



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

PROVIDER USE ONLY		1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 05/23/2014	TIME: 10:33
		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	6. DATE RECEIVED: _____	10. NPR DATE: _____	
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____	
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.	
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN		
	4 -REOPENED			
	5 -AMENDED			

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 RESURRECTION MEDICAL CENTER (14-0117) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-19,093	120,645	-110,950		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		12,824	15			3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		3,999				7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-2,270	120,660	-110,950		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 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.



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:										
1	STREET: 7435 WEST TALCOTT	P.O. BOX:							1	
2	CITY: CHICAGO	STATE: IL	ZIP CODE: 60631	COUNTY: COOK					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 RESURRECTION MEDICAL CENTER	14-0117	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF	RESURRECTION REHAB UNIT	14-T117	16974	5	07/01/1991	N	P	O	5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	RESURRECTION NURSING PAVILION	14-5324	16974		02/01/1980	N	P	O	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	RESURRECTION MEDICAL CENTER RDF	14-2335	16974		07/01/2004				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										
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.							1	2	
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	N	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.							3	N	23
		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS			
		1	2	3	4	5	6			
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	4,726	1,775			84	270		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 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.	298							25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1					26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			1					27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:			36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:			38	
							1	2		



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT
		1	2	3	4
OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	PROGRAM NAME	PROGRAM CODE		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						66
ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	PROGRAM NAME	PROGRAM CODE		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
INPATIENT PSYCHIATRIC FACILITY PPS				1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						71
INPATIENT REHABILITATION FACILITY PPS				1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N			76
LONG TERM CARE HOSPITAL PPS							
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.				N		80
TEFRA PROVIDERS							
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.				N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.						86



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX		
TITLE V AND XIX SERVICES		1	2		
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90	
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91	
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92	
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93	
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94	
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95	
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96	
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97	
RURAL PROVIDERS		1	2		
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105	
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106	
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107	
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108	
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:				118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N			118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N		N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			121
TRANSPLANT CENTER INFORMATION					
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.	N			125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				134



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS						
		1	2			
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	148082		140	
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.						
141	NAME: PRESENCE HEALTH	CONTRACTOR'S NAME: NGS		CONTRACTOR'S NUMBER: 00131	141	
142	STREET: 200 SOUTH WACKER DRIVE	P.O. BOX:			142	
143	CITY: CHICAGO	STATE: IL	ZIP CODE: 60606		143	
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y			144	
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N			145	
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N			146	
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			147	
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			148	
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			149	
DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)						
		TITLE XVIII		TITLE V	TITLE XIX	
		PART A	PART B	2	3	
155	HOSPITAL	N	N		155	
156	SUBPROVIDER - IPF	N	N		156	
157	SUBPROVIDER - IRF	N	N		157	
158	SUBPROVIDER - (OTHER)				158	
159	SNF	N	N		159	
160	HHA	N	N		160	
161	CMHC		N		161	
161.10	CORF				161.10	
MULTICAMPUS						
165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			165	
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.				166	
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5
HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT						
167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(m)? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y		167	
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)				168	
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)		1.00		169	
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)			10/03/2012	12/31/2012	170



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A	05/31/2014	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	Y			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.		Y		15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	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	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN 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: ALICIA	LAST NAME: JUMPER	TITLE: DIRECTOR OF REIMBURSEMENT
42	EMPLOYER: PRESENCE HEALTHCARE		
43	PHONE NUMBER: (847) 813-3713	E-MAIL ADDRESS: ALICIA.JUMPER@RESHEALTHCARE.ORG	



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	102,107,488		102,107,488	3,906,120.00	26.14	1
2							2
3							3
4		2,668,279		2,668,279	22,664.00	117.73	4
4.01		868,225		868,225	10,274.00	84.51	4.01
5		1,388,040		1,388,040	12,436.00	111.61	5
6							6
7	21		4,486,163	4,486,163	179,976.00	24.93	7
7.01							7.01
8							8
9	44	6,664,154	110,198	6,774,352	299,089.00	22.65	9
10		4,655,959	18,182	4,674,141	173,252.00	26.98	10
OTHER WAGES & RELATED COSTS							
11		5,903,500		5,903,500	183,401.00	32.19	11
12							12
13							13
14		12,479,084		12,479,084	364,069.00	34.28	14
15							15
16							16
WAGE-RELATED COSTS							
17		18,813,254		18,813,254			17
18							18
19		2,683,112		2,683,112			19
20							20
21							21
22		205,495		205,495			22
22.01		93,148		93,148			22.01
23		112,758		112,758			23
24							24
25		1,045,211		1,045,211			25
OVERHEAD COSTS - DIRECT SALARIES							
26		693,087		693,087	57,003.00	12.16	26
27		6,685,631	280,086	6,965,717	197,080.00	35.34	27
28							28
29		756,116		756,116	36,929.00	20.47	29
30		1,867,299	-390,284	1,477,015	84,657.00	17.45	30
31		167,345		167,345	15,328.00	10.92	31
32		1,875,561		1,875,561	157,297.00	11.92	32
33							33
34		2,661,287	-587,285	2,074,002	81,084.00	25.58	34
35							35
36			569,103	569,103	99,287.00	5.73	36
37							37
38		2,049,494		2,049,494	65,132.00	31.47	38
39		313,677		313,677	19,584.00	16.02	39
40		2,582,413		2,582,413	69,486.00	37.16	40
41		4,313,106		4,313,106	153,841.00	28.04	41
42		168,005		168,005	8,495.00	19.78	42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	99,851,223	-4,486,163	95,365,060	3,703,434.00	25.75	1
2	EXCLUDED AREA SALARIES (see instructions)	11,320,113	128,380	11,448,493	472,341.00	24.24	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	88,531,110	-4,614,543	83,916,567	3,231,093.00	25.97	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	18,382,584		18,382,584	547,470.00	33.58	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	19,018,749		19,018,749		22.66%	5
6	TOTAL (sum of lines 3 through 5)	125,932,443	-4,614,543	121,317,900	3,778,563.00	32.11	6
7	TOTAL OVERHEAD COST (see instructions)	24,133,021	-128,380	24,004,641	1,045,203.00	22.97	7



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	4,235,607	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	8,951,823	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	254,932	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	-44,385	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	509,690	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	1,156,095	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	7,355,935	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	228,754	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	252,081	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	22,900,532	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL	44,529	25
----	------------------------------------	--------	----



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	Supporting Exhibit for Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---	--	---

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

EXHIBIT 3

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

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

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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3

PART V - CONTRACT LABOR AND BENEFIT COST

PART V

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	2,965,102		1
2	HOSPITAL	2,965,102		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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	OUTPATIENT		TRAINING		HOME		
		REGULAR	HIGH FLUX	HEMO-DIALYSIS	CAPD CCPD	HEMO-DIALYSIS	CAPD CCPD	
		1	2	3	4	5	6	
1	NUMBER OF PATIENTS IN PROGRAM AT END OF COST REPORTING PERIOD	47						1
2	NUMBER OF TIMES PER WEEK PATIENT RECEIVES DIALYSIS	3.00						2
3	AVERAGE PATIENT DIALYSIS TIME INCLUDING SETUP	4.00						3
4	CAPD EXCHANGES PER DAY							4
5	NUMBER OF DAYS IN YEAR DIALYSIS FURNISHED	312						5
6	NUMBER OF STATIONS	12						6
7	TREATMENT CAPACITY PER DAY PER STATION	3						7
8	UTILIZATION (see instructions)							8
9	AVERAGE TIMES DIALYZERS RE-USED							9
10	PERCENTAGE OF PATIENTS RE-USING DIALYZERS							10

ESRD PPS

		1	2	
10.01	IS THE DIALYSIS FACILITY APPROVED AS A LOW-VOLUME FACILITY FOR THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)			10.01
10.02	DID YOUR FACILITY ELECT 100% PPS EFFECTIVE JANUARY 1, 2011? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions for 'new' providers)			10.02
10.03	IF YOU RESPONDED 'N' TO LINE 10.02, ENTER IN COLUMN 1 THE YEAR OF TRANSITION FOR PERIODS PRIOR TO JANUARY 1 AND ENTER IN COLUMN 2 THE YEAR OF TRANSITION FOR PERIODS AFTER DECEMBER 31. (see instructions)			10.03

TRANSPLANT INFORMATION

11	NUMBER OF PATIENTS ON TRANSPLANT LIST		11
12	NUMBER OF PATIENTS TRANSPLANTED DURING THE COST REPORTING PERIOD		12

EPOETIN

13	NET COSTS OF EPOETIN FURNISHED TO ALL MAINTENANCE DIALYSIS PATIENTS BY THE PROVIDER		13
14	EPOETIN AMOUNT FROM WORKSHEET A FOR HOME DIALYSIS PROGRAM		14
15	NUMBER OF EPO UNITS FURNISHED RELATING TO THE RENAL DIALYSIS DEPARTMENT		15
16	NUMBER OF EPO UNITS FURNISHED RELATING TO THE HOME DIALYSIS DEPARTMENT		16

ARANESP

17	NET COSTS OF ARANESP FURNISHED TO ALL MAINTENANCE DIALYSIS PATIENTS BY THE PROVIDER		17
18	ARANESP AMOUNT FROM WORKSHEET A FOR HOME DIALYSIS PROGRAM		18
19	NUMBER OF ARANESP UNITS FURNISHED RELATING TO THE RENAL DIALYSIS DEPARTMENT		19
20	NUMBER OF ARANESP UNITS FURNISHED RELATING TO THE HOME DIALYSIS DEPARTMENT		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP X	INITIAL METHOD	
----	-------	----------------	--

	ERYTHROPOIESIS-STIMULATING AGENTS (ESA) STATISTICS:	ESA DESCRIPTION	NET COST OF	NET COST OF	NUMBER OF	NUMBER OF	
			ESAs FOR RENAL PATIENTS	ESAs FOR HOME PATIENTS	ESA UNITS - RENAL DIALYSIS DEPT.	ESA UNITS - HOME DIALYSIS DEPT.	
		1	2	3	4	5	
22	ENTER IN COLUMN 1 THE ESA DESCRIPTION. ENTER IN COLUMN 2 THE NET COSTS OF ESAs FURNISHED TO ALL RENAL DIALYSIS PATIENTS. ENTER IN COLUMN 3 THE NET COST OF ESAs FURNISHED TO ALL HOME DIALYSIS PROGRAM PATIENTS. ENTER IN COLUMN 4 THE NUMBER OF ESA UNITS FURNISHED TO PATIENTS IN THE RENAL DIALYSIS DEPARTMENT. ENTER IN COLUMN 5 THE NUMBER OF UNITS FURNISHED TO PATIENTS IN THE HOME DIALYSIS PROGRAM. (see instructions)						22



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL		45	45	4
5	RVX		16	16	5
6	RVL		59	59	6
7	RHX		20	20	7
8	RHL		15	15	8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	636		636	12
13	RUB	4,827		4,827	13
14	RUA	940		940	14
15	RVC	1,725		1,725	15
16	RVB	4,074		4,074	16
17	RVA	994		994	17
18	RHC	860		860	18
19	RHB	784		784	19
20	RHA	314		314	20
21	RMC	167		167	21
22	RMB	192		192	22
23	RMA	74		74	23
24	RLB	1		1	24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	15		15	28
29	HE2	39		39	29
30	HE1	10		10	30
31	HD2	71		71	31
32	HD1	17		17	32
33	HC2				33
34	HC1	30		30	34
35	HB2				35
36	HB1	9		9	36
37	LE2	120		120	37
38	LE1	115		115	38
39	LD2	269		269	39
40	LD1	127		127	40
41	LC2	16		16	41
42	LC1	70		70	42
43	LB2				43
44	LB1	27		27	44
45	CE2	56		56	45
46	CE1	19		19	46
47	CD2	7		7	47
48	CD1	59		59	48
49	CC2				49
50	CC1	54		54	50
51	CB2				51
52	CB1	71		71	52
53	CA2				53
54	CA1	18		18	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1	7		7	68
69	PE2	7		7	69
70	PE1				70



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2	8		8	71
72	PD1				72
73	PC2	7		7	73
74	PC1	10		10	74
75	PB2				75
76	PB1	7		7	76
77	PA2	20		20	77
78	PA1	5		5	78
199	AAA	17		17	199
200	TOTAL	17,050		17,050	200

SNF SERVICES

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

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

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)	21,572,519			207



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.213870	1
---	--	--	----------	---

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		21,305,479	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		-4,761,662	5
6	MEDICAID CHARGES		104,154,847	6
7	MEDICAID COST (line 1 times line 6)		22,275,597	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.		5,731,780	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)		5,731,780		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	17,465,299	861,118	18,326,417	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	3,735,303	184,167	3,919,470	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	172,410	3,594,614	3,767,024	22
23	COST OF CHARITY CARE (line 21 minus line 22)	3,562,893	-3,410,447	152,446	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)		10,035,111	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		847,164	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		9,187,947	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		1,965,026	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		2,117,472	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		7,849,252	31



