
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				
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	05/01/2013	07/30/2013		170	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	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	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	Y			3
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	Y			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	Y			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	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
BAD DEBTS					
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
PART A					
PART B					
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA					
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	
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
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	
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	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21
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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 RELIEVED 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
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: TOM	LAST NAME: VERTIN	TITLE: DIR. OF REIMBURSEMENT
42	EMPLOYER: PRESENCE HEALTH		
43	PHONE NUMBER: 815-806-3126	E-MAIL ADDRESS: THOMAS.VERTIN@PRESENCEHEALTH.ORG	



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)		
	1	2	3	4	5	6		
SALARIES								
1	TOTAL SALARIES (see instructions)	200	128,358,399		128,358,399	4,292,845.00	29.90	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)			39,011	39,011	1,625.00	24.01	7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		5,921,710	238,788	6,160,498	164,917.00	37.36	10
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (see instructions)		3,914,347		3,914,347	31,059.00	126.03	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		775,280		775,280	6,283.00	123.39	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		22,282,579		22,282,579	440,304.00	50.61	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)		29,614,066		29,614,066			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		1,366,221		1,366,221			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	EMPLOYEE BENEFITS DEPARTMENT		107,942		107,942	3,537.00	30.52	26
27	ADMINISTRATIVE & GENERAL		12,147,358		12,147,358	398,074.00	30.52	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		3,015,266		3,015,266	119,491.00	25.23	30
31	LAUNDRY & LINEN SERVICE		373		373	9.00	41.44	31
32	HOUSEKEEPING		2,641,273		2,641,273	207,572.00	12.72	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		3,200,831	-1,859,832	1,340,999	81,391.00	16.48	34
35	DIETARY UNDER CONTRACT (see instructions)		554,127		554,127	11,672.00	47.47	35
36	CAFETERIA			1,859,832	1,859,832	145,041.00	12.82	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		4,886,789		4,886,789	119,337.00	40.95	38
39	CENTRAL SERVICES AND SUPPLY		936,862		936,862	51,139.00	18.32	39
40	PHARMACY		4,077,245	-238,788	3,838,457	101,490.00	37.82	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		3,431,877		3,431,877	153,817.00	22.31	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		128,912,526	-39,011	128,873,515	4,302,892.00	29.95	1
2	EXCLUDED AREA SALARIES (see instructions)		5,921,710	238,788	6,160,498	164,917.00	37.36	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		122,990,816	-277,799	122,713,017	4,137,975.00	29.66	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		26,972,206		26,972,206	477,646.00	56.47	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		29,614,066		29,614,066		24.13%	5



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		179,577,088	-277,799	179,299,289	4,615,621.00	38.85	6
7	TOTAL OVERHEAD COST (see instructions)		34,999,943	-238,788	34,761,155	1,392,570.00	24.96	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	4,906,325	2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	4,574,734	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)	14,618,155	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	330,281	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	67,705	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	406,714	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	2,277,812	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	6,073,601	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	277,129	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	656,344	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	34,188,800	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD				
1	WAGE INDEX FISCAL YEAR ENDING DATE	12/31/2013		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	01/01/2013	12/31/2013	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	7/01/2013		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	1/01/2012		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	1/01/2015		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)				
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

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

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD				
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	1/01/2012		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	1/01/2015		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S)	11
11.01		07/01/2012		11.01
11.02		07/01/2013		11.02
11.03		07/01/2014		11.03
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX				
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)	4,574,734		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	4,574,734		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	4,574,734		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	3,914,347		1
2	HOSPITAL	3,914,347		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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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)	0.190140	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	24,692,419	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	246,167,357	6
7	MEDICAID COST (line 1 times line 6)	46,806,261	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.	22,113,842	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)	22,113,842		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	84,783,012	3,100,524	87,883,536	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	16,120,642	589,534	16,710,176	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	671,774	1,407,818	2,079,592	22
23	COST OF CHARITY CARE (line 21 minus line 22)	15,448,868	-818,284	14,630,584	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	28,910,457	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,659,880	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	27,250,577	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	5,181,425	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	19,812,009	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	41,925,851	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	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	
194.0 5	07954	PRIMARY CARE PHYSICIAN								194.0 5
194.0 6	07955	PATIENT SITTERS								194.0 6
200		TOTAL (sum of lines 118-199)	128,358,399	255,917,340	384,275,739		384,275,739	-14,998,225	369,277,514	200



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CAFETERIA	A	CAFETERIA	11	1,859,832	1,742,607	1
500	TOTAL RECLASSIFICATIONS				1,859,832	1,742,607	500
	CODE LETTER - A						
1	CAPITAL INSURANCE	B	CAP REL COSTS-BLDG & FIXT	1		219,060	1
2	CAPITAL INSURANCE	B	CAP REL COSTS-MVBLE EQUIP	2		42,822	2
500	TOTAL RECLASSIFICATIONS					261,882	500
	CODE LETTER - B						
1	INTEREST	C	CAP REL COSTS-BLDG & FIXT	1		10,863,501	1
500	TOTAL RECLASSIFICATIONS					10,863,501	500
	CODE LETTER - C						
1	MED SUPPLIES	D	MEDICAL SUPPLIES CHARGED TO P	71		16,786,826	1
2	MED SUPPLIES	D	IMPL. DEV. CHARGED TO PATIENT	72		25,497,183	2
3	MED SUPPLIES	D					3
4	MED SUPPLIES	D					4
5	MED SUPPLIES	D					5
6	MED SUPPLIES	D					6
7	MED SUPPLIES	D					7
8	MED SUPPLIES	D					8
9	MED SUPPLIES	D					9
10	MED SUPPLIES	D					10
11	MED SUPPLIES	D					11
12	MED SUPPLIES	D					12
13	MED SUPPLIES	D					13
14	MED SUPPLIES	D					14
15	MED SUPPLIES	D					15
16	MED SUPPLIES	D					16
17	MED SUPPLIES	D					17
18	MED SUPPLIES	D					18
19	MED SUPPLIES	D					19
20	MED SUPPLIES	D					20
21	MED SUPPLIES	D					21
22	MED SUPPLIES	D					22
23	MED SUPPLIES	D					23
24	MED SUPPLIES	D					24
25	MED SUPPLIES	D					25
500	TOTAL RECLASSIFICATIONS					42,284,009	500
	CODE LETTER - D						
1	MME	F	CAP REL COSTS-MVBLE EQUIP	2		9,514,595	1
2	MME	F	CAP REL COSTS-BLDG & FIXT	1		74,769	2
500	TOTAL RECLASSIFICATIONS					9,589,364	500
	CODE LETTER - F						
1	IV THERAPY	G	OTHER	76	5,181,983	532,321	1
500	TOTAL RECLASSIFICATIONS				5,181,983	532,321	500
	CODE LETTER - G						
1	PHARMACIST TEACHING	I	PARAMED ED PRGM-(SPECIFY)	23	238,788		1
500	TOTAL RECLASSIFICATIONS				238,788		500
	CODE LETTER - I						
1	INTERNS & RESIDENTS	J	I&R SERVICES-OTHER PRGM COSTS	22		39,011	1
500	TOTAL RECLASSIFICATIONS					39,011	500
	CODE LETTER - J						
	GRAND TOTAL (INCREASES)				7,280,603	65,312,695	

(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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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	CAFETERIA	A	DIETARY	10	1,859,832	1,742,607		1
500	TOTAL RECLASSIFICATIONS				1,859,832	1,742,607		500
	CODE LETTER - A							
1	CAPITAL INSURANCE	B	ADMINISTRATIVE & GENERAL	5		261,882	12	1
2	CAPITAL INSURANCE	B					12	2
500	TOTAL RECLASSIFICATIONS					261,882		500
	CODE LETTER - B							
1	INTEREST	C	INTEREST EXPENSE	113		10,863,501	11	1
500	TOTAL RECLASSIFICATIONS					10,863,501		500
	CODE LETTER - C							
1	MED SUPPLIES	D	ADMINISTRATIVE & GENERAL	5		46,785		1
2	MED SUPPLIES	D	EMPLOYEE BENEFITS DEPARTMENT	4		3,300		2
3	MED SUPPLIES	D	OPERATION OF PLANT	7		5,707		3
4	MED SUPPLIES	D	HOUSEKEEPING	9		3,508		4
5	MED SUPPLIES	D	DIETARY	10		15,841		5
6	MED SUPPLIES	D	NURSING ADMINISTRATION	13		2,189		6
7	MED SUPPLIES	D	CENTRAL SERVICES & SUPPLY	14		1,331,468		7
8	MED SUPPLIES	D	PHARMACY	15		690,689		8
9	MED SUPPLIES	D	MEDICAL RECORDS & LIBRARY	16		37		9
10	MED SUPPLIES	D	ADULTS & PEDIATRICS	30		1,285,478		10
11	MED SUPPLIES	D	INTENSIVE CARE UNIT	31		366,418		11
12	MED SUPPLIES	D	SURGICAL INTENSIVE CARE UNIT	34		316,118		12
13	MED SUPPLIES	D	SUBPROVIDER - IRF	41		71,443		13
14	MED SUPPLIES	D	NURSERY	43		38,670		14
15	MED SUPPLIES	D	OPERATING ROOM	50		24,148,858		15
16	MED SUPPLIES	D	RADIOLOGY-DIAGNOSTIC	54		2,632,510		16
17	MED SUPPLIES	D	LABORATORY	60		2,258,510		17
18	MED SUPPLIES	D	RESPIRATORY THERAPY	65		257,601		18
19	MED SUPPLIES	D	PHYSICAL THERAPY	66		236,974		19
20	MED SUPPLIES	D	ELECTROCARDIOLOGY	69		7,887,259		20
21	MED SUPPLIES	D	ELECTROENCEPHALOGRAPHY	70		19,549		21
22	MED SUPPLIES	D	OTHER	76		8,827		22
23	MED SUPPLIES	D	CARDIAC REHABILITATION	76.97		2,491		23
24	MED SUPPLIES	D	EMERGENCY	91		642,337		24
25	MED SUPPLIES	D	OTHER NRCC	192.01		11,442		25
500	TOTAL RECLASSIFICATIONS					42,284,009		500
	CODE LETTER - D							
1	MME	F	CAP REL COSTS-BLDG & FIXT	1		9,514,595	9	1
2	MME	F	OTHER NRCC	192.01		74,769	9	2
500	TOTAL RECLASSIFICATIONS					9,589,364		500
	CODE LETTER - F							
1	IV THERAPY	G	ADULTS & PEDIATRICS	30	5,181,983	532,321		1
500	TOTAL RECLASSIFICATIONS				5,181,983	532,321		500
	CODE LETTER - G							
1	PHARMACIST TEACHING	I	PHARMACY	15	238,788			1
500	TOTAL RECLASSIFICATIONS				238,788			500
	CODE LETTER - I							
1	INTERNS & RESIDENTS	J	ADMINISTRATIVE & GENERAL	5		39,011		1
500	TOTAL RECLASSIFICATIONS					39,011		500
	CODE LETTER - J							
	GRAND TOTAL (DECREASES)				7,280,603	65,312,695		