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		13,895,823	13,895,823	-9,988,986	3,906,837	85,390	3,992,227	1
2	00200	CAP REL COSTS-MVBLE EQUIP				13,242,842	13,242,842	606,579	13,849,421	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	693,087	471,310	1,164,397		1,164,397	-1,265,531	-101,134	4
5.10	00541	NON PATIENT PHONES		372,993	372,993		372,993		372,993	5.10
5.20	00551	DATA PROCESSING						3,678,119	3,678,119	5.20
5.30	00561	PURCHASING AND STORES								5.30
5.50	00582	CASHIERS AR AND COLLECTIONS						5,286,239	5,286,239	5.50
5.60	00592	ADMINISTRATION & GENERAL	5,913,044	57,280,376	63,193,420	-3,281,739	59,911,681	-15,268,782	44,642,899	5.60
5.90	00593	RNP ADMINISTRATION	772,587	960,980	1,733,567	-593,348	1,140,219	-1,964,194	-823,975	5.90
6	00600	MAINTENANCE & REPAIRS	756,116	898,514	1,654,630		1,654,630		1,654,630	6
7	00700	OPERATION OF PLANT	1,697,789	7,863,395	9,561,184	-6,762,411	2,798,773		2,798,773	7
7.01	00701	ELECTRICITY				5,748,678	5,748,678		5,748,678	7.01
7.02	00702	RNP OPERATION OF PLANT	169,510	650,916	820,426	-205,544	614,882		614,882	7.02
8	00800	LAUNDRY & LINEN SERVICE		1,545,543	1,545,543		1,545,543		1,545,543	8
8.01	00801	RNP LAUNDRY	167,345	149,164	316,509		316,509	-35,068	281,441	8.01
9	00900	HOUSEKEEPING	1,507,217	1,827,640	3,334,857		3,334,857		3,334,857	9
9.01	00901	RNP HOSUEKEEPING	368,344	211,263	579,607		579,607		579,607	9.01
10	01000	DIETARY	2,032,838	2,408,733	4,441,571	-1,238,455	3,203,116		3,203,116	10
10.01	01001	RNP DIETARY	628,449	1,054,342	1,682,791		1,682,791	-3,495	1,679,296	10.01
11	01100	CAFETERIA				1,200,113	1,200,113	-1,100,834	99,279	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	2,049,494	530,787	2,580,281		2,580,281	-493,873	2,086,408	13
14	01400	CENTRAL SERVICES & SUPPLY	313,677	1,548,727	1,862,404	-1,501,495	360,909	1,584,022	1,944,931	14
15	01500	PHARMACY	2,582,413	11,577,782	14,160,195	-10,831,813	3,328,382		3,328,382	15
16	01600	MEDICAL RECORDS & LIBRARY	4,313,106	2,202,439	6,515,545		6,515,545	-146,595	6,368,950	16
17	01700	SOCIAL SERVICE								17
17.01	01701	RNP SOCIAL SERVICE	168,005	50,331	218,336		218,336		218,336	17.01
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				4,486,163	4,486,163		4,486,163	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	5,654,001	3,297,572	8,951,573	-1,808,208	7,143,365	-1,302,826	5,840,539	22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	18,867,264	6,375,266	25,242,530	-1,471,657	23,770,873	-69	23,770,804	30
31	03100	INTENSIVE CARE UNIT	6,218,482	2,355,932	8,574,414	-717,686	7,856,728	5,366	7,862,094	31
41	04100	SUBPROVIDER - IRF	4,655,959	1,373,051	6,029,010	-184,973	5,844,037	-469,062	5,374,975	41
43	04300	NURSERY	952,920	838,119	1,791,039	-46,363	1,744,676	-560,001	1,184,675	43
44	04400	SKILLED NURSING FACILITY	6,664,154	4,085,216	10,749,370	-112,276	10,637,094		10,637,094	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	4,363,961	16,809,319	21,173,280	-10,991,543	10,181,737		10,181,737	50
51	05100	RECOVERY ROOM	829,397	180,533	1,009,930	-31,032	978,898		978,898	51
52	05200	DELIVERY ROOM & LABOR ROOM	268,105	251,995	520,100	-1,742	518,358	-137,804	380,554	52
53	05300	ANESTHESIOLOGY	130,925	1,228,690	1,359,615	-402,743	956,872	-763,226	193,646	53
54	05400	RADIOLOGY-DIAGNOSTIC	3,969,782	2,504,425	6,474,207	-2,013,133	4,461,074	-6,089	4,454,985	54
55	05500	RADIOLOGY-THERAPEUTIC	1,642,267	1,006,601	2,648,868	231,715	2,880,583		2,880,583	55
56	05600	RADIOISOTOPE	1,115,727	660,409	1,776,136	395,462	2,171,598		2,171,598	56
57	05700	CT SCAN	728,910	385,463	1,114,373	-32,637	1,081,736		1,081,736	57
58	05800	MRI	409,653	664,865	1,074,518	7,922	1,082,440		1,082,440	58
59	05900	CARDIAC CATHETERIZATION	1,590,863	6,133,236	7,724,099	-5,384,717	2,339,382		2,339,382	59
60	06000	LABORATORY	928,376	11,085,330	12,013,706		12,013,706	-806,617	11,207,089	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	353	1,492,404	1,492,757	-734	1,492,023		1,492,023	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	1,391,108	567,013	1,958,121	-207,625	1,750,496	-11,052	1,739,444	65
66	06600	PHYSICAL THERAPY	3,250,706	751,218	4,001,924	-85,682	3,916,242	-60	3,916,182	66
66.01	06601	RNRC PHYSICAL THERAPY	1,175	1,536	2,711	-1,338	1,373		1,373	66.01
66.02	06602	DAY REHABILITATION FACILITY	527,073	125,171	652,244	-1,500	650,744		650,744	66.02
67	06700	OCCUPATIONAL THERAPY	1,678,050	366,976	2,045,026	31,132	2,076,158		2,076,158	67
68	06800	SPEECH PATHOLOGY	957,638	410,515	1,368,153	-201,645	1,166,508		1,166,508	68
69	06900	ELECTROCARDIOLOGY	1,085,691	1,233,143	2,318,834	9,152	2,327,986	-851,781	1,476,205	69
70	07000	ELECTROENCEPHALOGRAPHY	125,690	732,833	858,523	4,330	862,853	-704,458	158,395	70
70.01	07001	ELECTROPHYSIOLOGY								70.01
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		78,877	78,877	11,815,418	11,894,295		11,894,295	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				11,916,452	11,916,452		11,916,452	72
73	07300	DRUGS CHARGED TO PATIENTS				13,304,179	13,304,179		13,304,179	73
74	07400	RENAL DIALYSIS	1,054,284	695,399	1,749,683	-275,536	1,474,147		1,474,147	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	2,045,582	1,123,672	3,169,254	-562,003	2,607,251		2,607,251	90
90.01	09001	WELLNESS PROGRAM	146,336	82,338	228,674	-13,651	215,023	-21,381	193,642	90.01



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
91	09100	EMERGENCY	3,791,358	2,253,363	6,044,721	-733,484	5,311,237	-793,426	4,517,811	91
91.01	04040	FAMILY PRACTICE	2,928,677	1,041,781	3,970,458	-2,746,128	1,224,330	-329,152	895,178	91.01
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	102,107,488	175,693,319	277,800,807	-38,269	277,762,538	-15,789,661	261,972,877	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES								192
193	19300	NONPAID WORKERS		2,293	2,293	38,269	40,562		40,562	193
194	07950	OTHER								194
194.05	07955	NON EMPLOYEE CHILD CARE								194.05
200		TOTAL (sum of lines 118-199)	102,107,488	175,695,612	277,803,100		277,803,100	-15,789,661	262,013,439	200



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	MEDICAL SUPPLY & DRUGS	A	IMPL. DEV. CHARGED TO PATIENT	72		11,916,452	1
2	MEDICAL SUPPLY & DRUGS	A	DRUGS CHARGED TO PATIENTS	73		13,304,179	2
3	MEDICAL SUPPLY & DRUGS	A	MEDICAL SUPPLIES CHARGED TO P	71		11,815,418	3
4	MEDICAL SUPPLY & DRUGS	A					4
5	MEDICAL SUPPLY & DRUGS	A					5
6	MEDICAL SUPPLY & DRUGS	A					6
7	MEDICAL SUPPLY & DRUGS	A					7
8	MEDICAL SUPPLY & DRUGS	A					8
9	MEDICAL SUPPLY & DRUGS	A					9
10	MEDICAL SUPPLY & DRUGS	A					10
11	MEDICAL SUPPLY & DRUGS	A					11
12	MEDICAL SUPPLY & DRUGS	A					12
13	MEDICAL SUPPLY & DRUGS	A					13
14	MEDICAL SUPPLY & DRUGS	A					14
15	MEDICAL SUPPLY & DRUGS	A					15
16	MEDICAL SUPPLY & DRUGS	A					16
17	MEDICAL SUPPLY & DRUGS	A					17
18	MEDICAL SUPPLY & DRUGS	A					18
19	MEDICAL SUPPLY & DRUGS	A					19
20	MEDICAL SUPPLY & DRUGS	A					20
21	MEDICAL SUPPLY & DRUGS	A					21
22	MEDICAL SUPPLY & DRUGS	A					22
23	MEDICAL SUPPLY & DRUGS	A					23
24	MEDICAL SUPPLY & DRUGS	A					24
25	MEDICAL SUPPLY & DRUGS	A					25
26	MEDICAL SUPPLY & DRUGS	A					26
27	MEDICAL SUPPLY & DRUGS	A					27
28	MEDICAL SUPPLY & DRUGS	A					28
29	MEDICAL SUPPLY & DRUGS	A					29
30	MEDICAL SUPPLY & DRUGS	A					30
31	MEDICAL SUPPLY & DRUGS	A					31
32	MEDICAL SUPPLY & DRUGS	A					32
33	MEDICAL SUPPLY & DRUGS	A					33
34	MEDICAL SUPPLY & DRUGS	A					34
35	MEDICAL SUPPLY & DRUGS	A					35
500	TOTAL RECLASSIFICATIONS					37,036,049	500
	CODE LETTER - A						
1	DEFAULT	D	ELECTRICITY	7.01		2,786,866	1
2							2
500	TOTAL RECLASSIFICATIONS					2,786,866	500
	CODE LETTER - D						
1	DIETARY	F	CAFETERIA	11	569,103	631,010	1
2	DIETARY	F	NONPAID WORKERS	193	18,182	20,160	2
500	TOTAL RECLASSIFICATIONS				587,285	651,170	500
	CODE LETTER - F						
1	DEFAULT	G	I&R SERVICES-OTHER PRGM COSTS	22	730,094		1
2	DEFAULT	G	I&R SERVICES-OTHER PRGM COSTS	22	947,180		2
3	DEFAULT	G	I&R SERVICES-OTHER PRGM COSTS	22	53,501		3
500	TOTAL RECLASSIFICATIONS				1,730,775		500
	CODE LETTER - G						
1	NURSE ADMIN	H	SKILLED NURSING FACILITY	44	110,198	64,991	1
500	TOTAL RECLASSIFICATIONS				110,198	64,991	500
	CODE LETTER - H						
1	RADIOLOGY ADMIN	I	RADIOLOGY-THERAPEUTIC	55	196,178	99,048	1
2	RADIOLOGY ADMIN	I	RADIOISOTOPE	56	288,759	145,791	2
3	RADIOLOGY ADMIN	I	CT SCAN	57	128,164	64,708	3
4	RADIOLOGY ADMIN	I	MRI	58	72,029	36,367	4
500	TOTAL RECLASSIFICATIONS				685,130	345,914	500
	CODE LETTER - I						
1	BIO ENGINEERING	J	ELECTRICITY	7.01	44,116	2,917,696	1
500	TOTAL RECLASSIFICATIONS				44,116	2,917,696	500
	CODE LETTER - J						
1	THERAPY SUPV	K	OCCUPATIONAL THERAPY	67	37,972		1
2	THERAPY SUPV	K	SPEECH PATHOLOGY	68	15,792		2
500	TOTAL RECLASSIFICATIONS				53,764		500
	CODE LETTER - K						
1	SHARED SUPV	L	ELECTROCARDIOLOGY	69	33,548		1
2	SHARED SUPV	L	ELECTROENCEPHALOGRAPHY	70	5,464		2



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
500	TOTAL RECLASSIFICATIONS				39,012		500
	CODE LETTER - L						
1	EQUIP DEPREC	M	CAP REL COSTS-MVBLE EQUIP	2		13,242,842	1
500	TOTAL RECLASSIFICATIONS					13,242,842	500
	CODE LETTER - M						
1	SECURITY	N	ADMINISTRATION & GENERAL	5.60	390,284	828,993	1
500	TOTAL RECLASSIFICATIONS				390,284	828,993	500
	CODE LETTER - N						
1	RESIDENT RECLASS	O	I&R SERVICES-SALARY & FRINGES	21	4,486,163		1
2	RESIDENT RECLASS	O					2
500	TOTAL RECLASSIFICATIONS				4,486,163		500
	CODE LETTER - O						
1	PROPERTY INS	P	CAP REL COSTS-BLDG & FIXT	1		11,986	1
2	PROPERTY INS	P	CAP REL COSTS-BLDG & FIXT	1		219,990	2
500	TOTAL RECLASSIFICATIONS					231,976	500
	CODE LETTER - P						
1	CAPITAL INTEREST	S	CAP REL COSTS-BLDG & FIXT	1		3,021,880	1
2	CAPITAL INTEREST	S					2
500	TOTAL RECLASSIFICATIONS					3,021,880	500
	CODE LETTER - S						
	GRAND TOTAL (INCREASES)				8,126,727	61,128,377	

(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.



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	MEDICAL SUPPLY & DRUGS	A	ADMINISTRATION & GENERAL	5.60		1,665,319		1
2	MEDICAL SUPPLY & DRUGS	A	PHARMACY	15		10,831,813		2
3	MEDICAL SUPPLY & DRUGS	A	ADULTS & PEDIATRICS	30		1,471,657		3
4	MEDICAL SUPPLY & DRUGS	A	CENTRAL SERVICES & SUPPLY	14		1,501,495		4
5	MEDICAL SUPPLY & DRUGS	A	INTENSIVE CARE UNIT	31		717,686		5
6	MEDICAL SUPPLY & DRUGS	A	SUBPROVIDER - IRF	41		184,973		6
7	MEDICAL SUPPLY & DRUGS	A	NURSERY	43		46,363		7
8	MEDICAL SUPPLY & DRUGS	A	SKILLED NURSING FACILITY	44		287,465		8
9	MEDICAL SUPPLY & DRUGS	A	OPERATING ROOM	50		10,991,543		9
10	MEDICAL SUPPLY & DRUGS	A	RECOVERY ROOM	51		31,032		10
11	MEDICAL SUPPLY & DRUGS	A	DELIVERY ROOM & LABOR ROOM	52		1,742		11
12	MEDICAL SUPPLY & DRUGS	A	ANESTHESIOLOGY	53		402,743		12
13	MEDICAL SUPPLY & DRUGS	A	RADIOLOGY-DIAGNOSTIC	54		982,089		13
14	MEDICAL SUPPLY & DRUGS	A	RADIOLOGY-THERAPEUTIC	55		63,511		14
15	MEDICAL SUPPLY & DRUGS	A	RADIOISOTOPE	56		39,088		15
16	MEDICAL SUPPLY & DRUGS	A	CT SCAN	57		225,509		16
17	MEDICAL SUPPLY & DRUGS	A	MRI	58		100,474		17
18	MEDICAL SUPPLY & DRUGS	A	CARDIAC CATHETERIZATION	59		5,384,717		18
19	MEDICAL SUPPLY & DRUGS	A						19
20	MEDICAL SUPPLY & DRUGS	A	WHOLE BLOOD & PACKED RED BLOO	62		734		20
21	MEDICAL SUPPLY & DRUGS	A	RESPIRATORY THERAPY	65		168,613		21
22	MEDICAL SUPPLY & DRUGS	A	PHYSICAL THERAPY	66		31,918		22
23	MEDICAL SUPPLY & DRUGS	A	RNRC PHYSICAL THERAPY	66.01		1,338		23
24	MEDICAL SUPPLY & DRUGS	A	DAY REHABILITATION FACILITY	66.02		1,500		24
25	MEDICAL SUPPLY & DRUGS	A	OCCUPATIONAL THERAPY	67		6,840		25
26	MEDICAL SUPPLY & DRUGS	A	SPEECH PATHOLOGY	68		217,437		26
27	MEDICAL SUPPLY & DRUGS	A	ELECTROCARDIOLOGY	69		24,396		27
28	MEDICAL SUPPLY & DRUGS	A	ELECTROENCEPHALOGRAPHY	70		1,134		28
29	MEDICAL SUPPLY & DRUGS	A						29
30	MEDICAL SUPPLY & DRUGS	A	WELLNESS PROGRAM	90.01		13,651		30
31	MEDICAL SUPPLY & DRUGS	A	RENAL DIALYSIS	74		275,536		31
32	MEDICAL SUPPLY & DRUGS	A	CLINIC	90		562,003		32
33	MEDICAL SUPPLY & DRUGS	A	EMERGENCY	91		733,484		33
34	MEDICAL SUPPLY & DRUGS	A	FAMILY PRACTICE	91.01		68,173		34
35	MEDICAL SUPPLY & DRUGS	A	NONPAID WORKERS	193		73		35
500	TOTAL RECLASSIFICATIONS					37,036,049		500
	CODE LETTER - A							
1	DEFAULT	D	RNP OPERATION OF PLANT	7.02		205,544		1
2			OPERATION OF PLANT	7		2,581,322		2
500	TOTAL RECLASSIFICATIONS					2,786,866		500
	CODE LETTER - D							
1	DIETARY	F	DIETARY	10	587,285	651,170		1
2	DIETARY	F						2
500	TOTAL RECLASSIFICATIONS				587,285	651,170		500
	CODE LETTER - F							
1	DEFAULT	G	FAMILY PRACTICE	91.01	1,730,775			1
2	DEFAULT	G						2
3	DEFAULT	G						3
500	TOTAL RECLASSIFICATIONS				1,730,775			500
	CODE LETTER - G							
1	NURSE ADMIN	H	RNP ADMINISTRATION	5.90	110,198	64,991		1
500	TOTAL RECLASSIFICATIONS				110,198	64,991		500
	CODE LETTER - H							
1	RADIOLOGY ADMIN	I	RADIOLOGY-DIAGNOSTIC	54	685,130	345,914		1
2	RADIOLOGY ADMIN	I						2
3	RADIOLOGY ADMIN	I						3
4	RADIOLOGY ADMIN	I						4
500	TOTAL RECLASSIFICATIONS				685,130	345,914		500
	CODE LETTER - I							
1	BIO ENGINEERING	J	OPERATION OF PLANT	7	44,116	2,917,696		1
500	TOTAL RECLASSIFICATIONS				44,116	2,917,696		500
	CODE LETTER - J							
1	THERAPY SUPV	K	PHYSICAL THERAPY	66	53,764			1
2	THERAPY SUPV	K						2
500	TOTAL RECLASSIFICATIONS				53,764			500
	CODE LETTER - K							
1	SHARED SUPV	L	RESPIRATORY THERAPY	65	39,012			1



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
2	SHARED SUPV	L						2
500	TOTAL RECLASSIFICATIONS				39,012			500
	CODE LETTER - L							
1	EQUIP DEPREC	M	CAP REL COSTS-BLDG & FIXT	1		13,242,842	9	1
500	TOTAL RECLASSIFICATIONS					13,242,842		500
	CODE LETTER - M							
1	SECURITY	N	OPERATION OF PLANT	7	390,284	828,993		1
500	TOTAL RECLASSIFICATIONS				390,284	828,993		500
	CODE LETTER - N							
1	RESIDENT RECLASS	O	I&R SERVICES-OTHER PRGM COSTS	22	3,538,983			1
2	RESIDENT RECLASS	O	FAMILY PRACTICE	91.01	947,180			2
500	TOTAL RECLASSIFICATIONS				4,486,163			500
	CODE LETTER - O							
1	PROPERTY INS	P	ADMINISTRATION & GENERAL	5.60		11,986	12	1
2	PROPERTY INS	P	RNP ADMINISTRATION	5.90		219,990	12	2
500	TOTAL RECLASSIFICATIONS					231,976		500
	CODE LETTER - P							
1	CAPITAL INTEREST	S	ADMINISTRATION & GENERAL	5.60		2,823,711	11	1
2	CAPITAL INTEREST	S	RNP ADMINISTRATION	5.90		198,169	11	2
500	TOTAL RECLASSIFICATIONS					3,021,880		500
	CODE LETTER - S							
	GRAND TOTAL (DECREASES)				8,126,727	61,128,377		

(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.



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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 RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	580,293					580,293		1
2	LAND IMPROVEMENTS	306,463	2,247		2,247		308,710		2
3	BUILDINGS AND FIXTURES	13,183,342				2,058,471	11,124,871		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	123,266,131	3,688,264		3,688,264	116,143	126,838,252		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	137,336,229	3,690,511		3,690,511	2,174,614	138,852,126		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	137,336,229	3,690,511		3,690,511	2,174,614	138,852,126		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	13,895,823							13,895,823	1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (sum of lines 1-2)	13,895,823							13,895,823	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	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	12,013,874		12,013,874	0.086523					1
2	CAP REL COSTS-MVBLE EQU	126,838,252		126,838,252	0.913477					2
3	TOTAL (sum of lines 1-2)	138,852,126		138,852,126	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	738,371		3,021,880	231,976				3,992,227	1
2	CAP REL COSTS-MVBLE EQUIP	13,849,421							13,849,421	2
3	TOTAL (sum of lines 1-2)	14,587,792		3,021,880	231,976				17,841,648	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.)



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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. 5
				COST CENTER	LINE#	
		1	2	3	4	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-127,133	ADMINISTRATION & GENERAL	5.60	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	-9,637,812			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-2,211,104			12
13	LAUNDRY AND LINEN SERVICE	B	-35,068	RNP LAUNDRY	8.01	13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,100,834	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33						33
33.01	EMPLOYEE CHILD CARE REVENUE	B	-946,641	EMPLOYEE BENEFITS DEPARTMENT	4	33.01
33.07	NURSING REIMBURSEMENT	A	-493,873	NURSING ADMINISTRATION	13	33.07
33.12	PHASE 3 CARDIAC REVENUE	B	-92,377	ELECTROCARDIOLOGY	69	33.12
33.16	EMPLOYEE FITNESS REVENUE	B	-36,012	EMPLOYEE BENEFITS DEPARTMENT	4	33.16
33.18	PAVILION REVENUE	B	-13,803	CENTRAL SERVICES & SUPPLY	14	33.18
33.19	PAVILION REVENUE	B	-5	RNP ADMINISTRATION	5.90	33.19
33.20	PAVILION REVENUE	A	-3,495	RNP DIETARY	10.01	33.20
33.25	RNRC ADMINISTRATION MISC REV	B	-23,669	RNP ADMINISTRATION	5.90	33.25
33.50	MISC REVENUE	B	-720,086	ADMINISTRATION & GENERAL	5.60	33.50
34						34
35						35
36						36
37						37
38						38
39						39
40	MISC REVENUE	A	-134,610	MEDICAL RECORDS & LIBRARY	16	40
41	MISC REVENUE	A	-11,985	MEDICAL RECORDS & LIBRARY	16	41
42						42
43	MISC REVENUE	A	-1,560	DELIVERY ROOM & LABOR ROOM	52	43
44	MISC REVENUE	A	-6,089	RADIOLOGY-DIAGNOSTIC	54	44
45	MISC REVENUE	A	-60	PHYSICAL THERAPY	66	45
45.01	MISC REVENUE	A	-10,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22	45.01
45.02	MISC REVENUE	A	-69	ADULTS & PEDIATRICS	30	45.02
45.03	MISC REVENUE	A	-161,995	FAMILY PRACTICE	91.01	45.03
46	MISC REVENUE	A	-21,381	WELLNESS PROGRAM	90.01	46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-15,789,661			50



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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		LINE#	WKST A-7 REF.
		1	2	3		4	5

- (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.



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
1	2	3	4	5	6	7	
1	4	EMPLOYEE BENEFITS DEPARTMENT	HO BENEFITS	865,109	865,109	1	
2	5.20	DATA PROCESSING	HO DATA PROCESSING	3,678,119	3,678,119	2	
3	5.50	CASHIERS AR AND COLLECTIONS	HO PT ACCTS	5,286,239	5,286,239	3	
3.01	5.60	ADMINISTRATION & GENERAL	HO A & G	14,300,423	26,840,434	-12,540,011	3.01
3.02	1	CAP REL COSTS-BLDG & FIXT	HO BUILDING DEPR	85,390	85,390	9	3.02
3.03	2	CAP REL COSTS-MVBLE EQUIP	HO EQUIP DEPR	606,579	606,579	9	3.03
3.05	14	CENTRAL SERVICES & SUPPLY	HO CENT SUPPLY	1,597,825	1,597,825		3.05
3.06	31	INTENSIVE CARE UNIT	HO ICU	150,166	150,166		3.06
3.07	5.90	RNP ADMINISTRATION			1,940,520	-1,940,520	3.07
4							4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			26,569,850	28,780,954	-2,211,104	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	RMC	100.00	RMC	100.00	HEALTH CARE	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:



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5.60	ADMINISTRATION & GEN ADMINISTRATION	1,881,552	1,881,552						1
2	30	ADULTS & PEDIATRICS ADULTS & PEDIAT								2
3	31	INTENSIVE CARE UNIT INTENSIVE CARE	144,800	144,800						3
4	41	SUBPROVIDER - IRF SUBPROVIDER - I	560,001	469,062	90,939	177,700	2,080	177,700	8,885	4
5	43	NURSERY NURSERY	560,001	560,001						5
6	50	OPERATING ROOM OPERATING ROOM								6
7	52	DELIVERY ROOM & LABO DELIVERY ROOM &	136,244	136,244						7
8	53	ANESTHESIOLOGY ANESTHESIOLOGY	763,226	763,226						8
9	60	LABORATORY LABORATORY	928,376	727,636	200,740	192,300	1,317	121,759	6,088	9
10	65	RESPIRATORY THERAPY RESPIRATORY THE	11,052	11,052						10
11	69	ELECTROCARDIOLOGY ELECTROCARDIOLO	759,404	759,404						11
12	70	ELECTROENCEPHALOGRAP ELECTROENCEPHAL	704,458	704,458						12
13	70.01	ELECTROPHYSIOLOGY ELECTROPHYSIOLO								13
14	74	RENAL DIALYSIS RENAL DIALYSIS								14
15	91	EMERGENCY EMERGENCY	793,426	793,426						15
16	91.01	FAMILY PRACTICE FAMILY PRACTICE	1,199,907	48,487	1,151,420	162,000	13,260	1,032,750	51,638	16
17	22	I&R SERVICES-OTHER P I&R SRVCES-OTHE	1,926,339	1,039,914	886,425	162,000	8,134	633,513	31,676	17
18	4	EMPLOYEE BENEFITS DE EMPLOYEE BENEFI	1,147,987	1,147,987						18
200		TOTAL	11,516,773	9,187,249	2,329,524		24,791	1,965,722	98,287	200



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	5.60	ADMINISTRATION & GEN ADMINISTRATION							1,881,552	1
2	30	ADULTS & PEDIATRICS ADULTS & PEDIAT								2
3	31	INTENSIVE CARE UNIT INTENSIVE CARE							144,800	3
4	41	SUBPROVIDER - IRF SUBPROVIDER - I					177,700		469,062	4
5	43	NURSERY NURSERY							560,001	5
6	50	OPERATING ROOM OPERATING ROOM								6
7	52	DELIVERY ROOM & LABO DELIVERY ROOM &							136,244	7
8	53	ANESTHESIOLOGY ANESTHESIOLOGY							763,226	8
9	60	LABORATORY LABORATORY					121,759	78,981	806,617	9
10	65	RESPIRATORY THERAPY RESPIRATORY THE							11,052	10
11	69	ELECTROCARDIOLOGY ELECTROCARDIOLO							759,404	11
12	70	ELECTROENCEPHALOGRAP ELECTROENCEPHAL							704,458	12
13	70.01	ELECTROPHYSIOLOGY ELECTROPHYSIOLO								13
14	74	RENAL DIALYSIS RENAL DIALYSIS								14
15	91	EMERGENCY EMERGENCY							793,426	15
16	91.01	FAMILY PRACTICE FAMILY PRACTICE					1,032,750	118,670	167,157	16
17	22	I&R SERVICES-OTHER P I&R SRVCES-OTHE					633,513	252,912	1,292,826	17
18	4	EMPLOYEE BENEFITS DE EMPLOYEE BENEFI							1,147,987	18
200		TOTAL					1,965,722	450,563	9,637,812	200



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

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

PART I - GENERAL INFORMATION

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

PART II - SALARY EQUIVALENCY COMPUTATION

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



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater 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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater 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



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater 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