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



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	1,884,595					1,884,595		1
2	LAND IMPROVEMENTS	3,208,539					3,208,539		2
3	BUILDINGS AND FIXTURES	329,917,321	2,024,284		2,024,284		331,941,605		3
4	BUILDING IMPROVEMENTS	1,439,521					1,439,521		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	127,253,303	3,784,385		3,784,385	2,474,639	128,563,049		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	463,703,279	5,808,669		5,808,669	2,474,639	467,037,309		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	463,703,279	5,808,669		5,808,669	2,474,639	467,037,309		10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	26,735,055						26,735,055	1	
2	CAP REL COSTS-MVBLE EQUIP								2	
3	TOTAL (sum of lines 1-2)	26,735,055						26,735,055	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

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITALIZED 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	338,474,260		338,474,260	0.724726					1
2	CAP REL COSTS-MVBLE EQUIP	128,563,049		128,563,049	0.275274					2
3	TOTAL (sum of lines 1-2)	467,037,309		467,037,309	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	12,119,456		10,863,501	219,060			23,202,017	1	
2	CAP REL COSTS-MVBLE EQUIP	8,520,328			42,822			8,563,150	2	
3	TOTAL (sum of lines 1-2)	20,639,784		10,863,501	261,882			31,765,167	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,

Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)					7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-4,724,243			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-6,688,583			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS					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	MISC INCOME	B	-251	EMPLOYEE BENEFITS DEPARTMENT	4	33
34	MISC INCOME	B	-546,193	ADMINISTRATIVE & GENERAL	5	34
35	MISC INCOME	B	-68,127	OPERATION OF PLANT	7	35
36	MISC INCOME	B	-1,928,847	DIETARY	10	36
37	MISC INCOME	B	-10,266	NURSING ADMINISTRATION	13	37
38	MISC INCOME	B	854	CENTRAL SERVICES & SUPPLY	14	38
39	MISC INCOME	B	-170,742	PHARMACY	15	39
40	MISC INCOME	B	-14,970	MEDICAL RECORDS & LIBRARY	16	40
41	MISC INCOME	B	-27,753	ADULTS & PEDIATRICS	30	41
42	MISC INCOME	B	-5,044	INTENSIVE CARE UNIT	31	42
42.01	MISC INCOME	B	-20,078	RADIOLOGY-DIAGNOSTIC	54	42.01
42.02	MISC INCOME	B	-19,847	LABORATORY	60	42.02
42.03	MISC INCOME	B	-34,664	PHYSICAL THERAPY	66	42.03
43	MISC INCOME	B	-7,074	ELECTROCARDIOLOGY	69	43
44	MISC INCOME	B	-855	CARDIAC REHABILITATION	76,97	44
45	MISC INCOME	B	-210	EMERGENCY	91	45
45.01	NONALLOWABLE EXP	A	-31,808	ADMINISTRATIVE & GENERAL	5	45.01
45.02	MARKETING OFFSET	A	-502,402	ADMINISTRATIVE & GENERAL	5	45.02
45.03	DUES LOBBYING PORTION	A	-45,270	ADMINISTRATIVE & GENERAL	5	45.03
45.04	NRCC DEPR EXP	A	-74,769	CAP REL COSTS-BLDG & FIXT	1	9 45.04
45.05	PATIENT TRANSPORTATION	A	-77,083	PHYSICAL THERAPY	66	45.05
46						46
47						47
48						48



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.
		1	2	3	4	5
49						
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-14,998,225			

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

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



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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST A-7 REF.		
1	2	3	4	5	6	7		
1	2	CAP REL COSTS-MVBLE EQUIP	DEPR	4,547,214	5,541,481	-994,267	9	1
2	5	ADMINISTRATIVE & GENERAL	AG	41,199,009	41,792,321	-593,312		2
3	1	CAP REL COSTS-BLDG & FIXT	INTEREST	5,734,311	10,835,315	-5,101,004	9	3
3.01	60	LABORATORY	ALVERNO LAB	11,808,845	11,808,845			3.01
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			63,289,379	69,977,962	-6,688,583		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.

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

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN/ IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
2	5	ADMINISTRATIVE & GEN ADMINISTRATIVE	1,077,035	852,819	224,216	177,200	1,303	111,006	5,550	2
3	13	NURSING ADMINISTRATI NURSING ADMINIS	45,000	45,000						3
4	15	PHARMACY PHARMACY	20,854	20,854						4
5	30	ADULTS & PEDIATRICS ADULTS & PEDIAT	1,481,626	1,063,175	418,451	138,700	4,084	272,332	13,617	5
6	31	INTENSIVE CARE UNIT INTENSIVE CARE	48,568	48,568						6
7	41	SUBPROVIDER - IRF SUBPROVIDER - I	70,000	70,000						7
8	50	OPERATING ROOM OPERATING ROOM	887,608	844,608	43,000	208,000	215	21,500	1,075	8
9	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY- DIAGN	915,000	915,000						9
10	60	LABORATORY LABORATORY	200,004	200,004						10
11	65	RESPIRATORY THERAPY RESPIRATORY THE	27,000		27,000	177,200	270	23,002	1,150	11
12	69	ELECTROCARDIOLOGY ELECTROCARDIOLO	124,900	91,800	33,100	165,600	331	26,353	1,318	12
13	76	OTHER OTHER	2,425	850	1,575	165,600	16	1,274	64	13
14	91	EMERGENCY EMERGENCY	286,090	278,152	7,938	208,000	64	6,400	320	14
200		TOTAL	5,186,110	4,430,830	755,280		6,283	461,867	23,094	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATIO N	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT - ICE INSURANC E	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
2	5	ADMINISTRATIVE & GEN ADMINISTRATIVE					111,006	113,210	966,029	2
3	13	NURSING ADMINISTRATI NURSING ADMINIS							45,000	3
4	15	PHARMACY PHARMACY							20,854	4
5	30	ADULTS & PEDIATRICS ADULTS & PEDIAT					272,332	146,119	1,209,294	5
6	31	INTENSIVE CARE UNIT INTENSIVE CARE							48,568	6
7	41	SUBPROVIDER - IRF SUBPROVIDER - I							70,000	7
8	50	OPERATING ROOM OPERATING ROOM					21,500	21,500	866,108	8
9	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY- DIAGN							915,000	9
10	60	LABORATORY LABORATORY							200,004	10
11	65	RESPIRATORY THERAPY RESPIRATORY THE					23,002	3,998	3,998	11
12	69	ELECTROCARDIOLOGY ELECTROCARDIOLO					26,353	6,747	98,547	12
13	76	OTHER OTHER					1,274	301	1,151	13
14	91	EMERGENCY EMERGENCY					6,400	1,538	279,690	14
200		TOTAL					461,867	293,413	4,724,243	200



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS I-IV**

CHECK APPLICABLE BOX: 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
21	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 EXCLUDING AIDES AND TRAINEES (line 2 times line 21)								22
23	TOTAL SALARY EQUIVALENCY (see instructions)								23

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

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

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

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS V-VI**

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY 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
21	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 EXCLUDING AIDES AND TRAINEES (line 2 times line 21)								22
23	TOTAL SALARY EQUIVALENCY (see instructions)								23

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

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

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

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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



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PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

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



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PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISOR S	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 than 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 in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS V-VI**

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY 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
21	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 EXCLUDING AIDES AND TRAINEES (line 2 times line 21)								22
23	TOTAL SALARY EQUIVALENCY (see instructions)								23

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

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

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

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISOR S	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 than 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 in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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



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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)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	23,202,017	23,202,017					1
2	CAP REL COSTS-MVBLE EQUIP	8,563,150		8,563,150				2
4	EMPLOYEE BENEFITS DEPARTMENT	32,643,328	107,594	8,311	32,759,233			4
5	ADMINISTRATIVE & GENERAL	84,211,533	5,770,582	716,174	3,102,824	93,801,113	93,801,113	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	12,878,406	3,390,695	917,650	770,195	17,956,946	6,114,430	7
8	LAUNDRY & LINEN SERVICE	1,210,313	151,357	1,119	95	1,362,884	464,069	8
9	HOUSEKEEPING	3,966,735	283,686	95,566	674,666	5,020,653	1,709,557	9
10	DIETARY	570,573	230,962	34,889	342,534	1,178,958	401,441	10
11	CAFETERIA	3,602,439	314,386	47,489	475,061	4,439,375	1,511,629	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	5,132,141	91,135	50,071	1,248,242	6,521,589	2,220,634	13
14	CENTRAL SERVICES & SUPPLY	1,844,460	455,958	204,147	239,305	2,743,870	934,301	14
15	PHARMACY	18,136,695	69,371	16,231	980,465	19,202,762	6,538,636	15
16	MEDICAL RECORDS & LIBRARY	4,607,031	187,104	19,070	876,611	5,689,816	1,937,411	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	39,011				39,011	13,283	22
23	PARAMED ED PRGM-(SPECIFY)	537,999	5,659		131,630	675,288	229,939	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	32,099,949	6,281,696	641,674	8,019,809	47,043,128	16,018,443	30
31	INTENSIVE CARE UNIT	6,325,690	645,632	203,777	1,585,331	8,760,430	2,982,970	31
34	SURGICAL INTENSIVE CARE UNIT	4,204,741	512,290	143,899	1,028,063	5,888,993	2,005,232	34
41	SUBPROVIDER - IRF	2,765,565	403,116	7,496	694,495	3,870,672	1,317,983	41
43	NURSERY	1,475,382	203,279	37,764	372,386	2,088,811	711,251	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,712,408	929,766	1,834,458	2,406,804	18,883,436	6,429,904	50
54	RADIOLOGY-DIAGNOSTIC	11,176,329	1,044,669	2,440,345	2,389,349	17,050,692	5,805,846	54
60	LABORATORY	11,694,349	535,374	780	42	12,230,545	4,164,562	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,766,758	51,828	52,270	576,377	3,447,233	1,173,800	65
66	PHYSICAL THERAPY	8,667,181	27,517	88,122	1,737,267	10,520,087	3,582,142	66
69	ELECTROCARDIOLOGY	3,344,949	430,280	893,067	857,056	5,525,352	1,881,410	69
70	ELECTROENCEPHALOGRAPHY	394,170	96,747	19,911	97,760	608,588	207,227	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,786,826				16,786,826	5,715,998	71
72	IMPL. DEV. CHARGED TO PATIENTS	25,497,183				25,497,183	8,681,918	72
73	DRUGS CHARGED TO PATIENTS							73
76	OTHER	6,250,930		24,620	1,444,079	7,719,629	2,628,572	76
76.10	OP PSYCH	244,662		3,495	55,724	303,881	103,473	76.10
76.97	CARDIAC REHABILITATION	459,333	139,567	9,215	116,561	724,676	246,756	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	7,902,486	765,157	12,297	1,789,039	10,468,979	3,564,740	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	356,914,722	23,125,407	8,523,907	32,011,770	356,051,406	89,297,557	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC	12,362,792	76,610	39,243	747,463	13,226,108	4,503,556	192.01
194	OTHER NON-REIMBURSABLE							194
194.01	SHARED SERVICES							194.01
194.02	CASE MANAGEMENT							194.02
194.04	OUTPATIENT PHARMACY							194.04
194.05	PRIMARY CARE PHYSICIAN							194.05
194.06	PATIENT SITTERS							194.06
200	CROSS FOOT ADJUSTMENTS							200



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	369,277,514	23,202,017	8,563,150	32,759,233	369,277,514	93,801,113	202



PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		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	24,071,376						7
8	LAUNDRY & LINEN SERVICE	261,490	2,088,443					8
9	HOUSEKEEPING	490,105		7,220,315				9
10	DIETARY	399,018		353,168	2,332,585			10
11	CAFETERIA	543,145		91,915		6,586,064		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	157,448		50,907		234,402	9,184,980	13
14	CENTRAL SERVICES & SUPPLY	787,729		26,161		99,925		14
15	PHARMACY	119,848		10,606		204,965		15
16	MEDICAL RECORDS & LIBRARY	323,247		17,676		299,145		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	9,777				22,853		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	10,852,464	1,547,331	3,668,489	1,868,137	2,407,505	5,172,751	30
31	INTENSIVE CARE UNIT	1,115,416	155,264	530,635	187,457	323,298	694,637	31
34	SURGICAL INTENSIVE CARE UNIT	885,049	120,630	186,659	145,641	242,243	520,483	34
41	SUBPROVIDER - IRF	696,438	173,795	301,907	20,979	182,783	392,727	41
43	NURSERY	351,193	77,613	46,311	93,696	66,295	142,441	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,606,296		745,222		568,561	1,221,607	50
54	RADIOLOGY-DIAGNOSTIC	1,804,806		285,292		572,293		54
60	LABORATORY	924,931		143,530				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	89,540		24,746		158,085		65
66	PHYSICAL THERAPY	47,540		179,235		361,876		66
69	ELECTROCARDIOLOGY	743,366		149,539		188,192		69
70	ELECTROENCEPHALOGRAPHY	167,143		12,373		26,963		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	OTHER					24,027	51,625	76
76.10	OP PSYCH					10,190	21,893	76.10
76.97	CARDIAC REHABILITATION	241,122				27,550		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,321,911	13,810	395,944	16,675	449,976	966,816	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	23,939,022	2,088,443	7,220,315	2,332,585	6,471,127	9,184,980	118
	NONREIMBURSABLE COST CENTERS							
192.0	OTHER NRCC	132,354				114,937		192.0
1								1
194	OTHER NON-REIMBURSABLE							194
194.0	SHARED SERVICES							194.0
1								1
194.0	CASE MANAGEMENT							194.0
2								2
194.0	OUTPATIENT PHARMACY							194.0
4								4
194.0	PRIMARY CARE PHYSICIAN							194.0
5								5
194.0	PATIENT SITTERS							194.0
6								6
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	24,071,376	2,088,443	7,220,315	2,332,585	6,586,064	9,184,980	202



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL	
		14	15	16	22	23	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	4,591,986						14
15	PHARMACY		26,076,817					15
16	MEDICAL RECORDS & LIBRARY			8,267,295				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				52,294			22
23	PARAMED ED PRGM-(SPECIFY)					937,857		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			874,895	26,147		89,479,290	30
31	INTENSIVE CARE UNIT			189,306			14,939,413	31
34	SURGICAL INTENSIVE CARE UNIT			132,434			10,127,364	34
41	SUBPROVIDER - IRF			71,713			7,028,997	41
43	NURSERY			30,831			3,608,442	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			711,434	26,147		30,192,607	50
54	RADIOLOGY-DIAGNOSTIC			1,535,745			27,054,674	54
60	LABORATORY			1,134,169			18,597,737	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			236,846			5,130,250	65
66	PHYSICAL THERAPY			240,069			14,930,949	66
69	ELECTROCARDIOLOGY			536,283			9,024,142	69
70	ELECTROENCEPHALOGRAPHY			28,889			1,051,183	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,591,986		581,100			27,675,910	71
72	IMPL. DEV. CHARGED TO PATIENTS			429,417			34,608,518	72
73	DRUGS CHARGED TO PATIENTS		26,076,817	703,738		937,857	27,718,412	73
76	OTHER			173,358			10,597,211	76
76.10	OP PSYCH			5,673			445,110	76.10
76.97	CARDIAC REHABILITATION			9,551			1,249,655	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY			641,844			17,840,695	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	4,591,986	26,076,817	8,267,295	52,294	937,857	351,300,559	118
	NONREIMBURSABLE COST CENTERS							
192.0	OTHER NRCC						17,976,955	192.0
1								1
194	OTHER NON-REIMBURSABLE							194
194.0	SHARED SERVICES							194.0
1								1
194.0	CASE MANAGEMENT							194.0
2								2
194.0	OUTPATIENT PHARMACY							194.0
4								4
194.0	PRIMARY CARE PHYSICIAN							194.0
5								5
194.0	PATIENT SITTERS							194.0
6								6
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,591,986	26,076,817	8,267,295	52,294	937,857	369,277,514	202



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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
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	-26,147	89,453,143			30
31	INTENSIVE CARE UNIT		14,939,413			31
34	SURGICAL INTENSIVE CARE UNIT		10,127,364			34
41	SUBPROVIDER - IRF		7,028,997			41
43	NURSERY		3,608,442			43
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	-26,147	30,166,460			50
54	RADIOLOGY-DIAGNOSTIC		27,054,674			54
60	LABORATORY		18,597,737			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY		5,130,250			65
66	PHYSICAL THERAPY		14,930,949			66
69	ELECTROCARDIOLOGY		9,024,142			69
70	ELECTROENCEPHALOGRAPHY		1,051,183			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		27,675,910			71
72	IMPL. DEV. CHARGED TO PATIENTS		34,608,518			72
73	DRUGS CHARGED TO PATIENTS		27,718,412			73
76	OTHER		10,597,211			76
76.10	OP PSYCH		445,110			76.10
76.97	CARDIAC REHABILITATION		1,249,655			76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	EMERGENCY		17,840,695			91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
	SPECIAL PURPOSE COST CENTERS					
113	INTEREST EXPENSE					113
118	SUBTOTALS (sum of lines 1-117)	-52,294	351,248,265			118
	NONREIMBURSABLE COST CENTERS					
192.0	OTHER NRCC		17,976,955			192.0
1						1
194	OTHER NON-REIMBURSABLE					194
194.0	SHARED SERVICES					194.0
1						1
194.0	CASE MANAGEMENT					194.0
2						2
194.0	OUTPATIENT PHARMACY					194.0
4						4
194.0	PRIMARY CARE PHYSICIAN					194.0
5						5
194.0	PATIENT SITTERS					194.0
6						6
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (sum of lines 118-201)	-52,294	369,225,220			202



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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 DEPARTMEN T	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		107,594	8,311	115,905	115,905		4
5	ADMINISTRATIVE & GENERAL		5,770,582	716,174	6,486,756	10,981	6,497,737	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		3,390,695	917,650	4,308,345	2,726	423,550	7
8	LAUNDRY & LINEN SERVICE		151,357	1,119	152,476		32,146	8
9	HOUSEKEEPING		283,686	95,566	379,252	2,388	118,422	9
10	DIETARY		230,962	34,889	265,851	1,212	27,808	10
11	CAFETERIA		314,386	47,489	361,875	1,681	104,712	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		91,135	50,071	141,206	4,418	153,825	13
14	CENTRAL SERVICES & SUPPLY		455,958	204,147	660,105	847	64,720	14
15	PHARMACY		69,371	16,231	85,602	3,470	452,936	15
16	MEDICAL RECORDS & LIBRARY		187,104	19,070	206,174	3,102	134,206	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						920	22
23	PARAMED ED PRGM-(SPECIFY)		5,659		5,659	466	15,928	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		6,281,696	641,674	6,923,370	28,350	1,109,679	30
31	INTENSIVE CARE UNIT		645,632	203,777	849,409	5,611	206,632	31
34	SURGICAL INTENSIVE CARE UNIT		512,290	143,899	656,189	3,638	138,904	34
41	SUBPROVIDER - IRF		403,116	7,496	410,612	2,458	91,298	41
43	NURSERY		203,279	37,764	241,043	1,318	49,269	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		929,766	1,834,458	2,764,224	8,518	445,404	50
54	RADIOLOGY-DIAGNOSTIC		1,044,669	2,440,345	3,485,014	8,456	402,175	54
60	LABORATORY		535,374	780	536,154		288,482	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		51,828	52,270	104,098	2,040	81,310	65
66	PHYSICAL THERAPY		27,517	88,122	115,639	6,148	248,137	66
69	ELECTROCARDIOLOGY		430,280	893,067	1,323,347	3,033	130,326	69
70	ELECTROENCEPHALOGRAPHY		96,747	19,911	116,658	346	14,355	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						395,951	71
72	IMPL. DEV. CHARGED TO PATIENTS						601,402	72
73	DRUGS CHARGED TO PATIENTS							73
76	OTHER			24,620	24,620	5,111	182,083	76
76.10	OP PSYCH			3,495	3,495	197	7,168	76.10
76.97	CARDIAC REHABILITATION		139,567	9,215	148,782	413	17,093	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		765,157	12,297	777,454	6,332	246,932	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		23,125,407	8,523,907	31,649,314	113,260	6,185,773	118
	NONREIMBURSABLE COST CENTERS							
192.0	OTHER NRCC		76,610	39,243	115,853	2,645	311,964	192.0
1								1
194	OTHER NON-REIMBURSABLE							194
194.0	SHARED SERVICES							194.0
1								1
194.0	CASE MANAGEMENT							194.0
2								2
194.0	OUTPATIENT PHARMACY							194.0
4								4
194.0	PRIMARY CARE PHYSICIAN							194.0
5								5
194.0	PATIENT SITTERS							194.0
6								6
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201