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART I - GENERAL INFORMATION

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

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)						15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						20
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.							
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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater 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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NON PATIEN T PHONES	DATA PROCE SSING	
		0	1	2	4	5.10	5.20	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	3,992,227	3,992,227					1
2	CAP REL COSTS-MVBLE EQUIP	13,849,421		13,849,421				2
4	EMPLOYEE BENEFITS DEPARTMENT	-101,134	67,863	4,944	-28,327			4
5.10	NON PATIENT PHONES	372,993	21,874	830		395,697		5.10
5.20	DATA PROCESSING	3,678,119					3,678,119	5.20
5.30	PURCHASING AND STORES					10,438	130,758	5.30
5.50	CASHIERS AR AND COLLECTIONS	5,286,239		7,826		18,029	137,521	5.50
5.60	ADMINISTRATION & GENERAL	44,642,899	255,026	236,403		73,066	483,578	5.60
5.90	RNP ADMINISTRATION	-823,975		68,697		949	81,723	5.90
6	MAINTENANCE & REPAIRS	1,654,630	28,615	205,043		9,489		6
7	OPERATION OF PLANT	2,798,773	809,398	307,286		6,642	20,290	7
7.01	ELECTRICITY	5,748,678				7,591		7.01
7.02	RNP OPERATION OF PLANT	614,882		247,647				7.02
8	LAUNDRY & LINEN SERVICE	1,545,543	49,745			949		8
8.01	RNP LAUNDRY	281,441		58,764				8.01
9	HOUSEKEEPING	3,334,857	33,923	30,217		949		9
9.01	RNP HOSUEKEEPING	579,607						9.01
10	DIETARY	3,203,116	100,939	85,214		6,642	11,272	10
10.01	RNP DIETARY	1,679,296		18,271				10.01
11	CAFETERIA	99,279	37,250			5,693	9,581	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,086,408	17,369	76,419		18,029	82,287	13
14	CENTRAL SERVICES & SUPPLY	1,944,931	60,137	382,592		949	17,472	14
15	PHARMACY	3,328,382	47,818	153,931		8,540	212,481	15
16	MEDICAL RECORDS & LIBRARY	6,368,950	58,270	36,577		26,570	405,799	16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE	218,336		1,148				17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	4,486,163		174				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	5,840,539	29,969	17,138		10,438	6,763	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	23,770,804	813,137	4,032,082		37,008	187,682	30
31	INTENSIVE CARE UNIT	7,862,094	140,958	129,985		1,898	48,471	31
41	SUBPROVIDER - IRF	5,374,975	109,954	75,356		2,847	20,854	41
43	NURSERY	1,184,675	4,714	25,327		1,898	20,854	43
44	SKILLED NURSING FACILITY	10,637,094						44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,181,737	129,063	1,811,571		4,745	41,144	50
51	RECOVERY ROOM	978,898	10,172	1,029		949	13,527	51
52	DELIVERY ROOM & LABOR ROOM	380,554	123,567	177,007		949	27,053	52
53	ANESTHESIOLOGY	193,646	11,939	314,352		1,898		53
54	RADIOLOGY-DIAGNOSTIC	4,454,985	180,626	778,640		19,927	481,323	54
55	RADIOLOGY-THERAPEUTIC	2,880,583	74,461	951,881		11,387	27,053	55
56	RADIOISOTOPE	2,171,598	32,580	199,000		3,796	61,997	56
57	CT SCAN	1,081,736	14,544	23,280				57
58	MRI	1,082,440	27,744	869,688				58
59	CARDIAC CATHETERIZATION	2,339,382	50,896	826,293		949		59
60	LABORATORY	11,207,089	76,184	215,195		22,774	659,985	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,492,023	2,913	239		949	96,377	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,739,444	17,154	115,620		4,745	20,854	65
66	PHYSICAL THERAPY	3,916,182	41,077	24,492		10,438	32,126	66
66.01	RNRC PHYSICAL THERAPY	1,373						66.01
66.02	DAY REHABILITATION FACILITY	650,744	29,909	38,416				66.02
67	OCCUPATIONAL THERAPY	2,076,158	34,232	2,395		6,642	54,670	67
68	SPEECH PATHOLOGY	1,166,508	9,367	13,839		949		68
69	ELECTROCARDIOLOGY	1,476,205	99,617	227,190		8,540	13,527	69
70	ELECTROENCEPHALOGRAPHY	158,395	7,919	448,809		949	13,527	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,894,295		29,233				71
72	IMPL. DEV. CHARGED TO PATIENTS	11,916,452						72
73	DRUGS CHARGED TO PATIENTS	13,304,179	7,936					73
74	RENAL DIALYSIS	1,474,147	20,679	50,883		1,898	56,361	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,607,251	117,862	211,557		11,387	89,614	90
90.01	WELLNESS PROGRAM	193,642	11,972	1,913		949		90.01
91	EMERGENCY	4,517,811	94,187	294,297		11,387	55,234	91
91.01	FAMILY PRACTICE	895,178	48,346	18,992		19,927	56,361	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NON PATIEN T PHONES	DATA PROCE SSING	
		0	1	2	4	5.10	5.20	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	261,972,877	3,961,905	13,847,682		394,748	3,678,119	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					949		190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS	40,562	30,322	1,739				193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER				-28,327			201
202	TOTAL (sum of lines 118-201)	262,013,439	3,992,227	13,849,421	-28,327	395,697	3,678,119	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING AND STORES 5.30	CASHIERS AR AND COLLECTIONS 5.50	SUBTOTAL (cols.0-4) 4A	ADMINISTRATION & GENERAL 5.60	RNP ADMINISTRATION 5.90	MAINTENANCE & REPAIRS 6	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES	141,196						5.30
5.50	CASHIERS AR AND COLLECTIONS		5,449,615					5.50
5.60	ADMINISTRATION & GENERAL	9,037		45,700,009	45,700,009			5.60
5.90	RNP ADMINISTRATION	3,073		-669,533		-669,533		5.90
6	MAINTENANCE & REPAIRS	948		1,898,725	399,849		2,298,574	6
7	OPERATION OF PLANT	13,822		3,956,211	833,131		1,557,470	7
7.01	ELECTRICITY			5,756,269	1,212,201			7.01
7.02	RNP OPERATION OF PLANT	967		863,496	181,842		101,235	7.02
8	LAUNDRY & LINEN SERVICE	2,364		1,598,601	336,646			8
8.01	RNP LAUNDRY	126		340,331	71,670		8,705	8.01
9	HOUSEKEEPING	2,054		3,402,000	716,420		18,054	9
9.01	RNP HOUSEKEEPING	115		579,722	122,082		4,766	9.01
10	DIETARY	2,779		3,409,962	718,097		91,892	10
10.01	RNP DIETARY	1,391		1,698,958	357,780		13,928	10.01
11	CAFETERIA			151,803	31,968			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	76		2,280,588	480,264		1,920	13
14	CENTRAL SERVICES & SUPPLY	3,411		2,409,492	507,410		81	14
15	PHARMACY	331		3,751,483	790,017		1,199	15
16	MEDICAL RECORDS & LIBRARY	1,178		6,897,344	1,452,498		1,869	16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE			219,484	46,221			17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			4,486,337	944,769			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	354		5,905,201	1,243,564		157	22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	768	681,307	29,522,788	6,217,179		1,989	30
31	INTENSIVE CARE UNIT	327	151,962	8,335,695	1,755,397			31
41	SUBPROVIDER - IRF	215	128,981	5,713,182	1,203,128		2,555	41
43	NURSERY	231	30,623	1,268,322	267,093			43
44	SKILLED NURSING FACILITY	1,755	100,895	10,739,744	2,261,661		744	44
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	8,595	389,144	12,565,999	2,646,249		394,091	50
51	RECOVERY ROOM	8	78,911	1,083,494	228,171			51
52	DELIVERY ROOM & LABOR ROOM	113	957	710,200	149,560		7,365	52
53	ANESTHESIOLOGY	46	115,348	637,229	134,193			53
54	RADIOLOGY-DIAGNOSTIC	857	222,752	6,139,110	1,292,823		897	54
55	RADIOLOGY-THERAPEUTIC	640	91,454	4,037,459	850,240		402	55
56	RADIOISOTOPE	862	130,910	2,600,743	547,685		6,233	56
57	CT SCAN	15	227,102	1,346,677	283,594		169	57
58	MRI	898	90,932	2,071,702	436,276		169	58
59	CARDIAC CATHETERIZATION	60	294,841	3,512,421	739,674			59
60	LABORATORY	19,224	599,816	12,800,267	2,695,583		38,886	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,946	39,584	1,635,031	344,318			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	235	92,309	1,990,361	419,146		157	65
66	PHYSICAL THERAPY	65	99,208	4,123,588	868,378		892	66
66.01	RNRC PHYSICAL THERAPY	21	30,819	32,213	6,784			66.01
66.02	DAY REHABILITATION FACILITY	29	12,848	731,946	154,139		5,787	66.02
67	OCCUPATIONAL THERAPY	8	51,143	2,225,248	468,611		892	67
68	SPEECH PATHOLOGY	8	24,873	1,215,544	255,979		760	68
69	ELECTROCARDIOLOGY	756	154,498	1,980,333	417,034		12,184	69
70	ELECTROENCEPHALOGRAPHY	87	5,065	634,751	133,671		922	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,119	241,045	12,182,692	2,565,529			71
72	IMPL. DEV. CHARGED TO PATIENTS	19,145	187,101	12,122,698	2,552,895			72
73	DRUGS CHARGED TO PATIENTS	21,482	676,778	14,010,375	2,950,417			73
74	RENAL DIALYSIS	255	45,430	1,649,653	347,397		4,144	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	234	102,014	3,139,919	661,229		15,107	90
90.01	WELLNESS PROGRAM	96	425	208,997	44,012			90.01
91	EMERGENCY	639	350,540	5,324,095	1,121,191			91
91.01	FAMILY PRACTICE	430		1,039,234	218,850		2,953	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING AND STORE S	CASHIERS A R AND COLL ECTIONS	SUBTOTAL (cols.0-4) 4A	ADMINISTRA TION & GEN ERAL	RNP ADMINI STRATION	MAIN- TENANCE & REPAIRS	
		5.30	5.50		5.60	5.90	6	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	141,195	5,449,615	261,968,193	45,684,515		2,298,574	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			949	200			190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS	1		72,624	15,294			193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER			-28,327		-669,533		201
202	TOTAL (sum of lines 118-201)	141,196	5,449,615	262,013,439	45,700,009	-669,533	2,298,574	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	ELECTRICIT Y	RNP OPERAT ION OF PLA NT	LAUNDRY & LINEN SERVICE	RNP LAUNDR Y	HOUSE- KEEPING	
		7	7.01	7.02	8	8.01	9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	6,346,812						7
7.01	ELECTRICITY		6,968,470					7.01
7.02	RNP OPERATION OF PLANT			1,146,573				7.02
8	LAUNDRY & LINEN SERVICE	112,379	123,386	20,302	2,191,314			8
8.01	RNP LAUNDRY					420,706		8.01
9	HOUSEKEEPING	76,636	84,142	13,845			4,311,097	9
9.01	RNP HOUSEKEEPING							9.01
10	DIETARY	228,030	250,365	41,194			113,317	10
10.01	RNP DIETARY							10.01
11	CAFETERIA	84,150	92,393	15,202			28,329	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	39,239	43,082	7,089			15,682	13
14	CENTRAL SERVICES & SUPPLY	135,855	149,162	24,543	307		14,165	14
15	PHARMACY	108,025	118,605	19,515	341		33,388	15
16	MEDICAL RECORDS & LIBRARY	131,637	144,531	23,781			21,247	16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				21,411			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	67,704	74,335	12,231			5,059	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,836,952	2,016,878	331,850	870,953		1,454,230	30
31	INTENSIVE CARE UNIT	318,438	349,628	57,527	135,211		230,681	31
41	SUBPROVIDER - IRF	248,395	272,725	44,873	180,042		254,963	41
43	NURSERY	10,649	11,693	1,924			34,906	43
44	SKILLED NURSING FACILITY					420,706		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	291,565	320,124	52,672	259,082		532,184	50
51	RECOVERY ROOM	22,978	25,229	4,151	53,191		10,118	51
52	DELIVERY ROOM & LABOR ROOM	279,149	306,492	50,429	58,130		140,971	52
53	ANESTHESIOLOGY	26,972	29,614	4,873			10,118	53
54	RADIOLOGY-DIAGNOSTIC	408,050	448,018	73,716	89,132		99,152	54
55	RADIOLOGY-THERAPEUTIC	168,214	184,690	30,388	25,699		63,741	55
56	RADIOISOTOPE	73,601	80,810	13,296			20,235	56
57	CT SCAN	32,856	36,075	5,936				57
58	MRI	62,677	68,817	11,323				58
59	CARDIAC CATHETERIZATION	114,979	126,241	20,771	23,054			59
60	LABORATORY	172,108	188,965	31,092			115,678	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,581	7,226	1,189			7,082	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	38,753	42,549	7,001			19,223	65
66	PHYSICAL THERAPY	92,797	101,886	16,764	47,504		30,353	66
66.01	RNRC PHYSICAL THERAPY							66.01
66.02	DAY REHABILITATION FACILITY	67,567	74,185	12,206				66.02
67	OCCUPATIONAL THERAPY	77,333	84,907	13,970			40,470	67
68	SPEECH PATHOLOGY	21,162	23,235	3,823				68
69	ELECTROCARDIOLOGY	225,044	247,086	40,655	34,185		25,294	69
70	ELECTROENCEPHALOGRAPHY	17,890	19,642	3,232			6,071	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS	17,927	19,683	3,239			5,059	73
74	RENAL DIALYSIS	46,716	51,291	8,439	24,642			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	266,261	292,340	48,101	52,335		204,712	90
90.01	WELLNESS PROGRAM	27,047	29,696	4,886	634			90.01
91	EMERGENCY	212,777	233,618	38,439	313,339		256,312	91
91.01	FAMILY PRACTICE	109,219	119,917	19,731	2,122		48,564	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	ELECTRICITY	RNP OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	RNP LAUNDRY	HOUSE-KEEPING	
		7	7.01	7.02	8	8.01	9	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	6,278,312	6,893,261	1,134,198	2,191,314	420,706	3,841,304	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						3,541	190
192	PHYSICIANS' PRIVATE OFFICES						383,220	192
193	NONPAID WORKERS	68,500	75,209	12,375			80,941	193
194	OTHER						2,091	194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	6,346,812	6,968,470	1,146,573	2,191,314	420,706	4,311,097	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	RNP HOSUEK EEPING	DIETARY	RNP DIETAR Y	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		9.01	10	10.01	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
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	ELECTRICITY							7.01
7.02	RNP OPERATION OF PLANT							7.02
8	LAUNDRY & LINEN SERVICE							8
8.01	RNP LAUNDRY							8.01
9	HOUSEKEEPING							9
9.01	RNP HOSUEKEEPING	706,570						9.01
10	DIETARY	290,311	5,143,168					10
10.01	RNP DIETARY			2,070,666				10.01
11	CAFETERIA				403,845			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION				10,542	2,878,406		13
14	CENTRAL SERVICES & SUPPLY				2,795		3,243,810	14
15	PHARMACY				9,902			15
16	MEDICAL RECORDS & LIBRARY				23,142			16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE	27,316			1,119			17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				23,077			22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		1,525,390	614,130	85,408	76,040		30
31	INTENSIVE CARE UNIT		304,650	122,654	22,010	482,206		31
41	SUBPROVIDER - IRF		513,202	206,618	21,039	474,789		41
43	NURSERY		116,560	46,928	3,209			43
44	SKILLED NURSING FACILITY		2,683,366	1,080,336	40,930			44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM				19,928	395,039		50
51	RECOVERY ROOM				2,950	463,661		51
52	DELIVERY ROOM & LABOR ROOM				5,115	480,353		52
53	ANESTHESIOLOGY				914			53
54	RADIOLOGY-DIAGNOSTIC				23,175			54
55	RADIOLOGY-THERAPEUTIC				6,489			55
56	RADIOISOTOPE				4,444			56
57	CT SCAN				3,281			57
58	MRI				2,048			58
59	CARDIAC CATHETERIZATION				5,448			59
60	LABORATORY				2,074			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY				6,735			65
66	PHYSICAL THERAPY				13,251			66
66.01	RNRC PHYSICAL THERAPY	329,193			2,246			66.01
66.02	DAY REHABILITATION FACILITY				2,860			66.02
67	OCCUPATIONAL THERAPY				7,235			67