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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 DEPARTMEN T	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
202	TOTAL (sum of lines 118-201)		23,202,017	8,563,150	31,765,167	115,905	6,497,737	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		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	4,734,621						7
8	LAUNDRY & LINEN SERVICE	51,433	236,055					8
9	HOUSEKEEPING	96,399		596,461				9
10	DIETARY	78,483		29,175	402,529			10
11	CAFETERIA	106,832		7,593		582,693		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	30,969		4,205		20,738	355,361	13
14	CENTRAL SERVICES & SUPPLY	154,939		2,161		8,841		14
15	PHARMACY	23,573		876		18,134		15
16	MEDICAL RECORDS & LIBRARY	63,580		1,460		26,466		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)	1,923				2,022		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,134,581	174,894	303,050	322,380	213,002	200,131	30
31	INTENSIVE CARE UNIT	219,392	17,549	43,835	32,349	28,603	26,875	31
34	SURGICAL INTENSIVE CARE UNIT	174,081	13,635	15,420	25,133	21,432	20,137	34
41	SUBPROVIDER - IRF	136,983	19,644	24,940	3,620	16,171	15,194	41
43	NURSERY	69,076	8,772	3,826	16,169	5,865	5,511	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	315,944		61,562		50,303	47,263	50
54	RADIOLOGY-DIAGNOSTIC	354,989		23,568		50,633		54
60	LABORATORY	181,925		11,857				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	17,612		2,044		13,986		65
66	PHYSICAL THERAPY	9,351		14,806		32,017		66
69	ELECTROCARDIOLOGY	146,213		12,353		16,650		69
70	ELECTROENCEPHALOGRAPHY	32,876		1,022		2,385		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	OTHER					2,126	1,997	76
76.10	OP PSYCH					902	847	76.10
76.97	CARDIAC REHABILITATION	47,426				2,437		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	260,008	1,561	32,708	2,878	39,811	37,406	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	4,708,588	236,055	596,461	402,529	572,524	355,361	118
	NONREIMBURSABLE COST CENTERS							
192.0	OTHER NRCC	26,033				10,169		192.0
1								1
194	OTHER NON-REIMBURSABLE							194
194.0	SHARED SERVICES							194.0
1								1
194.0	CASE MANAGEMENT							194.0
2								2
194.0	OUTPATIENT PHARMACY							194.0
4								4
194.0	PRIMARY CARE PHYSICIAN							194.0
5								5
194.0	PATIENT SITTERS							194.0
6								6
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,734,621	236,055	596,461	402,529	582,693	355,361	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL	
		14	15	16	22	23	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	891,613						14
15	PHARMACY		584,591					15
16	MEDICAL RECORDS & LIBRARY			434,988				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				920			22
23	PARAMED ED PRGM-(SPECIFY)					25,998		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			45,944			11,455,381	30
31	INTENSIVE CARE UNIT			9,941			1,440,196	31
34	SURGICAL INTENSIVE CARE UNIT			6,955			1,075,524	34
41	SUBPROVIDER - IRF			3,766			724,686	41
43	NURSERY			1,619			402,468	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			37,360			3,730,578	50
54	RADIOLOGY-DIAGNOSTIC			81,487			4,406,322	54
60	LABORATORY			59,560			1,077,978	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			12,438			233,528	65
66	PHYSICAL THERAPY			12,607			438,705	66
69	ELECTROCARDIOLOGY			28,162			1,660,084	69
70	ELECTROENCEPHALOGRAPHY			1,517			169,159	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	891,613		30,516			1,318,080	71
72	IMPL. DEV. CHARGED TO PATIENTS			22,550			623,952	72
73	DRUGS CHARGED TO PATIENTS		584,591	36,956			621,547	73
76	OTHER			9,104			225,041	76
76.10	OP PSYCH			298			12,907	76.10
76.97	CARDIAC REHABILITATION			502			216,653	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY			33,706			1,438,796	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	891,613	584,591	434,988			31,271,585	118
	NONREIMBURSABLE COST CENTERS							
192.0	OTHER NRCC						466,664	192.0
1								1
194	OTHER NON-REIMBURSABLE							194
194.0	SHARED SERVICES							194.0
1								1
194.0	CASE MANAGEMENT							194.0
2								2
194.0	OUTPATIENT PHARMACY							194.0
4								4
194.0	PRIMARY CARE PHYSICIAN							194.0
5								5
194.0	PATIENT SITTERS							194.0
6								6
200	CROSS FOOT ADJUSTMENTS				920	25,998	26,918	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	891,613	584,591	434,988	920	25,998	31,765,167	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		25	26		
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS DEPARTMENT				4
5	ADMINISTRATIVE & GENERAL				5
6	MAINTENANCE & REPAIRS				6
7	OPERATION OF PLANT				7
8	LAUNDRY & LINEN SERVICE				8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
12	MAINTENANCE OF PERSONNEL				12
13	NURSING ADMINISTRATION				13
14	CENTRAL SERVICES & SUPPLY				14
15	PHARMACY				15
16	MEDICAL RECORDS & LIBRARY				16
17	SOCIAL SERVICE				17
19	NONPHYSICIAN ANESTHETISTS				19
20	NURSING SCHOOL				20
21	I&R SERVICES-SALARY & FRINGES APPRVD				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	PARAMED ED PRGM-(SPECIFY)				23
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS		11,455,381		30
31	INTENSIVE CARE UNIT		1,440,196		31
34	SURGICAL INTENSIVE CARE UNIT		1,075,524		34
41	SUBPROVIDER - IRF		724,686		41
43	NURSERY		402,468		43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM		3,730,578		50
54	RADIOLOGY-DIAGNOSTIC		4,406,322		54
60	LABORATORY		1,077,978		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY		233,528		65
66	PHYSICAL THERAPY		438,705		66
69	ELECTROCARDIOLOGY		1,660,084		69
70	ELECTROENCEPHALOGRAPHY		169,159		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,318,080		71
72	IMPL. DEV. CHARGED TO PATIENTS		623,952		72
73	DRUGS CHARGED TO PATIENTS		621,547		73
76	OTHER		225,041		76
76.10	OP PSYCH		12,907		76.10
76.97	CARDIAC REHABILITATION		216,653		76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY		1,438,796		91
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
	SPECIAL PURPOSE COST CENTERS				
113	INTEREST EXPENSE				113
118	SUBTOTALS (sum of lines 1-117)		31,271,585		118
	NONREIMBURSABLE COST CENTERS				
192.0	OTHER NRCC		466,664		192.0
1					1
194	OTHER NON-REIMBURSABLE				194
194.0	SHARED SERVICES				194.0
1					1
194.0	CASE MANAGEMENT				194.0
2					2
194.0	OUTPATIENT PHARMACY				194.0
4					4
194.0	PRIMARY CARE PHYSICIAN				194.0
5					5
194.0	PATIENT SITTERS				194.0
6					6
200	CROSS FOOT ADJUSTMENTS		26,918		200
201	NEGATIVE COST CENTER				201
202	TOTAL (sum of lines 118-201)		31,765,167		202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	983,988						1
2	CAP REL COSTS-MVBLE EQUIP		9,111,832					2
4	EMPLOYEE BENEFITS DEPARTMENT	4,563	8,844	128,250,457				4
5	ADMINISTRATIVE & GENERAL	244,728	762,062	12,147,358	-93,801,113	275,476,401		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	143,798	976,448	3,015,266		17,956,946	590,899	7
8	LAUNDRY & LINEN SERVICE	6,419	1,191	373		1,362,884	6,419	8
9	HOUSEKEEPING	12,031	101,689	2,641,273		5,020,653	12,031	9
10	DIETARY	9,795	37,125	1,340,999		1,178,958	9,795	10
11	CAFETERIA	13,333	50,532	1,859,832		4,439,375	13,333	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,865	53,279	4,886,789		6,521,589	3,865	13
14	CENTRAL SERVICES & SUPPLY	19,337	217,228	936,862		2,743,870	19,337	14
15	PHARMACY	2,942	17,271	3,838,457		19,202,762	2,942	15
16	MEDICAL RECORDS & LIBRARY	7,935	20,292	3,431,877		5,689,816	7,935	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					39,011		22
23	PARAMED ED PRGM-(SPECIFY)	240		515,324		675,288	240	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	266,404	682,789	31,397,187		47,043,128	266,404	30
31	INTENSIVE CARE UNIT	27,381	216,834	6,206,470		8,760,430	27,381	31
34	SURGICAL INTENSIVE CARE UNIT	21,726	153,119	4,024,803		5,888,993	21,726	34
41	SUBPROVIDER - IRF	17,096	7,976	2,718,904		3,870,672	17,096	41
43	NURSERY	8,621	40,184	1,457,868		2,088,811	8,621	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	39,431	1,952,000	9,422,484		18,883,436	39,431	50
54	RADIOLOGY-DIAGNOSTIC	44,304	2,596,711	9,354,150		17,050,692	44,304	54
60	LABORATORY	22,705	830	163		12,230,545	22,705	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,198	55,619	2,256,479		3,447,233	2,198	65
66	PHYSICAL THERAPY	1,167	93,768	6,801,291		10,520,087	1,167	66
69	ELECTROCARDIOLOGY	18,248	950,290	3,355,321		5,525,352	18,248	69
70	ELECTROENCEPHALOGRAPHY	4,103	21,187	382,725		608,588	4,103	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					16,786,826		71
72	IMPL. DEV. CHARGED TO PATIENTS					25,497,183		72
73	DRUGS CHARGED TO PATIENTS							73
76	OTHER		26,198	5,653,477		7,719,629		76
76.10	OP PSYCH		3,719	218,154		303,881		76.10
76.97	CARDIAC REHABILITATION	5,919	9,805	456,327		724,676	5,919	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	32,450	13,085	7,003,974		10,468,979	32,450	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	980,739	9,070,075	125,324,187	-93,801,113	262,250,293	587,650	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC	3,249	41,757	2,926,270		13,226,108	3,249	192.01
194	OTHER NON-REIMBURSABLE							194
194.01	SHARED SERVICES							194.01
194.02	CASE MANAGEMENT							194.02
194.04	OUTPATIENT PHARMACY							194.04
194.05	PRIMARY CARE PHYSICIAN							194.05
194.06	PATIENT SITTERS							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMEN T GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
202	COST TO BE ALLOC PER B PT I	23,202.017	8,563.150	32,759.233		93,801,113	24,071,376	202
203	UNIT COST MULT-WS B PT I	23.579573	0.939784	0.255432		0.340505	40.736870	203
204	COST TO BE ALLOC PER B PT II			115,905		6,497.737	4,734,621	204
205	UNIT COST MULT-WS B PT II			0.000904		0.023587	8.012572	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING PATIENT DAYS	DIETARY MEALS SERVED	CAFETERIA FTE S	NURSING ADMINISTRATION FTE S	CENTRAL SERVICES & SUPPLY SUPPLIES	
		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	2,210,565						8
9	HOUSEKEEPING		20,424					9
10	DIETARY		999	506,667				10
11	CAFETERIA		260		157,064			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		144		5,590	101,947		13
14	CENTRAL SERVICES & SUPPLY		74		2,383		42,284,010	14
15	PHARMACY		30		4,888			15
16	MEDICAL RECORDS & LIBRARY		50		7,134			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)				545			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,637,811	10,377	405,783	57,414	57,414		30
31	INTENSIVE CARE UNIT	164,343	1,501	40,718	7,710	7,710		31
34	SURGICAL INTENSIVE CARE UNIT	127,684	528	31,635	5,777	5,777		34
41	SUBPROVIDER - IRF	183,958	854	4,557	4,359	4,359		41
43	NURSERY	82,151	131	20,352	1,581	1,581		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		2,108		13,559	13,559		50
54	RADIOLOGY-DIAGNOSTIC		807		13,648			54
60	LABORATORY		406					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		70		3,770			65
66	PHYSICAL THERAPY		507		8,630			66
69	ELECTROCARDIOLOGY		423		4,488			69
70	ELECTROENCEPHALOGRAPHY		35		643			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						42,284,010	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	OTHER				573	573		76
76.10	OP PSYCH				243	243		76.10
76.97	CARDIAC REHABILITATION				657			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	14,618	1,120	3,622	10,731	10,731		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,210,565	20,424	506,667	154,323	101,947	42,284,010	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC				2,741			192.01
194	OTHER NON-REIMBURSABLE							194
194.01	SHARED SERVICES							194.01
194.02	CASE MANAGEMENT							194.02
194.04	OUTPATIENT PHARMACY							194.04
194.05	PRIMARY CARE PHYSICIAN							194.05
194.06	PATIENT SITTERS							194.06
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,088,443	7,220,315	2,332,585	6,586,064	9,184,980	4,591,986	202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING PATIENT DAYS	DIETARY MEALS SERVED	CAFETERIA FTE S	NURSING ADMINISTRATION FTE S	CENTRAL SERVICES & SUPPLY SUPPLIES	
		8	9	10	11	13	14	
203	UNIT COST MULT-WS B PT I	0.944755	353.521103	4.603783	41.932359	90.095638	0.108599	203
204	COST TO BE ALLOC PER B PT II	236.055	596.461	402.529	582.693	355.361	891.613	204
205	UNIT COST MULT-WS B PT II	0.106785	29.203927	0.794465	3.709908	3.485743	0.021086	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHAR GES	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
	15	16	22	23			

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
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	13,851,475					15
16	MEDICAL RECORDS & LIBRARY		1,847,313,062				16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			100			22
23	PARAMED ED PRGM-(SPECIFY)				100		23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		195,507,182	50			30
31	INTENSIVE CARE UNIT		42,303,033				31
34	SURGICAL INTENSIVE CARE UNIT		29,594,087				34
41	SUBPROVIDER - IRF		16,025,188				41
43	NURSERY		6,889,529				43
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		158,979,690	50			50
54	RADIOLOGY-DIAGNOSTIC		343,056,154				54
60	LABORATORY		253,445,669				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		52,926,409				65
66	PHYSICAL THERAPY		53,646,686				66
69	ELECTROCARDIOLOGY		119,839,810				69
70	ELECTROENCEPHALOGRAPHY		6,455,643				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		129,854,757				71
72	IMPL. DEV. CHARGED TO PATIENTS		95,959,204				72
73	DRUGS CHARGED TO PATIENTS	13,851,475	157,259,859		100		73
76	OTHER		38,739,203				76
76.10	OP PSYCH		1,267,788				76.10
76.97	CARDIAC REHABILITATION		2,134,352				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		143,428,819				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	13,851,475	1,847,313,062	100	100		118
NONREIMBURSABLE COST CENTERS							
192.0	OTHER NRCC						192.0
1							1
194	OTHER NON-REIMBURSABLE						194
194.0	SHARED SERVICES						194.0
1							1
194.0	CASE MANAGEMENT						194.0
2							2
194.0	OUTPATIENT PHARMACY						194.0
4							4
194.0	PRIMARY CARE PHYSICIAN						194.0
5							5
194.0	PATIENT SITTERS						194.0
6							6
200	CROSS FOOT ADJUSTMENTS						200



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHAR GES	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
		15	16	22	23			
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	26,076.817	8,267.295	52.294	937.857			202
203	UNIT COST MULT-WS B PT I	1.882602	0.004475	522.940000	9,378.570000			203
204	COST TO BE ALLOC PER B PT II	584.591	434.988	920	25,998			204
205	UNIT COST MULT-WS B PT II	0.042204	0.000235	9.200000	259.980000			205



COMPU-MAX

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET		
DESCRIPTION		PART	LINE NO.	AMOUNT
1		2	3	4



COMPU-MAX

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	89,453,143		89,453,143	146,119	89,599,262	30
31	INTENSIVE CARE UNIT	14,939,413		14,939,413		14,939,413	31
34	SURGICAL INTENSIVE CARE UNIT	10,127,364		10,127,364		10,127,364	34
41	SUBPROVIDER - IRF	7,028,997		7,028,997		7,028,997	41
43	NURSERY	3,608,442		3,608,442		3,608,442	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	30,166,460		30,166,460	21,500	30,187,960	50
54	RADIOLOGY-DIAGNOSTIC	27,054,674		27,054,674		27,054,674	54
60	LABORATORY	18,597,737		18,597,737		18,597,737	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	5,130,250		5,130,250	3,998	5,134,248	65
66	PHYSICAL THERAPY	14,930,949		14,930,949		14,930,949	66
69	ELECTROCARDIOLOGY	9,024,142		9,024,142	6,747	9,030,889	69
70	ELECTROENCEPHALOGRAPHY	1,051,183		1,051,183		1,051,183	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,675,910		27,675,910		27,675,910	71
72	IMPL. DEV. CHARGED TO PATIENTS	34,608,518		34,608,518		34,608,518	72
73	DRUGS CHARGED TO PATIENTS	27,718,412		27,718,412		27,718,412	73
76	OTHER	10,597,211		10,597,211	301	10,597,512	76
76.10	OP PSYCH	445,110		445,110		445,110	76.10
76.97	CARDIAC REHABILITATION	1,249,655		1,249,655		1,249,655	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	17,840,695		17,840,695	1,538	17,842,233	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	11,478,845		11,478,845		11,478,845	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	362,727,110		362,727,110	180,203	362,907,313	200
201	LESS OBSERVATION BEDS	11,478,845		11,478,845		11,478,845	201
202	TOTAL (SEE INSTRUCTIONS)	351,248,265		351,248,265		351,428,468	202



COMPU-MAX

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	166,090,254		166,090,254				30
31	INTENSIVE CARE UNIT	42,303,033		42,303,033				31
34	SURGICAL INTENSIVE CARE UNIT	29,594,087		29,594,087				34
41	SUBPROVIDER - IRF	16,025,182		16,025,182				41
43	NURSERY	6,889,529		6,889,529				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	75,407,071	83,572,618	158,979,689	0.189750	0.189750	0.189886	50
54	RADIOLOGY-DIAGNOSTIC	113,097,704	229,958,450	343,056,154	0.078864	0.078864	0.078864	54
60	LABORATORY	127,107,098	126,338,570	253,445,668	0.073380	0.073380	0.073380	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	47,989,820	4,936,589	52,926,409	0.096932	0.096932	0.097007	65
66	PHYSICAL THERAPY	28,164,872	25,481,814	53,646,686	0.278320	0.278320	0.278320	66
69	ELECTROCARDIOLOGY	49,158,320	70,681,490	119,839,810	0.075302	0.075302	0.075358	69
70	ELECTROENCEPHALOGRAPHY	2,062,459	4,393,185	6,455,644	0.162832	0.162832	0.162832	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,571,713	45,283,044	129,854,757	0.213130	0.213130	0.213130	71
72	IMPL. DEV. CHARGED TO PATIENTS	66,081,157	29,878,047	95,959,204	0.360659	0.360659	0.360659	72
73	DRUGS CHARGED TO PATIENTS	121,284,278	35,975,581	157,259,859	0.176259	0.176259	0.176259	73
76	OTHER	4,117,402	34,621,801	38,739,203	0.273553	0.273553	0.273560	76
76.10	OP PSYCH	668,155	599,633	1,267,788	0.351092	0.351092	0.351092	76.10
76.97	CARDIAC REHABILITATION	12,475	2,121,877	2,134,352	0.585496	0.585496	0.585496	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	47,140,249	96,288,570	143,428,819	0.124387	0.124387	0.124398	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	6,820,445	22,596,483	29,416,928	0.390212	0.390212	0.390212	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	1,034,585,303	812,727,752	1,847,313,055				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	1,034,585,303	812,727,752	1,847,313,055				202



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	11,455,381		11,455,381	91,404	125.33	41,509	5,202,323	30
31	INTENSIVE CARE UNIT	1,440,196		1,440,196	7,926	181.71	3,893	707,397	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT	1,075,524		1,075,524	6,158	174.65	3,210	560,627	34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	724,686		724,686	8,872	81.68	7,255	592,588	41
42	SUBPROVIDER I								42
43	NURSERY	402,468		402,468	3,962	101.58			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	15,098,255		15,098,255	118,322		55,867	7,062,935	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0007

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,730,578	158,979,689	0.023466	28,115,289	659,753	50
54	RADIOLOGY-DIAGNOSTIC	4,406,322	343,056,154	0.012844	61,322,199	787,622	54
60	LABORATORY	1,077,978	253,445,668	0.004253	67,270,985	286,103	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	233,528	52,926,409	0.004412	27,595,852	121,753	65
66	PHYSICAL THERAPY	438,705	53,646,686	0.008178	10,279,446	84,065	66
69	ELECTROCARDIOLOGY	1,660,084	119,839,810	0.013853	32,913,592	455,952	69
70	ELECTROENCEPHALOGRAPHY	169,159	6,455,644	0.026203	1,142,263	29,931	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,318,080	129,854,757	0.010150	46,615,470	473,147	71
72	IMPL. DEV. CHARGED TO PATIENTS	623,952	95,959,204	0.006502	29,320,234	190,640	72
73	DRUGS CHARGED TO PATIENTS	621,547	157,259,859	0.003952	61,722,465	243,927	73
76	OTHER	225,041	38,739,203	0.005809	1,936,290	11,248	76
76.10	OP PSYCH	12,907	1,267,788	0.010181	182,896	1,862	76.10
76.97	CARDIAC REHABILITATION	216,653	2,134,352	0.0101508	7,665	778	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,438,796	143,428,819	0.010031	24,236,549	243,117	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,467,582	29,416,928	0.049889	4,394,416	219,233	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	17,640,912	1,586,410,970		397,055,611	3,809,131	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
		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



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	91,404		41,509		30
31	INTENSIVE CARE UNIT	7,926		3,893		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT	6,158		3,210		34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	8,872		7,255		41
42	SUBPROVIDER I					42
43	NURSERY	3,962				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	118,322		55,867		200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0007

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			937,857		937,857	937,857	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			937,857		937,857	937,857	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0007

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	158,979,689			28,115,289		17,229,644		50
54	RADIOLOGY-DIAGNOSTIC	343,056,154			61,322,199		60,945,860		54
60	LABORATORY	253,445,668			67,270,985		4,893,165		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	52,926,409			27,595,852		1,430,065		65
66	PHYSICAL THERAPY	53,646,686			10,279,446				66
69	ELECTROCARDIOLOGY	119,839,810			32,913,592		34,277,135		69
70	ELECTROENCEPHALOGRAPHY	6,455,644			1,142,263		1,241,787		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,854,757			46,615,470		17,174,901		71
72	IMPL. DEV. CHARGED TO PATIENTS	95,959,204			29,320,234		12,341,742		72
73	DRUGS CHARGED TO PATIENTS	157,259,859	0.005964	0.005964	61,722,465	368,113	12,567,870	74,955	73
76	OTHER	38,739,203			1,936,290		10,188,086		76
76.10	OP PSYCH	1,267,788			182,896		1,523		76.10
76.97	CARDIAC REHABILITATION	2,134,352			7,665		1,108,099		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	143,428,819			24,236,549		16,179,320		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	29,416,928			4,394,416		6,523,399		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,586,410,970			397,055,611	368,113	196,102,596	74,955	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0007

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	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.)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.189750	17,229,644			3,269,325		50
54	RADIOLOGY-DIAGNOSTIC	0.078864	60,945,860			4,806,434		54
60	LABORATORY	0.073380	4,893,165			359,060		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.096932	1,430,065			138,619		65
66	PHYSICAL THERAPY	0.278320						66
69	ELECTROCARDIOLOGY	0.075302	34,277,135			2,581,137		69
70	ELECTROENCEPHALOGRAPHY	0.162832	1,241,787			202,203		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213130	17,174,901			3,660,487		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.360659	12,341,742			4,451,160		72
73	DRUGS CHARGED TO PATIENTS	0.176259	12,567,870			2,215,200		73
76	OTHER	0.273553	10,188,086			2,786,981		76
76.10	OP PSYCH	0.351092	1,523			535		76.10
76.97	CARDIAC REHABILITATION	0.585496	1,108,099			648,788		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.124387	16,179,320			2,012,497		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.390212	6,523,399			2,545,509		92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)		196,102,596			29,677,935		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		196,102,596			29,677,935		202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T007

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,730,578	158,979,689	0.023466	133,259	3,127	50
54	RADIOLOGY-DIAGNOSTIC	4,406,322	343,056,154	0.012844	792,793	10,183	54
60	LABORATORY	1,077,978	253,445,668	0.004253	2,136,279	9,086	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	233,528	52,926,409	0.004412	768,557	3,391	65
66	PHYSICAL THERAPY	438,705	53,646,686	0.008178	10,508,124	85,935	66
69	ELECTROCARDIOLOGY	1,660,084	119,839,810	0.013853	229,863	3,184	69
70	ELECTROENCEPHALOGRAPHY	169,159	6,455,644	0.026203	16,299	427	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,318,080	129,854,757	0.010150	1,009,258	10,244	71
72	IMPL. DEV. CHARGED TO PATIENTS	623,952	95,959,204	0.006502			72
73	DRUGS CHARGED TO PATIENTS	621,547	157,259,859	0.003952	3,184,857	12,587	73
76	OTHER	225,041	38,739,203	0.005809			76
76.10	OP PSYCH	12,907	1,267,788	0.010181			76.10
76.97	CARDIAC REHABILITATION	216,653	2,134,352	0.101508			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,438,796	143,428,819	0.010031	26,239	263	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		29,416,928				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	16,173,330	1,586,410,970		18,805,528	138,427	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T007