68	SPEECH PATHOLOGY				4,095			68
69	ELECTROCARDIOLOGY				5,131			69
70	ELECTROENCEPHALOGRAPHY				755			70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,750					1,577,249	71
72	IMPL. DEV. CHARGED TO PATIENTS						1,666,561	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS				4,126	31,529		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC				8,242			90
90.01	WELLNESS PROGRAM				479			90.01
91	EMERGENCY				16,893	474,789		91
91.01	FAMILY PRACTICE				12,758			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	RNP HOSUEK EEPING	DIETARY	RNP DIETAR Y	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		9.01	10	10.01	11	13	14	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	706,570	5,143,168	2,070,666	403,845	2,878,406	3,243,810	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	706,570	5,143,168	2,070,666	403,845	2,878,406	3,243,810	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	RNP SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		15	16	17.01	21	22	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	ELECTRICITY							7.01
7.02	RNP OPERATION OF PLANT							7.02
8	LAUNDRY & LINEN SERVICE							8
8.01	RNP LAUNDRY							8.01
9	HOUSEKEEPING							9
9.01	RNP HOSUEKEEPING							9.01
10	DIETARY							10
10.01	RNP DIETARY							10.01
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	4,832,475						15
16	MEDICAL RECORDS & LIBRARY		8,696,049					16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE			294,140				17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				5,452,517			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					7,331,328		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		593,983		3,037,283	4,083,860	52,268,913	30
31	INTENSIVE CARE UNIT		38,337		387,820	521,454	13,061,708	31
41	SUBPROVIDER - IRF		48,323				9,183,834	41
43	NURSERY		274,584		38,398	51,629	2,125,895	43
44	SKILLED NURSING FACILITY			294,140			17,521,627	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		56,917		337,902	454,336	18,326,088	50
51	RECOVERY ROOM		26,250				1,920,193	51
52	DELIVERY ROOM & LABOR ROOM		9,659		76,796	103,258	2,377,477	52
53	ANESTHESIOLOGY		46,462				890,375	53
54	RADIOLOGY-DIAGNOSTIC		2,164,868		38,398	51,629	10,828,968	54
55	RADIOLOGY-THERAPEUTIC		341,046				5,708,368	55
56	RADIOISOTOPE		1,019,885				4,366,932	56
57	CT SCAN						1,708,588	57
58	MRI						2,653,012	58
59	CARDIAC CATHETERIZATION						4,542,588	59
60	LABORATORY		499,552		76,796	103,258	16,724,259	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		65,439				2,066,866	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		265,735		191,990	258,145	3,239,795	65
66	PHYSICAL THERAPY		132,953				5,428,366	66
66.01	RNRC PHYSICAL THERAPY		91,604				462,040	66.01
66.02	DAY REHABILITATION FACILITY						1,048,690	66.02
67	OCCUPATIONAL THERAPY						2,918,666	67
68	SPEECH PATHOLOGY						1,524,598	68
69	ELECTROCARDIOLOGY		1,234,726		191,990	258,145	4,671,807	69
70	ELECTROENCEPHALOGRAPHY		368,006		38,398	51,629	1,274,967	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		517,805				16,903,025	71
72	IMPL. DEV. CHARGED TO PATIENTS						16,342,154	72
73	DRUGS CHARGED TO PATIENTS	4,832,475	136,333				21,975,508	73
74	RENAL DIALYSIS						2,167,937	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		492,251		76,796	103,258	5,360,551	90
90.01	WELLNESS PROGRAM				76,796	103,258	495,805	90.01
91	EMERGENCY		271,331		575,970	774,436	9,613,190	91
91.01	FAMILY PRACTICE				307,184	413,033	2,293,565	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	RNP SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
		15	16	17.01	21	22	24	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,832,475	8,696,049	294,140	5,452,517	7,331,328	261,996,355	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						4,690	190
192	PHYSICIANS' PRIVATE OFFICES						383,220	192
193	NONPAID WORKERS						324,943	193
194	OTHER						2,091	194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER						-697,860	201
202	TOTAL (sum of lines 118-201)	4,832,475	8,696,049	294,140	5,452,517	7,331,328	262,013,439	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.10	NON PATIENT PHONES						5.10
5.20	DATA PROCESSING						5.20
5.30	PURCHASING AND STORES						5.30
5.50	CASHIERS AR AND COLLECTIONS						5.50
5.60	ADMINISTRATION & GENERAL						5.60
5.90	RNP ADMINISTRATION						5.90
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
7.01	ELECTRICITY						7.01
7.02	RNP OPERATION OF PLANT						7.02
8	LAUNDRY & LINEN SERVICE						8
8.01	RNP LAUNDRY						8.01
9	HOUSEKEEPING						9
9.01	RNP HOSUEKEEPING						9.01
10	DIETARY						10
10.01	RNP DIETARY						10.01
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
17.01	RNP SOCIAL SERVICE						17.01
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	-7,121,143	45,147,770				30
31	INTENSIVE CARE UNIT	-909,274	12,152,434				31
41	SUBPROVIDER - IRF		9,183,834				41
43	NURSERY	-90,027	2,035,868				43
44	SKILLED NURSING FACILITY		17,521,627				44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	-792,238	17,533,850				50
51	RECOVERY ROOM		1,920,193				51
52	DELIVERY ROOM & LABOR ROOM	-180,054	2,197,423				52
53	ANESTHESIOLOGY		890,375				53
54	RADIOLOGY-DIAGNOSTIC	-90,027	10,738,941				54
55	RADIOLOGY-THERAPEUTIC		5,708,368				55
56	RADIOISOTOPE		4,366,932				56
57	CT SCAN		1,708,588				57
58	MRI		2,653,012				58
59	CARDIAC CATHETERIZATION		4,542,588				59
60	LABORATORY	-180,054	16,544,205				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		2,066,866				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	-450,135	2,789,660				65
66	PHYSICAL THERAPY		5,428,366				66
66.01	RNRC PHYSICAL THERAPY		462,040				66.01
66.02	DAY REHABILITATION FACILITY		1,048,690				66.02
67	OCCUPATIONAL THERAPY		2,918,666				67
68	SPEECH PATHOLOGY		1,524,598				68
69	ELECTROCARDIOLOGY	-450,135	4,221,672				69
70	ELECTROENCEPHALOGRAPHY	-90,027	1,184,940				70
70.01	ELECTROPHYSIOLOGY						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		16,903,025				71
72	IMPL. DEV. CHARGED TO PATIENTS		16,342,154				72
73	DRUGS CHARGED TO PATIENTS		21,975,508				73
74	RENAL DIALYSIS		2,167,937				74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	-180,054	5,180,497				90
90.01	WELLNESS PROGRAM	-180,054	315,751				90.01
91	EMERGENCY	-1,350,406	8,262,784				91
91.01	FAMILY PRACTICE	-720,217	1,573,348				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)						92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	-12,783,845	249,212,510				118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		4,690				190
192	PHYSICIANS' PRIVATE OFFICES		383,220				192
193	NONPAID WORKERS		324,943				193
194	OTHER		2,091				194
194.05	NON EMPLOYEE CHILD CARE						194.05
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER		-697,860				201
202	TOTAL (sum of lines 118-201)	-12,783,845	249,229,594				202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON PATIEN T PHONES	
		0	1	2	2A	4	5.10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT	38,398	67,863	4,944	111,205	111,205		4
5.10	NON PATIENT PHONES	17,021	21,874	830	39,725		39,725	5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES						1,048	5.30
5.50	CASHIERS AR AND COLLECTIONS			7,826	7,826		1,810	5.50
5.60	ADMINISTRATION & GENERAL	2,921,017	255,026	236,403	3,412,446		7,337	5.60
5.90	RNP ADMINISTRATION	11,254		68,697	79,951		95	5.90
6	MAINTENANCE & REPAIRS	528	28,615	205,043	234,186		953	6
7	OPERATION OF PLANT	5,070	809,398	307,286	1,121,754		667	7
7.01	ELECTRICITY						762	7.01
7.02	RNP OPERATION OF PLANT			247,647	247,647			7.02
8	LAUNDRY & LINEN SERVICE	149	49,745		49,894		95	8
8.01	RNP LAUNDRY			58,764	58,764			8.01
9	HOUSEKEEPING	2,106	33,923	30,217	66,246		95	9
9.01	RNP HOSUEKEEPING							9.01
10	DIETARY	5,940	100,939	85,214	192,093		667	10
10.01	RNP DIETARY	8,114		18,271	26,385			10.01
11	CAFETERIA		37,250		37,250		572	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	4,346	17,369	76,419	98,134		1,810	13
14	CENTRAL SERVICES & SUPPLY	156,630	60,137	382,592	599,359		95	14
15	PHARMACY	3,131	47,818	153,931	204,880		857	15
16	MEDICAL RECORDS & LIBRARY	19,328	58,270	36,577	114,175		2,667	16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE			1,148	1,148			17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			174	174			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,481	29,969	17,138	51,588		1,048	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,685	813,137	4,032,082	4,851,904		3,715	30
31	INTENSIVE CARE UNIT	2,154	140,958	129,985	273,097		191	31
41	SUBPROVIDER - IRF	49,605	109,954	75,356	234,915		286	41
43	NURSERY	-648	4,714	25,327	29,393		191	43
44	SKILLED NURSING FACILITY							44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	54,669	129,063	1,811,571	1,995,303		476	50
51	RECOVERY ROOM	441	10,172	1,029	11,642		95	51
52	DELIVERY ROOM & LABOR ROOM	20,792	123,567	177,007	321,366		95	52
53	ANESTHESIOLOGY	706	11,939	314,352	326,997		191	53
54	RADIOLOGY-DIAGNOSTIC	90,152	180,626	778,640	1,049,418		2,001	54
55	RADIOLOGY-THERAPEUTIC	41,624	74,461	951,881	1,067,966		1,143	55
56	RADIOISOTOPE	1,191	32,580	199,000	232,771		381	56
57	CT SCAN		14,544	23,280	37,824			57
58	MRI	11,721	27,744	869,688	909,153			58
59	CARDIAC CATHETERIZATION	1,908	50,896	826,293	879,097		95	59
60	LABORATORY	2,452	76,184	215,195	293,831		2,286	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		2,913	239	3,152		95	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,590	17,154	115,620	137,364		476	65
66	PHYSICAL THERAPY	3,373	41,077	24,492	68,942		1,048	66
66.01	RNRC PHYSICAL THERAPY							66.01
66.02	DAY REHABILITATION FACILITY		29,909	38,416	68,325			66.02
67	OCCUPATIONAL THERAPY		34,232	2,395	36,627		667	67
68	SPEECH PATHOLOGY		9,367	13,839	23,206		95	68
69	ELECTROCARDIOLOGY	48,426	99,617	227,190	375,233		857	69
70	ELECTROENCEPHALOGRAPHY		7,919	448,809	456,728		95	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			29,233	29,233			71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS		7,936		7,936			73
74	RENAL DIALYSIS	1,350	20,679	50,883	72,912		191	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	3,473	117,862	211,557	332,892		1,143	90
90.01	WELLNESS PROGRAM		11,972	1,913	13,885		95	90.01
91	EMERGENCY	2,898	94,187	294,297	391,382		1,143	91
91.01	FAMILY PRACTICE	59,631	48,346	18,992	126,969		2,001	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON PATIEN T PHONES	
		0	1	2	2A	4	5.10	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,604,706	3,961,905	13,847,682	21,414,293		39,630	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						95	190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS	425	30,322	1,739	32,486			193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER					111,205		201
202	TOTAL (sum of lines 118-201)	3,605,131	3,992,227	13,849,421	21,446,779	111,205	39,725	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PURCHASING AND STORES	CASHIERS A R AND COLL ECTIONS	ADMINISTRA TION & GEN ERAL	RNP ADMINI STRATION	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		5.30	5.50	5.60	5.90	6	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES	1,048						5.30
5.50	CASHIERS AR AND COLLECTIONS		9,636					5.50
5.60	ADMINISTRATION & GENERAL	67		3,419,850				5.60
5.90	RNP ADMINISTRATION	23			80,069			5.90
6	MAINTENANCE & REPAIRS	7		29,922		265,068		6
7	OPERATION OF PLANT	103		62,346		179,605	1,364,475	7
7.01	ELECTRICITY			90,713				7.01
7.02	RNP OPERATION OF PLANT	7		13,608		11,674		7.02
8	LAUNDRY & LINEN SERVICE	18		25,192			24,160	8
8.01	RNP LAUNDRY	1		5,363		1,004		8.01
9	HOUSEKEEPING	15		53,612		2,082	16,476	9
9.01	RNP HOUSEKEEPING	1		9,136		550		9.01
10	DIETARY	21		53,738		10,597	49,023	10
10.01	RNP DIETARY	10		26,774		1,606		10.01
11	CAFETERIA			2,392			18,091	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1		35,940		221	8,436	13
14	CENTRAL SERVICES & SUPPLY	25		37,971		9	29,207	14
15	PHARMACY	2		59,120		138	23,224	15
16	MEDICAL RECORDS & LIBRARY	9		108,695		216	28,300	16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE			3,459				17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			70,700				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	3		93,060		18	14,555	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6	1,478	465,220		229	394,918	30
31	INTENSIVE CARE UNIT	2	260	131,362			68,460	31
41	SUBPROVIDER - IRF	2	221	90,034		295	53,402	41
43	NURSERY	2	52	19,987			2,289	43
44	SKILLED NURSING FACILITY	13	173	169,248		86		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	64	666	198,028		45,446	62,682	50
51	RECOVERY ROOM		135	17,075			4,940	51
52	DELIVERY ROOM & LABOR ROOM	1	2	11,192		849	60,013	52
53	ANESTHESIOLOGY		197	10,042			5,799	53
54	RADIOLOGY-DIAGNOSTIC	6	381	96,746		103	87,725	54
55	RADIOLOGY-THERAPEUTIC	5	156	63,626		46	36,164	55
56	RADIOISOTOPE	6	224	40,985		719	15,823	56
57	CT SCAN		388	21,222		20	7,064	57
58	MRI	7	156	32,648		20	13,475	58
59	CARDIAC CATHETERIZATION		504	55,352			24,719	59
60	LABORATORY	143	1,026	201,719		4,484	37,001	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	22	68	25,766			1,415	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2	158	31,366		18	8,331	65
66	PHYSICAL THERAPY		170	64,984		103	19,950	66
66.01	RNRC PHYSICAL THERAPY		53	508				66.01
66.02	DAY REHABILITATION FACILITY		22	11,535		667	14,526	66.02
67	OCCUPATIONAL THERAPY		87	35,068		103	16,625	67
68	SPEECH PATHOLOGY		43	19,156		88	4,550	68
69	ELECTROCARDIOLOGY	6	264	31,208		1,405	48,381	69
70	ELECTROENCEPHALOGRAPHY	1	9	10,003		106	3,846	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	135	412	191,987				71
72	IMPL. DEV. CHARGED TO PATIENTS	142	320	191,042				72
73	DRUGS CHARGED TO PATIENTS	157	1,158	220,789			3,854	73
74	RENAL DIALYSIS	2	78	25,997		478	10,043	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2	174	49,482		1,742	57,242	90
90.01	WELLNESS PROGRAM	1	1	3,294			5,815	90.01
91	EMERGENCY	5	600	83,902			45,744	91
91.01	FAMILY PRACTICE	3		16,377		341	23,481	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PURCHASING AND STORE S	CASHIERS A R AND COLL ECTIONS	ADMINISTRA TION & GEN ERAL	RNP ADMINI STRATION	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		5.30	5.50	5.60	5.90	6	7	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,048	9,636	3,418,691		265,068	1,349,749	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			15				190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS			1,144			14,726	193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER				80,069			201
202	TOTAL (sum of lines 118-201)	1,048	9,636	3,419,850	80,069	265,068	1,364,475	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ELECTRICIT Y	RNP OPERAT ION OF PLA NT	LAUNDRY & LINEN SERVICE	RNP LAUNDR Y	HOUSE- KEEPING	RNP HOSUEK EEPING	
		7.01	7.02	8	8.01	9	9.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	ELECTRICITY	91,475						7.01
7.02	RNP OPERATION OF PLANT		272,936					7.02
8	LAUNDRY & LINEN SERVICE	1,620	4,833	105,812				8
8.01	RNP LAUNDRY				65,132			8.01
9	HOUSEKEEPING	1,105	3,296			142,927		9
9.01	RNP HOSUEKEEPING						9,687	9.01
10	DIETARY	3,287	9,806			3,757	3,980	10
10.01	RNP DIETARY							10.01
11	CAFETERIA	1,213	3,619			939		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	566	1,687			520		13
14	CENTRAL SERVICES & SUPPLY	1,958	5,842	15		470		14
15	PHARMACY	1,557	4,645	16		1,107		15
16	MEDICAL RECORDS & LIBRARY	1,897	5,661			704		16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE						375	17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			1,034				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	976	2,911			168		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	26,473	78,995	42,056		48,213		30
31	INTENSIVE CARE UNIT	4,590	13,694	6,529		7,648		31
41	SUBPROVIDER - IRF	3,580	10,682	8,694		8,453		41
43	NURSERY	153	458			1,157		43
44	SKILLED NURSING FACILITY				65,132			44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,202	12,538	12,510		17,644		50
51	RECOVERY ROOM	331	988	2,568		335		51
52	DELIVERY ROOM & LABOR ROOM	4,023	12,004	2,807		4,674		52
53	ANESTHESIOLOGY	389	1,160			335		53
54	RADIOLOGY-DIAGNOSTIC	5,881	17,548	4,304		3,287		54
55	RADIOLOGY-THERAPEUTIC	2,424	7,234	1,241		2,113		55
56	RADIOISOTOPE	1,061	3,165			671		56
57	CT SCAN	474	1,413					57
58	MRI	903	2,695					58
59	CARDIAC CATHETERIZATION	1,657	4,945	1,113				59
60	LABORATORY	2,481	7,401			3,835		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	95	283			235		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	559	1,667			637		65
66	PHYSICAL THERAPY	1,337	3,991	2,294		1,006		66
66.01	RNRC PHYSICAL THERAPY						4,513	66.01
66.02	DAY REHABILITATION FACILITY	974	2,906					66.02
67	OCCUPATIONAL THERAPY	1,115	3,326			1,342		67
68	SPEECH PATHOLOGY	305	910					68
69	ELECTROCARDIOLOGY	3,244	9,678	1,651		839		69
70	ELECTROENCEPHALOGRAPHY	258	769			201		70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						819	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS	258	771			168		73
74	RENAL DIALYSIS	673	2,009	1,190				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	3,838	11,450	2,527		6,787		90
90.01	WELLNESS PROGRAM	390	1,163	31				90.01
91	EMERGENCY	3,067	9,150	15,130		8,498		91
91.01	FAMILY PRACTICE	1,574	4,697	102		1,610		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ELECTRICIT Y	RNP OPERAT ION OF PLA NT	LAUNDRY & LINEN SERVICE	RNP LAUNDR Y	HOUSE- KEEPING	RNP HOSUEK EEPING	
		7.01	7.02	8	8.01	9	9.01	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	90,488	269,990	105,812	65,132	127,353	9,687	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					117		190
192	PHYSICIANS' PRIVATE OFFICES					12,705		192
193	NONPAID WORKERS	987	2,946			2,683		193
194	OTHER					69		194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	91,475	272,936	105,812	65,132	142,927	9,687	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	--------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	RNP DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	10.01	11	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	ELECTRICITY							7.01
7.02	RNP OPERATION OF PLANT							7.02
8	LAUNDRY & LINEN SERVICE							8
8.01	RNP LAUNDRY							8.01
9	HOUSEKEEPING							9
9.01	RNP HOUSEKEEPING							9.01
10	DIETARY	326,969						10
10.01	RNP DIETARY		54,775					10.01
11	CAFETERIA			64,076				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			1,673	148,988			13
14	CENTRAL SERVICES & SUPPLY			443		675,394		14
15	PHARMACY			1,571			297,117	15
16	MEDICAL RECORDS & LIBRARY			3,672				16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE			177				17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			3,662				22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	96,974	16,245	13,550	3,936			30
31	INTENSIVE CARE UNIT	19,368	3,245	3,492	24,961			31
41	SUBPROVIDER - IRF	32,626	5,466	3,338	24,575			41
43	NURSERY	7,410	1,241	509				43
44	SKILLED NURSING FACILITY	170,591	28,578	6,494				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			3,162	20,447			50
51	RECOVERY ROOM			468	23,999			51
52	DELIVERY ROOM & LABOR ROOM			812	24,863			52
53	ANESTHESIOLOGY			145				53
54	RADIOLOGY-DIAGNOSTIC			3,677				54
55	RADIOLOGY-THERAPEUTIC			1,030				55
56	RADIOISOTOPE			705				56
57	CT SCAN			521				57
58	MRI			325				58
59	CARDIAC CATHETERIZATION			864				59
60	LABORATORY			329				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			1,069				65
66	PHYSICAL THERAPY			2,103				66
66.01	RNRC PHYSICAL THERAPY			356				66.01
66.02	DAY REHABILITATION FACILITY			454				66.02
67	OCCUPATIONAL THERAPY			1,148				67
68	SPEECH PATHOLOGY			650				68
69	ELECTROCARDIOLOGY			814				69
70	ELECTROENCEPHALOGRAPHY			120				70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					328,399		71
72	IMPL. DEV. CHARGED TO PATIENTS					346,995		72
73	DRUGS CHARGED TO PATIENTS						297,117	73
74	RENAL DIALYSIS			655	1,632			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC			1,308				90
90.01	WELLNESS PROGRAM			76				90.01
91	EMERGENCY			2,680	24,575			91
91.01	FAMILY PRACTICE			2,024				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	RNP DIETAR Y	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	10.01	11	13	14	15	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	326,969	54,775	64,076	148,988	675,394	297,117	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	326,969	54,775	64,076	148,988	675,394	297,117	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	RNP SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		16	17.01	21	22	24	25	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	ELECTRICITY							7.01
7.02	RNP OPERATION OF PLANT							7.02
8	LAUNDRY & LINEN SERVICE							8
8.01	RNP LAUNDRY							8.01
9	HOUSEKEEPING							9
9.01	RNP HOSUEKEEPING							9.01
10	DIETARY							10
10.01	RNP DIETARY							10.01
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	265,996						16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE		5,159					17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			71,908				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				167,989			22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	18,169				6,062,081		30
31	INTENSIVE CARE UNIT	1,173				558,072		31
41	SUBPROVIDER - IRF	1,478				478,047		41
43	NURSERY	8,399				71,241		43
44	SKILLED NURSING FACILITY		5,159			445,474		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,741				2,374,909		50
51	RECOVERY ROOM	803				63,379		51
52	DELIVERY ROOM & LABOR ROOM	295				442,996		52
53	ANESTHESIOLOGY	1,421				346,676		53
54	RADIOLOGY-DIAGNOSTIC	66,219				1,337,296		54
55	RADIOLOGY-THERAPEUTIC	10,432				1,193,580		55
56	RADIOISOTOPE	31,196				327,707		56
57	CT SCAN					68,926		57
58	MRI					959,382		58
59	CARDIAC CATHETERIZATION					968,346		59
60	LABORATORY	15,280				569,816		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,002				33,133		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	8,128				189,775		65
66	PHYSICAL THERAPY	4,067				169,995		66
66.01	RNRC PHYSICAL THERAPY	2,802				8,232		66.01
66.02	DAY REHABILITATION FACILITY					99,409		66.02
67	OCCUPATIONAL THERAPY					96,108		67
68	SPEECH PATHOLOGY					49,003		68
69	ELECTROCARDIOLOGY	37,768				511,348		69
70	ELECTROENCEPHALOGRAPHY	11,257				483,393		70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,839				566,824		71
72	IMPL. DEV. CHARGED TO PATIENTS					538,499		72
73	DRUGS CHARGED TO PATIENTS	4,170				536,378		73
74	RENAL DIALYSIS					115,860		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	15,057				483,644		90
90.01	WELLNESS PROGRAM					24,751		90.01
91	EMERGENCY	8,300				594,176		91
91.01	FAMILY PRACTICE					179,179		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	RNP SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		16	17.01	21	22	24	25	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	265,996	5,159			20,947,635		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					227		190
192	PHYSICIANS' PRIVATE OFFICES					12,705		192
193	NONPAID WORKERS					54,972		193
194	OTHER					69		194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS			71,908	167,989	239,897		200
201	NEGATIVE COST CENTER					191,274		201
202	TOTAL (sum of lines 118-201)	265,996	5,159	71,908	167,989	21,446,779		202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	ELECTRICITY							7.01
7.02	RNP OPERATION OF PLANT							7.02
8	LAUNDRY & LINEN SERVICE							8
8.01	RNP LAUNDRY							8.01
9	HOUSEKEEPING							9
9.01	RNP HOSUEKEEPING							9.01
10	DIETARY							10
10.01	RNP DIETARY							10.01
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE							17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,062,081						30
31	INTENSIVE CARE UNIT	558,072						31
41	SUBPROVIDER - IRF	478,047						41
43	NURSERY	71,241						43
44	SKILLED NURSING FACILITY	445,474						44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,374,909						50
51	RECOVERY ROOM	63,379						51
52	DELIVERY ROOM & LABOR ROOM	442,996						52
53	ANESTHESIOLOGY	346,676						53
54	RADIOLOGY-DIAGNOSTIC	1,337,296						54
55	RADIOLOGY-THERAPEUTIC	1,193,580						55
56	RADIOISOTOPE	327,707						56
57	CT SCAN	68,926						57
58	MRI	959,382						58
59	CARDIAC CATHETERIZATION	968,346						59
60	LABORATORY	569,816						60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,133						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	189,775						65
66	PHYSICAL THERAPY	169,995						66
66.01	RNRC PHYSICAL THERAPY	8,232						66.01
66.02	DAY REHABILITATION FACILITY	99,409						66.02
67	OCCUPATIONAL THERAPY	96,108						67
68	SPEECH PATHOLOGY	49,003						68
69	ELECTROCARDIOLOGY	511,348						69
70	ELECTROENCEPHALOGRAPHY	483,393						70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,824						71
72	IMPL. DEV. CHARGED TO PATIENTS	538,499						72
73	DRUGS CHARGED TO PATIENTS	536,378						73
74	RENAL DIALYSIS	115,860						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	483,644						90
90.01	WELLNESS PROGRAM	24,751						90.01
91	EMERGENCY	594,176						91
91.01	FAMILY PRACTICE	179,179						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	20,947,635					118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	227					190
192	PHYSICIANS' PRIVATE OFFICES	12,705					192
193	NONPAID WORKERS	54,972					193
194	OTHER	69					194
194.05	NON EMPLOYEE CHILD CARE						194.05
200	CROSS FOOT ADJUSTMENTS	239,897					200
201	NEGATIVE COST CENTER	191,274					201
202	TOTAL (sum of lines 118-201)	21,446,779					202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT PHONES NUMBER OF PHONES	DATA PROCESSING MACHINE TIME	PURCHASING AND STORES SUPPLY COST	
		1	2	4	5.10	5.20	5.30	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	724,931						1
2	CAP REL COSTS-MVBLE EQUIP		2,787,137					2
4	EMPLOYEE BENEFITS DEPARTMENT	12,323	995	101,414,401				4
5.10	NON PATIENT PHONES	3,972	167		417			5.10
5.20	DATA PROCESSING					7,209,220		5.20
5.30	PURCHASING AND STORES					256,289	38,879,094	5.30
5.50	CASHIERS AR AND COLLECTIONS		1,575			269,545		5.50
5.60	ADMINISTRATION & GENERAL	46,309	47,575	6,303,328	77	947,826	2,488,089	5.60
5.90	RNP ADMINISTRATION		13,825	662,389	1	160,180	846,058	5.90
6	MAINTENANCE & REPAIRS	5,196	41,264	756,116	10		261,032	6
7	OPERATION OF PLANT	146,975	61,840	1,263,389	7	39,769	3,805,570	7
7.01	ELECTRICITY			44,116	8			7.01
7.02	RNP OPERATION OF PLANT		49,838	169,510			266,179	7.02
8	LAUNDRY & LINEN SERVICE	9,033			1		650,910	8
8.01	RNP LAUNDRY		11,826	167,345			34,556	8.01
9	HOUSEKEEPING	6,160	6,081	1,507,217	1		565,456	9
9.01	RNP HOUSEKEEPING			368,344			31,760	9.01
10	DIETARY	18,329	17,149	1,445,553	7	22,094	765,097	10
10.01	RNP DIETARY		3,677	628,449			383,047	10.01
11	CAFETERIA	6,764		569,103	6	18,780		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,154	15,379	2,049,494	19	161,285	20,991	13
14	CENTRAL SERVICES & SUPPLY	10,920	76,995	313,677	1	34,245	939,041	14
15	PHARMACY	8,683	30,978	2,582,413	9	416,469	91,234	15
16	MEDICAL RECORDS & LIBRARY	10,581	7,361	4,313,106	28	795,378	324,212	16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE		231	168,005				17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		35	4,486,163				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	5,442	3,449	3,845,793	11	13,256	97,584	22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	147,654	811,439	18,867,264	39	367,862	211,349	30
31	INTENSIVE CARE UNIT	25,596	26,159	6,218,482	2	95,004	90,129	31
41	SUBPROVIDER - IRF	19,966	15,165	4,655,959	3	40,874	59,143	41
43	NURSERY	856	5,097	952,920	2	40,874	63,608	43
44	SKILLED NURSING FACILITY			6,774,352			483,336	44
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	23,436	364,571	4,363,961	5	80,643	2,366,345	50
51	RECOVERY ROOM	1,847	207	829,397	1	26,513	2,095	51
52	DELIVERY ROOM & LABOR ROOM	22,438	35,622	268,105	1	53,025	31,047	52
53	ANESTHESIOLOGY	2,168	63,262	130,925	2		12,688	53
54	RADIOLOGY-DIAGNOSTIC	32,799	156,698	3,284,652	21	943,407	236,094	54
55	RADIOLOGY-THERAPEUTIC	13,521	191,562	1,838,445	12	53,025	176,348	55
56	RADIOISOTOPE	5,916	40,048	1,404,486	4	121,516	237,469	56
57	CT SCAN	2,641	4,685	857,074			4,015	57
58	MRI	5,038	175,021	481,682			247,374	58
59	CARDIAC CATHETERIZATION	9,242	166,288	1,590,863	1		16,559	59
60	LABORATORY	13,834	43,307	928,376	24	1,293,593	5,292,949	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	529	48	353	1	188,902	811,100	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,115	23,268	1,352,096	5	40,874	64,578	65
66	PHYSICAL THERAPY	7,459	4,929	3,196,942	11	62,967	17,988	66
66.01	RNRC PHYSICAL THERAPY			1,175			5,775	66.01
66.02	DAY REHABILITATION FACILITY	5,431	7,731	527,073			8,023	66.02
67	OCCUPATIONAL THERAPY	6,216	482	1,716,022	7	107,155	2,233	67
68	SPEECH PATHOLOGY	1,701	2,785	973,430	1		2,121	68
69	ELECTROCARDIOLOGY	18,089	45,721	1,119,239	9	26,513	208,281	69
70	ELECTROENCEPHALOGRAPHY	1,438	90,321	131,154	1	26,513	23,948	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		5,883				4,988,596	71
72	IMPL. DEV. CHARGED TO PATIENTS						5,271,079	72
73	DRUGS CHARGED TO PATIENTS	1,441					5,918,627	73
74	RENAL DIALYSIS	3,755	10,240	1,054,284	2	110,469	70,184	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	21,402	42,575	2,045,582	12	175,646	64,333	90
90.01	WELLNESS PROGRAM	2,174	385	146,336	1		26,308	90.01
91	EMERGENCY	17,103	59,226	3,791,358	12	108,260	175,852	91
91.01	FAMILY PRACTICE	8,779	3,822	250,722	21	110,469	118,516	91.01