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			937,857		937,857	937,857	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			937,857		937,857	937,857	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T007

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	158,979,689			133,259			50
54	RADIOLOGY-DIAGNOSTIC	343,056,154			792,793			54
60	LABORATORY	253,445,668			2,136,279			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	52,926,409			768,557			65
66	PHYSICAL THERAPY	53,646,686			10,508,124			66
69	ELECTROCARDIOLOGY	119,839,810			229,863			69
70	ELECTROENCEPHALOGRAPHY	6,455,644			16,299			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,854,757			1,009,258			71
72	IMPL. DEV. CHARGED TO PATIENTS	95,959,204						72
73	DRUGS CHARGED TO PATIENTS	157,259,859	0.005964	0.005964	3,184,857	18,994		73
76	OTHER	38,739,203						76
76.10	OP PSYCH	1,267,788						76.10
76.97	CARDIAC REHABILITATION	2,134,352						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	143,428,819			26,239			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	29,416,928						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,586,410,970			18,805,528	18,994		200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T007

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			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.)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.189750						50
54	RADIOLOGY-DIAGNOSTIC	0.078864						54
60	LABORATORY	0.073380						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.096932						65
66	PHYSICAL THERAPY	0.278320						66
69	ELECTROCARDIOLOGY	0.075302						69
70	ELECTROENCEPHALOGRAPHY	0.162832						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213130						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.360659						72
73	DRUGS CHARGED TO PATIENTS	0.176259						73
76	OTHER	0.273553						76
76.10	OP PSYCH	0.351092						76.10
76.97	CARDIAC REHABILITATION	0.585496						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.124387						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.390212						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



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUSTMENT	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)	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	11,455,381		11,455,381	91,404	125.33	12,870	1,612,997	30
31	INTENSIVE CARE UNIT	1,440,196		1,440,196	7,926	181.71	450	81,770	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT	1,075,524		1,075,524	6,158	174.65	298	52,046	34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	724,686		724,686	8,872	81.68	181	14,784	41
42	SUBPROVIDER I								42
43	NURSERY	402,468		402,468	3,962	101.58	1,941	197,167	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	15,098,255		15,098,255	118,322		15,740	1,958,764	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0007

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,730,578	158,979,689	0.023466			50
54	RADIOLOGY-DIAGNOSTIC	4,406,322	343,056,154	0.012844			54
60	LABORATORY	1,077,978	253,445,668	0.004253			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	233,528	52,926,409	0.004412			65
66	PHYSICAL THERAPY	438,705	53,646,686	0.008178			66
69	ELECTROCARDIOLOGY	1,660,084	119,839,810	0.013853			69
70	ELECTROENCEPHALOGRAPHY	169,159	6,455,644	0.026203			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,318,080	129,854,757	0.010150			71
72	IMPL. DEV. CHARGED TO PATIENTS	623,952	95,959,204	0.006502			72
73	DRUGS CHARGED TO PATIENTS	621,547	157,259,859	0.003952			73
76	OTHER	225,041	38,739,203	0.005809			76
76.10	OP PSYCH	12,907	1,267,788	0.010181			76.10
76.97	CARDIAC REHABILITATION	216,653	2,134,352	0.101508			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,438,796	143,428,819	0.010031			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,467,582	29,416,928	0.049889			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	17,640,912	1,586,410,970				200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
		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



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	91,404		12,870		30
31	INTENSIVE CARE UNIT	7,926		450		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT	6,158		298		34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	8,872		181		41
42	SUBPROVIDER I					42
43	NURSERY	3,962		1,941		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	118,322		15,740		200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0007

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			937,857		937,857	937,857	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			937,857		937,857	937,857	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0007

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13
		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	158,979,689						50
54	RADIOLOGY-DIAGNOSTIC	343,056,154						54
60	LABORATORY	253,445,668						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	52,926,409						65
66	PHYSICAL THERAPY	53,646,686						66
69	ELECTROCARDIOLOGY	119,839,810						69
70	ELECTROENCEPHALOGRAPHY	6,455,644						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,854,757						71
72	IMPL. DEV. CHARGED TO PATIENTS	95,959,204						72
73	DRUGS CHARGED TO PATIENTS	157,259,859	0.005964	0.005964				73
76	OTHER	38,739,203						76
76.10	OP PSYCH	1,267,788						76.10
76.97	CARDIAC REHABILITATION	2,134,352						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	143,428,819						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	29,416,928						92
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,586,410,970						200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0007

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			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.)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.189750						50
54	RADIOLOGY-DIAGNOSTIC	0.078864						54
60	LABORATORY	0.073380						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.096932						65
66	PHYSICAL THERAPY	0.278320						66
69	ELECTROCARDIOLOGY	0.075302						69
70	ELECTROENCEPHALOGRAPHY	0.162832						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213130						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.360659						72
73	DRUGS CHARGED TO PATIENTS	0.176259						73
76	OTHER	0.273553						76
76.10	OP PSYCH	0.351092						76.10
76.97	CARDIAC REHABILITATION	0.585496						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.124387						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.390212						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



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T007

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,730,578	158,979,689	0.023466			50
54	RADIOLOGY-DIAGNOSTIC	4,406,322	343,056,154	0.012844			54
60	LABORATORY	1,077,978	253,445,668	0.004253			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	233,528	52,926,409	0.004412			65
66	PHYSICAL THERAPY	438,705	53,646,686	0.008178			66
69	ELECTROCARDIOLOGY	1,660,084	119,839,810	0.013853			69
70	ELECTROENCEPHALOGRAPHY	169,159	6,455,644	0.026203			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,318,080	129,854,757	0.010150			71
72	IMPL. DEV. CHARGED TO PATIENTS	623,952	95,959,204	0.006502			72
73	DRUGS CHARGED TO PATIENTS	621,547	157,259,859	0.003952			73
76	OTHER	225,041	38,739,203	0.005809			76
76.10	OP PSYCH	12,907	1,267,788	0.010181			76.10
76.97	CARDIAC REHABILITATION	216,653	2,134,352	0.101508			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,438,796	143,428,819	0.010031			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		29,416,928				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	16,173,330	1,586,410,970				200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T007

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			937,857		937,857	937,857	73
76	OTHER							76
76.10	OP PSYCH							76.10
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			937,857		937,857	937,857	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T007

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	158,979,689						50
54	RADIOLOGY-DIAGNOSTIC	343,056,154						54
60	LABORATORY	253,445,668						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	52,926,409						65
66	PHYSICAL THERAPY	53,646,686						66
69	ELECTROCARDIOLOGY	119,839,810						69
70	ELECTROENCEPHALOGRAPHY	6,455,644						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,854,757						71
72	IMPL. DEV. CHARGED TO PATIENTS	95,959,204						72
73	DRUGS CHARGED TO PATIENTS	157,259,859	0.005964	0.005964				73
76	OTHER	38,739,203						76
76.10	OP PSYCH	1,267,788						76.10
76.97	CARDIAC REHABILITATION	2,134,352						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	143,428,819						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	29,416,928						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,586,410,970						200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T007

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			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.)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.189750						50
54	RADIOLOGY-DIAGNOSTIC	0.078864						54
60	LABORATORY	0.073380						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.096932						65
66	PHYSICAL THERAPY	0.278320						66
69	ELECTROCARDIOLOGY	0.075302						69
70	ELECTROENCEPHALOGRAPHY	0.162832						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213130						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.360659						72
73	DRUGS CHARGED TO PATIENTS	0.176259						73
76	OTHER	0.273553						76
76.10	OP PSYCH	0.351092						76.10
76.97	CARDIAC REHABILITATION	0.585496						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.124387						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.390212						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



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0007

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	91,404	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	91,404	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)	79,694	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)	41,509	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)	89,599,262	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	89,599,262	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)	89,599,262	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0007

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					980.26	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					40,689,612	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)					40,689,612	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	14,939,413	7,926	1,884.86	3,893	7,337,760	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT	10,127,364	6,158	1,644.59	3,210	5,279,134	46
47	OTHER SPECIAL CARE (SPECIFY)						47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					60,032,449	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					113,338,955	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					6,470,347	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					4,177,244	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					10,647,591	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					102,691,364	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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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0007

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					11,710	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					980.26	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					11,478,845	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	11,455,381	89,599,262	0.127851	11,478,845	1,467,582	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T007

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	8,872	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	8,872	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)	8,872	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)	7,255	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)	7,028,997	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	7,028,997	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)	7,028,997	37



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PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T007

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	792.27	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	5,747,919	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)	5,747,919	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	4,043,466	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	9,791,385	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	592,588	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	157,421	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	750,009	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	9,041,376	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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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0007

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	91,404	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	91,404	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)	79,694	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	12,870	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)	3,962	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	1,941	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)	89,453,143	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	89,453,143	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)	89,453,143	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0007

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1					
	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							
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					978.66	38					
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					12,595,354	39					
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					12,595,354	41					
42	NURSERY (Titles V and XIX only)					3,608,442	3,962	910.76	1,941	1,767,785	42	
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS												
43	INTENSIVE CARE UNIT					14,939,413	7,926	1,884.86	450	848,187	43	
44	CORONARY CARE UNIT										44	
45	BURN INTENSIVE CARE UNIT										45	
46	SURGICAL INTENSIVE CARE UNIT					10,127,364	6,158	1,644.59	298	490,088	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)					15,701,414	49	

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					1,943,980	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)					1,943,980	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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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0007

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					11,710	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 OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T007

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	8,872	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	8,872	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)	8,872	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)	181	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)	7,028,997	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	7,028,997	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)	7,028,997	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T007

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	792.27	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	143,401	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)	143,401	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	143,401	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	14,784	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)	14,784	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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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0007

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		80,748,416		30
31	INTENSIVE CARE UNIT		22,816,944		31
34	SURGICAL INTENSIVE CARE UNIT		17,676,924		34
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.189886	28,115,289	5,338,700	50
54	RADIOLOGY-DIAGNOSTIC	0.078864	61,322,199	4,836,114	54
60	LABORATORY	0.073380	67,270,985	4,936,345	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.097007	27,595,852	2,676,991	65
66	PHYSICAL THERAPY	0.278320	10,279,446	2,860,975	66
69	ELECTROCARDIOLOGY	0.075358	32,913,592	2,480,302	69
70	ELECTROENCEPHALOGRAPHY	0.162832	1,142,263	185,997	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213130	46,615,470	9,935,155	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.360659	29,320,234	10,574,606	72
73	DRUGS CHARGED TO PATIENTS	0.176259	61,722,465	10,879,140	73
76	OTHER	0.273560	1,936,290	529,691	76
76.10	OP PSYCH	0.351092	182,896	64,213	76.10
76.97	CARDIAC REHABILITATION	0.585496	7,665	4,488	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.124398	24,236,549	3,014,978	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.390212	4,394,416	1,714,754	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		397,055,611	60,032,449	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		397,055,611		202

(A) Worksheet A line numbers



COMPU-MAX

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T007

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
41	SUBPROVIDER - IRF		13,229,780		41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.189886	133,259	25,304	50
54	RADIOLOGY-DIAGNOSTIC	0.078864	792,793	62,523	54
60	LABORATORY	0.073380	2,136,279	156,760	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.097007	768,557	74,555	65
66	PHYSICAL THERAPY	0.278320	10,508,124	2,924,621	66
69	ELECTROCARDIOLOGY	0.075358	229,863	17,322	69
70	ELECTROENCEPHALOGRAPHY	0.162832	16,299	2,654	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213130	1,009,258	215,103	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.360659			72
73	DRUGS CHARGED TO PATIENTS	0.176259	3,184,857	561,360	73
76	OTHER	0.273560			76
76.10	OP PSYCH	0.351092			76.10
76.97	CARDIAC REHABILITATION	0.585496			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.124398	26,239	3,264	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.390212			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		18,805,528	4,043,466	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		18,805,528		202

(A) Worksheet A line numbers



COMPU-MAX

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0007

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.189750			50
54	RADIOLOGY-DIAGNOSTIC	0.078864			54
60	LABORATORY	0.073380			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.096932			65
66	PHYSICAL THERAPY	0.278320			66
69	ELECTROCARDIOLOGY	0.075302			69
70	ELECTROENCEPHALOGRAPHY	0.162832			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213130			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.360659			72
73	DRUGS CHARGED TO PATIENTS	0.176259			73
76	OTHER	0.273553			76
76.10	OP PSYCH	0.351092			76.10
76.97	CARDIAC REHABILITATION	0.585496			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.124387			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.390212			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



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T007

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34	SURGICAL INTENSIVE CARE UNIT				34
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.189750			50
54	RADIOLOGY-DIAGNOSTIC	0.078864			54
60	LABORATORY	0.073380			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.096932			65
66	PHYSICAL THERAPY	0.278320			66
69	ELECTROCARDIOLOGY	0.075302			69
70	ELECTROENCEPHALOGRAPHY	0.162832			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213130			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.360659			72
73	DRUGS CHARGED TO PATIENTS	0.176259			73
76	OTHER	0.273553			76
76.10	OP PSYCH	0.351092			76.10
76.97	CARDIAC REHABILITATION	0.585496			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.124387			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.390212			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



COMPU-MAX

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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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)	63,379,487			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	21,277,500			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)	2,827,510			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	7,920,832			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	382.92			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)	9.00			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	5.85			7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)	5.85			8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)	9.00			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	0.94			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	0.94			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	1.30			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	1.04			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	1.09			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	1.09			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.002847			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.002948			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.002847			21
22	IME PAYMENT ADJUSTMENT (see instructions)	143,959			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)	-8.06			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)	143,959			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0357			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.1592			31
32	SUM OF LINES 30 AND 31	0.1949			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0542			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	3,723,478			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		



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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

**CHECK
APPLICABLE BOX:**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		4,457,416		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,123,514		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,123,514			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	92,475,448			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)	92,475,448			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	7,426,044			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)	77,658			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES	5,657			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)	368,113			58
59	TOTAL (sum of amounts on lines 49 through 58)	100,352,920			59
60	PRIMARY PAYER PAYMENTS	16,910			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	100,336,010			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7,602,852			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	421,993			63
64	ALLOWABLE BAD DEBTS (see instructions)	1,520,401			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	988,261			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	728,325			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	93,299,426			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)	-42,961			70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	164,600			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-870,034			70.94
71	AMOUNT DUE PROVIDER (see instructions)	92,551,031			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,397,521			71.01
72	INTERIM PAYMENTS	89,783,136			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	1,370,374			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	208,577			75

TO BE COMPLETED BY CONTRACTOR

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0007

**WORKSHEET E
PART B**

CHECK APPLICABLE BOX: 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)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	29,602,980			2
3	PPS PAYMENTS	28,080,424			3
4	OUTLIER PAYMENT (see instructions)	65,796			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	74,955			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	28,221,175			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	5,811,001			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	22,410,174			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	18,716			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	22,428,890			30
31	PRIMARY PAYER PAYMENTS	7,054			31
32	SUBTOTAL (line 30 minus line 31)	22,421,836			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)	1,032,128			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	670,883			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	538,919			36
37	SUBTOTAL (see instructions)	23,092,719			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	280			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	23,092,439			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	348,696			40.01
41	INTERIM PAYMENTS	21,904,624			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	839,119			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 (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T007

WORKSHEET E
PART B

CHECK APPLICABLE BOX: 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)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see 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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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0007

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		89,858,901		21,981,563	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					3.01	
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02	
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM				3.03	
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO				3.04	
		PROVIDER				3.05	
						3.06	
						3.07	
						3.08	
						3.09	
						3.10	
						3.50	
			07/08/2013	75,765	07/08/2013	76,939	3.51
		PROVIDER				3.52	
		TO				3.53	
		PROGRAM				3.54	
						3.55	
						3.56	
						3.57	
						3.58	
						3.59	
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-75,765		-76,939	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)		89,783,136		21,904,624	4	
	TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01	
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02	
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				5.03	
		TO				5.04	
		PROVIDER				5.05	
						5.06	
						5.07	
						5.08	
						5.09	
						5.10	
						5.50	
						5.51	
		PROVIDER				5.52	
		TO				5.53	
		PROGRAM				5.54	
						5.55	
						5.56	
						5.57	
						5.58	
						5.59	
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99	
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		2,767,895		1,187,815	6.01	
	BASED ON THE COST REPORT (1)					6.02	
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		92,551,031		23,092,439	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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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-T007

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		10,071,856		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				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.01			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO			3.04
		PROVIDER			3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
					3.51
		PROVIDER			3.52
		TO			3.53
		PROGRAM			3.54
					3.55
					3.56
					3.57
					3.58
					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)		10,071,856		4
	TO BE COMPLETED BY CONTRACTOR				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				5.01
		PROGRAM			5.02
		TO			5.03
		PROVIDER			5.04
					5.05
					5.06
					5.07
					5.08
					5.09
					5.10
					5.50
					5.51
		PROVIDER			5.52
		TO			5.53
		PROGRAM			5.54
					5.55
					5.56
					5.57
					5.58
					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) BASED ON THE COST REPORT (1)	.01	198,419		6.01
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		10,270,275		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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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL [] CAH
 APPLICABLE BOX:

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	21,969	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	48,612	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	4,734	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	93,778	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,847,313.055	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	87,883.536	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)	3,681,757	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	73,635	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	3,608,122	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	3,475,365	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	132,757	32



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T007

WORKSHEET E-3
PART III

CHECK HOSPITAL
 APPLICABLE SUBPROVIDER IRF
 BOX:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	7,404,455	2,673,587	1
2	MEDICARE SSI RATIO (see instructions)	0.016500		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	125,135	31,014	3
4	OUTLIER PAYMENTS	95,541		4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (see instructions)			5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)			9
10	AVERAGE DAILY CENSUS (see instructions)	24.306849		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	10,329,732		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	10,329,732		17
18	PRIMARY PAYER PAYMENTS			18
19	SUBTOTAL (line 17 less line 18)	10,329,732		19
20	DEDUCTIBLES	39,044		20
21	SUBTOTAL (line 19 minus line 20)	10,290,688		21
22	COINSURANCE	41,144		22
23	SUBTOTAL (line 21 minus line 22)	10,249,544		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	1,132		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	736		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			26
27	SUBTOTAL (sum of lines 23 and 25)	10,250,280		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)	18,994		29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	1,001		31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	10,270,275		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	155,081		32.01
33	INTERIM PAYMENTS	10,071,856		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	43,338		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			36

TO BE COMPLETED BY CONTRACTOR

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0007

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	INPATIENT HOSPITAL SNF/NF SERVICES	15,701,414		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	15,701,414		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	15,701,414		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)	15,701,414		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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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T007

WORKSHEET E-3
PART VII

CHECK TITLE V
 APPLICABLE TITLE XIX
 BOXES:

PPS
 TEFRA
 OTHER

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	143,401		1
2			2
3			3
4	143,401		4
5			5
6			6
7	143,401		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1	1	15
16			16
17			17
18	143,401		18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43



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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII
 BOX: [] 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)			9.00	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)			5.85	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)			5.85	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)			9.00	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			0.94	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			0.94	7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.44	0.37	0.81	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	0.44	0.37	0.81	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.44	0.37		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.60	1.98		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.96	0.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.67	0.78		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	0.67	0.78		17
18	PER RESIDENT AMOUNT	113,208.82	113,208.82		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	75,850	88,303	164,153	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)			164,153	25
		INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	55,867	5,123		26
27	TOTAL INPATIENT DAYS (see instructions)	102,650	102,650		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.544247	0.049907		28
29	PROGRAM DIRECT GME AMOUNT	89,340	8,192		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		1,158		30
31	NET PROGRAM DIRECT GME AMOUNT			96,374	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)			123,130,340	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)			16,910	40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			123,113,430	41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			29,677,935	42
43	PRIMARY PAYER PAYMENTS (see instructions)			7,054	43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			29,670,881	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			152,784,311	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.805799	46



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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK TITLE V
 APPLICABLE TITLE XVIII
 BOX: TITLE XIX

47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)	0.194201	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	TOTAL PROGRAM GME PAYMENT (line 31)	96,374	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)	77,658	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)	18,716	50



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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII
 BOX: [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
		INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	13,799			26
27	TOTAL INPATIENT DAYS (see instructions)	102,650			27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.134428	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



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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK TITLE V
 APPLICABLE TITLE XVIII
 BOX: TITLE XIX

47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)		47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	TOTAL PROGRAM GME PAYMENT (line 31)		48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)		49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)		50



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	18,575,721				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	72,290,831				4
5	OTHER RECEIVABLES	5,580,420				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	7,949,282				7
8	PREPAID EXPENSES	1,110,433				8
9	OTHER CURRENT ASSETS	89,733				9
10	DUE FROM OTHER FUNDS	4,299,656				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	109,896,076				11
FIXED ASSETS						
12	LAND	1,884,595				12
13	LAND IMPROVEMENTS	3,208,539				13
14	ACCUMULATED DEPRECIATION	-3,205,238				14
15	BUILDINGS	333,922,788				15
16	ACCUMULATED DEPRECIATION	-141,351,489				16
17	LEASEHOLD IMPROVEMENTS	1,439,521				17
18	ACCUMULATED AMORTIZATION	-994,996				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS	750,458				21
22	ACCUMULATED DEPRECIATION	-706,526				22
23	MAJOR MOVABLE EQUIPMENT	125,831,409				23
24	ACCUMULATED DEPRECIATION	-92,880,888				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)	227,898,173				30
OTHER ASSETS						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	5,761,886				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	5,761,886				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	343,556,135				36
LIABILITIES AND FUND BALANCES						
	(Omit Cents)	1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	13,107,421				37
38	SALARIES, WAGES & FEES PAYABLE	11,701,926				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	54,616,139				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	79,425,486				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	4,310,514				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	4,310,514				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	83,736,000				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	259,820,135				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	259,820,135				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	343,556,135				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCES AT BEGINNING OF PERIOD		278,512,114		1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		13,315,159		2
3	TOTAL (sum of line 1 and line 2)		291,827,273		3
4	ADDITIONS (credit adjustments)				4
5					5
6					6
7					7
8					8
9					9
10	TOTAL ADDITIONS (sum of lines 4-9)				10
11	SUBTOTAL (line 3 plus line 10)		291,827,273		11
12	DEDUCTIONS (debit adjustments)				12
13					13
14	ASSETS RELEASED FROM RESTRICTIONS	32,007,138			14
15					15
16					16
17					17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		32,007,138		18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		259,820,135		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 (sum of line 1 and line 2)				3
4	ADDITIONS (credit adjustments)				4
5					5
6					6
7					7
8					8
9					9
10	TOTAL ADDITIONS (sum of lines 4-9)				10
11	SUBTOTAL (line 3 plus line 10)				11
12	DEDUCTIONS (debit adjustments)				12
13					13
14	ASSETS RELEASED FROM RESTRICTIONS				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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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	179,800,228		179,800,228	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	16,025,182		16,025,182	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	195,825,410		195,825,410	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	42,303,033		42,303,033	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT	29,594,087		29,594,087	14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	71,897,120		71,897,120	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	267,722,530		267,722,530	17
18	ANCILLARY SERVICES	766,891,374	814,405,524	1,581,296,898	18
19	OUTPATIENT SERVICES		12,889,525	12,889,525	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	1,034,613,904	827,295,049	1,861,908,953	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		384,275,739	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				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)		384,275,739	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	1,861,908,953	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	1,476,503,009	2
3	NET PATIENT REVENUES (line 1 minus line 2)	385,405,944	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	384,275,739	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	1,130,205	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER OPERATING REVENUE)	9,660,611	24
24.0	OTHER (NON OPERATING REVENUE)	2,524,343	24.0
1			1
25	TOTAL OTHER INCOME (sum of lines 6-24)	12,184,954	25
26	TOTAL (line 5 plus line 25)	13,315,159	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	13,315,159	29