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET)	CAP MOVEABLE EQUIPMENT DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT PHONES NUMBER OF PHONES	DATA PROCESSING MACHINE TIME	PURCHASING AND STORES SUPPLY COST	
		1	2	4	5.10	5.20	5.30	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	719,425	2,786,787	101,396,219	416	7,209,220	38,878,921	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				1			190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS	5,506	350	18,182			173	193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,992,227	13,849,421		395,697	3,678,119	141,196	202
203	UNIT COST MULT-WS B PT I	5.507044	4.969049		948.913669	0.510197	0.003632	203
204	COST TO BE ALLOC PER B PT II				39,725		1,048	204
205	UNIT COST MULT-WS B PT II				95.263789		0.000027	205



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CASHIERS A R AND COLL ECTIONS GROSS REVENUE	RECON- CILIATION	ADMINISTRA TION & GEN ERAL ACCUM COST	RNP ADMINI STRATION RNP DIRECT EXP	MAIN- TENANCE & REPAIRS MTCE REQS	OPERATION OF PLANT SQUARE FEE T)	
		5.50	5A.60	5.60	5.90	6	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS	1,165,253,540						5.50
5.60	ADMINISTRATION & GENERAL		-45,700,009	217,011,290				5.60
5.90	RNP ADMINISTRATION		669,533		14,430,874			5.90
6	MAINTENANCE & REPAIRS			1,898,725		1,303,626		6
7	OPERATION OF PLANT			3,956,211		883,312	510,156	7
7.01	ELECTRICITY			5,756,269				7.01
7.02	RNP OPERATION OF PLANT			863,496	820,426	57,415		7.02
8	LAUNDRY & LINEN SERVICE			1,598,601			9,033	8
8.01	RNP LAUNDRY			340,331	314,639	4,937		8.01
9	HOUSEKEEPING			3,402,000		10,239	6,160	9
9.01	RNP HOUSEKEEPING			579,722	579,607	2,703		9.01
10	DIETARY			3,409,962		52,116	18,329	10
10.01	RNP DIETARY			1,698,958	1,682,791	7,899		10.01
11	CAFETERIA			151,803			6,764	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			2,280,588		1,089	3,154	13
14	CENTRAL SERVICES & SUPPLY			2,409,492	62,994	46	10,920	14
15	PHARMACY			3,751,483		680	8,683	15
16	MEDICAL RECORDS & LIBRARY			6,897,344		1,060	10,581	16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE			219,484	218,336			17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			4,486,337				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			5,905,201		89	5,442	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	145,730,766		29,522,788		1,128	147,654	30
31	INTENSIVE CARE UNIT	32,491,418		8,335,695			25,596	31
41	SUBPROVIDER - IRF	27,577,813		5,713,182		1,449	19,966	41
43	NURSERY	6,547,560		1,268,322			856	43
44	SKILLED NURSING FACILITY	21,572,519		10,739,744	10,749,370	422		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	83,203,862		12,565,999		223,507	23,436	50
51	RECOVERY ROOM	16,872,041		1,083,494			1,847	51
52	DELIVERY ROOM & LABOR ROOM	204,623		710,200		4,177	22,438	52
53	ANESTHESIOLOGY	24,662,712		637,229			2,168	53
54	RADIOLOGY-DIAGNOSTIC	47,627,172		6,139,110		509	32,799	54
55	RADIOLOGY-THERAPEUTIC	19,554,043		4,037,459		228	13,521	55
56	RADIOISOTOPE	27,990,149		2,600,743		3,535	5,916	56
57	CT SCAN	48,557,256		1,346,677		96	2,641	57
58	MRI	19,442,439		2,071,702		96	5,038	58
59	CARDIAC CATHETERIZATION	63,040,706		3,512,421			9,242	59
60	LABORATORY	128,248,045		12,800,267		22,054	13,834	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,463,611		1,635,031			529	62
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	19,736,751		1,990,361		89	3,115	65
66	PHYSICAL THERAPY	21,211,813		4,123,588		506	7,459	66
66.01	RNRC PHYSICAL THERAPY	6,589,390		32,213	2,711			66.01
66.02	DAY REHABILITATION FACILITY	2,747,130		731,946		3,282	5,431	66.02
67	OCCUPATIONAL THERAPY	10,934,922		2,225,248		506	6,216	67
68	SPEECH PATHOLOGY	5,318,124		1,215,544		431	1,701	68
69	ELECTROCARDIOLOGY	33,033,570		1,980,333		6,910	18,089	69
70	ELECTROENCEPHALOGRAPHY	1,082,892		634,751		523	1,438	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,538,481		12,182,692				71
72	IMPL. DEV. CHARGED TO PATIENTS	40,004,498		12,122,698				72
73	DRUGS CHARGED TO PATIENTS	144,703,473		14,010,375			1,441	73
74	RENAL DIALYSIS	9,713,430		1,649,653		2,350	3,755	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	21,811,783		3,139,919		8,568	21,402	90
90.01	WELLNESS PROGRAM	90,882		208,997			2,174	90.01
91	EMERGENCY	74,949,666		5,324,095			17,103	91
91.01	FAMILY PRACTICE			1,039,234		1,675	8,779	91.01



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CASHIERS A R AND COLL ECTIONS GROSS REVENUE	RECON- CILIATION	ADMINISTRA TION & GEN ERAL ACCUM COST	RNP ADMINI STRATION RNP DIRECT EXP	MAIN- TENANCE & REPAIRS MTCE REQS	OPERATION OF PLANT SQUARE FEE T)	
		5.50	5A.60	5.60	5.90	6	7	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,165,253,540	-45,030,476	216,937,717	14,430,874	1,303,626	504,650	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			949				190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS			72,624			5,506	193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	5,449,615		45,700,009		2,298,574	6,346,812	202
203	UNIT COST MULT-WS B PT I	0.004677		0.210588		1.763216	12.440924	203
204	COST TO BE ALLOC PER B PT II	9,636		3,419,850		265,068	1,364,475	204
205	UNIT COST MULT-WS B PT II	0.000008		0.015759		0.203331	2.674623	205



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ELECTRICITY SQUARE FEET	RNP OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	RNP LAUNDRY RNP POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	RNP HOUSEKEEPING RNP HSKPG HRS OF SVC	
		7.01	7.02	8	8.01	9	9.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	ELECTRICITY	510,156						7.01
7.02	RNP OPERATION OF PLANT		510,156					7.02
8	LAUNDRY & LINEN SERVICE	9,033	9,033	1,264,166				8
8.01	RNP LAUNDRY				49,828			8.01
9	HOUSEKEEPING	6,160	6,160			127,830		9
9.01	RNP HOUSEKEEPING						10,631	9.01
10	DIETARY	18,329	18,329			3,360	4,368	10
10.01	RNP DIETARY							10.01
11	CAFETERIA	6,764	6,764			840		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,154	3,154			465		13
14	CENTRAL SERVICES & SUPPLY	10,920	10,920	177		420		14
15	PHARMACY	8,683	8,683	197		990		15
16	MEDICAL RECORDS & LIBRARY	10,581	10,581			630		16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE						411	17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			12,352				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	5,442	5,442			150		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	147,654	147,654	502,451		43,120		30
31	INTENSIVE CARE UNIT	25,596	25,596	78,003		6,840		31
41	SUBPROVIDER - IRF	19,966	19,966	103,866		7,560		41
43	NURSERY	856	856			1,035		43
44	SKILLED NURSING FACILITY				49,828			44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	23,436	23,436	149,464		15,780		50
51	RECOVERY ROOM	1,847	1,847	30,686		300		51
52	DELIVERY ROOM & LABOR ROOM	22,438	22,438	33,535		4,180		52
53	ANESTHESIOLOGY	2,168	2,168			300		53
54	RADIOLOGY-DIAGNOSTIC	32,799	32,799	51,420		2,940		54
55	RADIOLOGY-THERAPEUTIC	13,521	13,521	14,826		1,890		55
56	RADIOISOTOPE	5,916	5,916			600		56
57	CT SCAN	2,641	2,641					57
58	MRI	5,038	5,038					58
59	CARDIAC CATHETERIZATION	9,242	9,242	13,300				59
60	LABORATORY	13,834	13,834			3,430		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	529	529			210		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,115	3,115			570		65
66	PHYSICAL THERAPY	7,459	7,459	27,405		900		66
66.01	RNRC PHYSICAL THERAPY						4,953	66.01
66.02	DAY REHABILITATION FACILITY	5,431	5,431					66.02
67	OCCUPATIONAL THERAPY	6,216	6,216			1,200		67
68	SPEECH PATHOLOGY	1,701	1,701					68
69	ELECTROCARDIOLOGY	18,089	18,089	19,721		750		69
70	ELECTROENCEPHALOGRAPHY	1,438	1,438			180		70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						899	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS	1,441	1,441			150		73
74	RENAL DIALYSIS	3,755	3,755	14,216				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	21,402	21,402	30,192		6,070		90
90.01	WELLNESS PROGRAM	2,174	2,174	366				90.01
91	EMERGENCY	17,103	17,103	180,765		7,600		91
91.01	FAMILY PRACTICE	8,779	8,779	1,224		1,440		91.01