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0007

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	6,740,545	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	405,766	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)	256.93	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	1.09	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	0.12	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	8,089	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0357	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1592	8
9	SUM OF LINES 7 AND 8	0.1949	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0403	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	271,644	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	7,426,044	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
34	SURGICAL INTENSIVE CARE UNIT						34
41	SUBPROVIDER - IRF						41
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76	OTHER						76
76.10	OP PSYCH						76.10
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
192.0	OTHER NRCC						192.0
1							1
194	OTHER NON-REIMBURSABLE						194
194.0	SHARED SERVICES						194.0
1							1
194.0	CASE MANAGEMENT						194.0
2							2
194.0	OUTPATIENT PHARMACY						194.0
4							4
194.0	PRIMARY CARE PHYSICIAN						194.0
5							5
194.0	PATIENT SITTERS						194.0
6							6
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202



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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	45.41		14.08				59.49	30
31	INTENSIVE CARE UNIT	49.12		5.68				54.80	31
34	SURGICAL INTENSIVE CARE UNIT	52.13		4.84				56.97	34
43	NURSERY			48.99				48.99	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	17.68	10.84					28.52	50
54	RADIOLOGY-DIAGNOSTIC	17.88	17.77					35.65	54
60	LABORATORY	26.54	1.93					28.47	60
65	RESPIRATORY THERAPY	52.14	2.70					54.84	65
66	PHYSICAL THERAPY	19.16						19.16	66
69	ELECTROCARDIOLOGY	27.46	28.60					56.06	69
70	ELECTROENCEPHALOGRAPHY	17.69	19.24					36.93	70
71	MEDICAL SUPPLIES CHARGED TO PAT	35.90	13.23					49.13	71
72	IMPL. DEV. CHARGED TO PATIENTS	30.55	12.86					43.41	72
73	DRUGS CHARGED TO PATIENTS	39.25	7.99					47.24	73
76	OTHER	5.00	26.30					31.30	76
76.10	OP PSYCH	14.43	0.12					14.55	76.10
76.97	CARDIAC REHABILITATION	0.36	51.92					52.28	76.97
91	EMERGENCY	16.90	11.28					28.18	91
92	OBSERVATION BEDS (NON-DISTINCT	14.94	22.18					37.12	92
200	TOTAL CHARGES	25.03	12.36					37.39	200



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PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	Non CMS worksheet CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IRF

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
41	SUBPROVIDER - IRF	81.77		2.04				83.81	41
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	0.08						0.08	50
54	RADIOLOGY-DIAGNOSTIC	0.23						0.23	54
60	LABORATORY	0.84						0.84	60
65	RESPIRATORY THERAPY	1.45						1.45	65
66	PHYSICAL THERAPY	19.59						19.59	66
69	ELECTROCARDIOLOGY	0.19						0.19	69
70	ELECTROENCEPHALOGRAPHY	0.25						0.25	70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.78						0.78	71
73	DRUGS CHARGED TO PATIENTS	2.03						2.03	73
91	EMERGENCY	0.02						0.02	91
200	TOTAL CHARGES	1.19						1.19	200



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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	23,202,017	6.28	-23,202,017	-11.53			1
2	CAP REL COSTS-MVBLE EQUIP	8,563,150	2.32	-8,563,150	-4.26			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	32,643,328	8.84	-32,643,328	-16.23			4
5	ADMINISTRATIVE & GENERAL	84,211,533	22.80	-84,211,533	-41.87			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	12,878,406	3.49	-12,878,406	-6.40			7
8	LAUNDRY & LINEN SERVICE	1,210,313	0.33	-1,210,313	-0.60			8
9	HOUSEKEEPING	3,966,735	1.07	-3,966,735	-1.97			9
10	DIETARY	570,573	0.15	-570,573	-0.28			10
11	CAFETERIA	3,602,439	0.98	-3,602,439	-1.79			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	5,132,141	1.39	-5,132,141	-2.55			13
14	CENTRAL SERVICES & SUPPLY	1,844,460	0.50	-1,844,460	-0.92			14
15	PHARMACY	18,136,695	4.91	-18,136,695	-9.02			15
16	MEDICAL RECORDS & LIBRARY	4,607,031	1.25	-4,607,031	-2.29			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	39,011	0.01	-39,011	-0.02			22
23	PARAMED ED PRGM-(SPECIFY)	537,999	0.15	-537,999	-0.27			23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	ADULTS & PEDIATRICS	32,099,949	8.69	57,379,341	28.53	89,479,290	24.23	30
31	INTENSIVE CARE UNIT	6,325,690	1.71	8,613,723	4.28	14,939,413	4.05	31
34	SURGICAL INTENSIVE CARE UNIT	4,204,741	1.14	5,922,623	2.94	10,127,364	2.74	34
41	SUBPROVIDER - IRF	2,765,565	0.75	4,263,432	2.12	7,028,997	1.90	41
43	NURSERY	1,475,382	0.40	2,133,060	1.06	3,608,442	0.98	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,712,408	3.71	16,480,199	8.19	30,192,607	8.18	50
54	RADIOLOGY-DIAGNOSTIC	11,176,329	3.03	15,878,345	7.89	27,054,674	7.33	54
60	LABORATORY	11,694,349	3.17	6,903,388	3.43	18,597,737	5.04	60
	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,766,758	0.75	2,363,492	1.18	5,130,250	1.39	65
66	PHYSICAL THERAPY	8,667,181	2.35	6,263,768	3.11	14,930,949	4.04	66
69	ELECTROCARDIOLOGY	3,344,949	0.91	5,679,193	2.82	9,024,142	2.44	69
70	ELECTROENCEPHALOGRAPHY	394,170	0.11	657,013	0.33	1,051,183	0.28	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,786,826	4.55	10,889,084	5.41	27,675,910	7.49	71
72	IMPL. DEV. CHARGED TO PATIENTS	25,497,183	6.90	9,111,335	4.53	34,608,518	9.37	72
73	DRUGS CHARGED TO PATIENTS			27,718,412	13.78	27,718,412	7.51	73
76	OTHER	6,250,930	1.69	4,346,281	2.16	10,597,211	2.87	76
	OP PSYCH	244,662	0.07	200,448	0.10	445,110	0.12	76.10
76.10	CARDIAC REHABILITATION	459,333	0.12	790,322	0.39	1,249,655	0.34	76.97
76.97	HYPERBARIC OXYGEN THERAPY							76.98
76.98	LITHOTRIPSY							76.99
76.99	EMERGENCY	7,902,486	2.14	9,938,209	4.94	17,840,695	4.83	91
91	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
192.0	OTHER NRCC	12,362,792	3.35	5,614,163	2.79	17,976,955	4.87	192.0
1								1
194	OTHER NON-REIMBURSABLE							194
194.0	SHARED SERVICES							194.0
1								1
194.0	CASE MANAGEMENT							194.0
2								2
194.0	OUTPATIENT PHARMACY							194.0
4								4
194.0	PRIMARY CARE PHYSICIAN							194.0
5								5
194.0	PATIENT SITTERS							194.0
6								6
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201



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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
202	TOTAL	369,277,514	100.00			369,277,514	100.00	202



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

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,730,578	158,979,689	0.023466	28,115,289	659,753	50
54	RADIOLOGY-DIAGNOSTIC	4,406,322	343,056,154	0.012844	61,322,199	787,622	54
60	LABORATORY	1,077,978	253,445,668	0.004253	67,270,985	286,103	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	233,528	52,926,409	0.004412	27,595,852	121,753	65
66	PHYSICAL THERAPY	438,705	53,646,686	0.008178	10,279,446	84,065	66
69	ELECTROCARDIOLOGY	1,660,084	119,839,810	0.013853	32,913,592	455,952	69
70	ELECTROENCEPHALOGRAPHY	169,159	6,455,644	0.026203	1,142,263	29,931	70
71	MEDICAL SUPPLIES CHARGED TO PAT	1,318,080	129,854,757	0.010150	46,615,470	473,147	71
72	IMPL. DEV. CHARGED TO PATIENTS	623,952	95,959,204	0.006502	29,320,234	190,640	72
73	DRUGS CHARGED TO PATIENTS	621,547	157,259,859	0.003952	61,722,465	243,927	73
76	OTHER	225,041	38,739,203	0.005809	1,936,290	11,248	76
76.10	OP PSYCH	12,907	1,267,788	0.010181	182,896	1,862	76.10
76.97	CARDIAC REHABILITATION	216,653	2,134,352	0.101508	7,665	778	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,438,796	143,428,819	0.010031	24,236,549	243,117	91
92	OBSERVATION BEDS (NON-DISTINCT	1,467,582	29,416,928	0.049889	4,394,416	219,233	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	17,640,912	1,586,410,970		397,055,611	3,809,131	200



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PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	Non CMS worksheet CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	11,455,381		11,455,381	91,404	125.33	41,509	5,202,323	30
31	INTENSIVE CARE UNIT	1,440,196		1,440,196	7,926	181.71	3,893	707,397	31
34	SURGICAL INTENSIVE CARE UNIT	1,075,524		1,075,524	6,158	174.65	3,210	560,627	34
200	TOTAL	13,971,101		13,971,101	105,488		48,612	6,470,347	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	6,470,347
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	3,809,131
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	10,279,478
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	9,868
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	48,612
PER DISCHARGE CAPITAL COSTS	1,041.70



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PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	Non CMS worksheet CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/27/2014 Run Time: 15:57 Version: 2014.03
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I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	102,691,364
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	518,297,895
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.198

COST TO CHARGE RATIO FOR REHAB SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 41 + Worksheet D, Part IV, column 11, line 200))	9,772,391
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 41, column 2 plus Worksheet D-3, line 202, column 2)	32,035,308
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.305

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	10,279,478
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.020

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01 & 2.02 x (Worksheet B, Part I, column 26 - columns 20 & 23 / Worksheet C, Part I, column 8) less lines 61, 66-68, 74, 94, 95 & 96) (see CR 5999)	29,602,980
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	196,102,596
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.151