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ELECTRICIT Y SQUARE FEE T)	RNP OPERAT ION OF PLA NT SQUARE FEE T)	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY)	RNP LAUNDR Y RNP POUNDS OF LAUNDR	HOUSE- KEEPING HOURS OF S ERVICE)	RNP HOSUEK EEPING RNP HSKPG HRS OF SVC	
		7.01	7.02	8	8.01	9	9.01	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	504,650	504,650	1,264,166	49,828	113,900	10,631	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					105		190
192	PHYSICIANS' PRIVATE OFFICES					11,363		192
193	NONPAID WORKERS	5,506	5,506			2,400		193
194	OTHER					62		194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	6,968,470	1,146,573	2,191,314	420,706	4,311,097	706,570	202
203	UNIT COST MULT-WS B PT I	13.659488	2.247495	1.733407	8.443164	33.725237	66.463174	203
204	COST TO BE ALLOC PER B PT II	91,475	272,936	105,812	65,132	142,927	9,687	204
205	UNIT COST MULT-WS B PT II	0.179308	0.535005	0.083701	1.307137	1.118102	0.911203	205



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	DIETARY	RNP DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		PATIENT DAYS	PATIENT DAYS	MEALS SERVED)	MEALS SERVED)	COSTED REQ UIS)	COSTED REQ UIS)	
		10	10.01	11	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.10	NON PATIENT PHONES							5.10
5.20	DATA PROCESSING							5.20
5.30	PURCHASING AND STORES							5.30
5.50	CASHIERS AR AND COLLECTIONS							5.50
5.60	ADMINISTRATION & GENERAL							5.60
5.90	RNP ADMINISTRATION							5.90
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	ELECTRICITY							7.01
7.02	RNP OPERATION OF PLANT							7.02
8	LAUNDRY & LINEN SERVICE							8
8.01	RNP LAUNDRY							8.01
9	HOUSEKEEPING							9
9.01	RNP HOSUEKEEPING							9.01
10	DIETARY	149,053						10
10.01	RNP DIETARY		149,053					10.01
11	CAFETERIA			1,418,786				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			37,036	12,416			13
14	CENTRAL SERVICES & SUPPLY			9,819		10,259,675		14
15	PHARMACY			34,788			5,023,253	15
16	MEDICAL RECORDS & LIBRARY			81,302				16
17	SOCIAL SERVICE							17
17.01	RNP SOCIAL SERVICE			3,930				17.01
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			81,074				22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	44,207	44,207	300,065	328			30
31	INTENSIVE CARE UNIT	8,829	8,829	77,327	2,080			31
41	SUBPROVIDER - IRF	14,873	14,873	73,914	2,048			41
43	NURSERY	3,378	3,378	11,275				43
44	SKILLED NURSING FACILITY	77,766	77,766	143,794				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			70,011	1,704			50
51	RECOVERY ROOM			10,364	2,000			51
52	DELIVERY ROOM & LABOR ROOM			17,970	2,072			52
53	ANESTHESIOLOGY			3,210				53
54	RADIOLOGY-DIAGNOSTIC			81,417				54
55	RADIOLOGY-THERAPEUTIC			22,796				55
56	RADIOISOTOPE			15,612				56
57	CT SCAN			11,526				57
58	MRI			7,194				58
59	CARDIAC CATHETERIZATION			19,139				59
60	LABORATORY			7,288				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			23,660				65
66	PHYSICAL THERAPY			46,555				66
66.01	RNRC PHYSICAL THERAPY			7,889				66.01
66.02	DAY REHABILITATION FACILITY			10,046				66.02
67	OCCUPATIONAL THERAPY			25,418				67
68	SPEECH PATHOLOGY			14,387				68
69	ELECTROCARDIOLOGY			18,026				69
70	ELECTROENCEPHALOGRAPHY			2,654				70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					4,988,596		71
72	IMPL. DEV. CHARGED TO PATIENTS					5,271,079		72
73	DRUGS CHARGED TO PATIENTS						5,023,253	73
74	RENAL DIALYSIS			14,494	136			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC			28,956				90
90.01	WELLNESS PROGRAM			1,682				90.01
91	EMERGENCY			59,348	2,048			91
91.01	FAMILY PRACTICE			44,820				91.01



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	DIETARY PATIENT DAYS	RNP DIETAR Y PATIENT DAYS	CAFETERIA MEALS SERV ED)	NURSING ADMINIS- TRATION MEALS SERV ED)	CENTRAL SERVICES & SUPPLY COSTED REQ UIS)	PHARMACY COSTED REQ UIS)	
		10	10.01	11	13	14	15	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	149,053	149,053	1,418,786	12,416	10,259,675	5,023,253	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	5,143,168	2,070,666	403,845	2,878,406	3,243,810	4,832,475	202
203	UNIT COST MULT-WS B PT I	34,505,632	13,892,146	0,284,641	231,830,380	0,316,171	0,962,021	203
204	COST TO BE ALLOC PER B PT II	326,969	54,775	64,076	148,988	675,394	297,117	204
205	UNIT COST MULT-WS B PT II	2,193,643	0,367,487	0,045,163	11,999,678	0,065,830	0,059,148	205



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	RNP SOCIAL SERVICE RNP TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME)	I&R PROGRAM COSTS ASSIGNED TIME)
	16	17	17.01	21	22

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.10	NON PATIENT PHONES						5.10
5.20	DATA PROCESSING						5.20
5.30	PURCHASING AND STORES						5.30
5.50	CASHIERS AR AND COLLECTIONS						5.50
5.60	ADMINISTRATION & GENERAL						5.60
5.90	RNP ADMINISTRATION						5.90
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
7.01	ELECTRICITY						7.01
7.02	RNP OPERATION OF PLANT						7.02
8	LAUNDRY & LINEN SERVICE						8
8.01	RNP LAUNDRY						8.01
9	HOUSEKEEPING						9
9.01	RNP HOSUEKEEPING						9.01
10	DIETARY						10
10.01	RNP DIETARY						10.01
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	612,211					16
17	SOCIAL SERVICE		100				17
17.01	RNP SOCIAL SERVICE			100			17.01
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD				1,420		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					1,420	22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	41,817	100		791	791	30
31	INTENSIVE CARE UNIT	2,699			101	101	31
41	SUBPROVIDER - IRF	3,402					41
43	NURSERY	19,331			10	10	43
44	SKILLED NURSING FACILITY			100			44
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,007			88	88	50
51	RECOVERY ROOM	1,848					51
52	DELIVERY ROOM & LABOR ROOM	680			20	20	52
53	ANESTHESIOLOGY	3,271					53
54	RADIOLOGY-DIAGNOSTIC	152,409			10	10	54
55	RADIOLOGY-THERAPEUTIC	24,010					55
56	RADIOISOTOPE	71,801					56
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY	35,169			20	20	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,607					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	18,708			50	50	65
66	PHYSICAL THERAPY	9,360					66
66.01	RNRC PHYSICAL THERAPY	6,449					66.01
66.02	DAY REHABILITATION FACILITY						66.02
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	86,926			50	50	69
70	ELECTROENCEPHALOGRAPHY	25,908			10	10	70
70.01	ELECTROPHYSIOLOGY						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,454					71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS	9,598					73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	34,655			20	20	90
90.01	WELLNESS PROGRAM				20	20	90.01



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT)	SOCIAL SERVICE TIME SPENT)	RNP SOCIAL SERVICE RNP TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME)	I&R PROGRAM COSTS ASSIGNED TIME)		
		16	17	17.01	21	22		
91	EMERGENCY	19,102			150	150		91
91.01	FAMILY PRACTICE				80	80		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	612,211	100	100	1,420	1,420		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	8,696,049		294,140	5,452,517	7,331,328		202
203	UNIT COST MULT-WS B PT I	14,204,333		2,941,400,000	3,839,800,704	5,162,907,042		203
204	COST TO BE ALLOC PER B PT II	265,996		5,159	71,908	167,989		204
205	UNIT COST MULT-WS B PT II	0,434,484		51,590,000	50,639,437	118,302,113		205



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	--------------------------------	--	---

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	45,147,770		45,147,770		45,147,770	30
31	INTENSIVE CARE UNIT	12,152,434		12,152,434		12,152,434	31
41	SUBPROVIDER - IRF	9,183,834		9,183,834		9,183,834	41
43	NURSERY	2,035,868		2,035,868		2,035,868	43
44	SKILLED NURSING FACILITY	17,521,627		17,521,627		17,521,627	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	17,533,850		17,533,850		17,533,850	50
51	RECOVERY ROOM	1,920,193		1,920,193		1,920,193	51
52	DELIVERY ROOM & LABOR ROOM	2,197,423		2,197,423		2,197,423	52
53	ANESTHESIOLOGY	890,375		890,375		890,375	53
54	RADIOLOGY-DIAGNOSTIC	10,738,941		10,738,941		10,738,941	54
55	RADIOLOGY-THERAPEUTIC	5,708,368		5,708,368		5,708,368	55
56	RADIOISOTOPE	4,366,932		4,366,932		4,366,932	56
57	CT SCAN	1,708,588		1,708,588		1,708,588	57
58	MRI	2,653,012		2,653,012		2,653,012	58
59	CARDIAC CATHETERIZATION	4,542,588		4,542,588		4,542,588	59
60	LABORATORY	16,544,205		16,544,205	78,981	16,623,186	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,066,866		2,066,866		2,066,866	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,789,660		2,789,660		2,789,660	65
66	PHYSICAL THERAPY	5,428,366		5,428,366		5,428,366	66
66.01	RNRC PHYSICAL THERAPY	462,040		462,040		462,040	66.01
66.02	DAY REHABILITATION FACILITY	1,048,690		1,048,690		1,048,690	66.02
67	OCCUPATIONAL THERAPY	2,918,666		2,918,666		2,918,666	67
68	SPEECH PATHOLOGY	1,524,598		1,524,598		1,524,598	68
69	ELECTROCARDIOLOGY	4,221,672		4,221,672		4,221,672	69
70	ELECTROENCEPHALOGRAPHY	1,184,940		1,184,940		1,184,940	70
70.01	ELECTROPHYSIOLOGY						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,903,025		16,903,025		16,903,025	71
72	IMPL. DEV. CHARGED TO PATIENTS	16,342,154		16,342,154		16,342,154	72
73	DRUGS CHARGED TO PATIENTS	21,975,508		21,975,508		21,975,508	73
74	RENAL DIALYSIS	2,167,937		2,167,937		2,167,937	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	5,180,497		5,180,497		5,180,497	90
90.01	WELLNESS PROGRAM	315,751		315,751		315,751	90.01
91	EMERGENCY	8,262,784		8,262,784		8,262,784	91
91.01	FAMILY PRACTICE	1,573,348		1,573,348	118,670	1,692,018	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,092,226		5,092,226		5,092,226	92
	OTHER REIMBURSABLE COST CENTERS						
200	SUBTOTAL (SEE INSTRUCTIONS)	254,304,736		254,304,736	197,651	254,502,387	200
201	LESS OBSERVATION BEDS	5,092,226		5,092,226		5,092,226	201
202	TOTAL (SEE INSTRUCTIONS)	249,212,510		249,212,510		249,410,161	202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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	126,646,545		126,646,545				30
31	INTENSIVE CARE UNIT	32,491,418		32,491,418				31
41	SUBPROVIDER - IRF	27,577,813		27,577,813				41
43	NURSERY	6,547,560		6,547,560				43
44	SKILLED NURSING FACILITY	21,572,519		21,572,519				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	51,511,207	31,692,655	83,203,862	0.210734	0.210734	0.210734	50
51	RECOVERY ROOM	9,212,334	7,659,707	16,872,041	0.113809	0.113809	0.113809	51
52	DELIVERY ROOM & LABOR ROOM	111	204,512	204,623	10.738886	10.738886	10.738886	52
53	ANESTHESIOLOGY	13,678,884	10,983,828	24,662,712	0.036102	0.036102	0.036102	53
54	RADIOLOGY-DIAGNOSTIC	16,120,618	31,506,554	47,627,172	0.225479	0.225479	0.225479	54
55	RADIOLOGY-THERAPEUTIC	1,370,227	18,183,816	19,554,043	0.291928	0.291928	0.291928	55
56	RADIOISOTOPE	8,546,007	19,444,142	27,990,149	0.156017	0.156017	0.156017	56
57	CT SCAN	18,971,017	29,586,239	48,557,256	0.035187	0.035187	0.035187	57
58	MRI	4,713,833	14,728,606	19,442,439	0.136455	0.136455	0.136455	58
59	CARDIAC CATHETERIZATION	33,358,135	29,682,571	63,040,706	0.072058	0.072058	0.072058	59
60	LABORATORY	78,544,528	49,703,517	128,248,045	0.129002	0.129002	0.129617	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,572,017	1,891,594	8,463,611	0.244206	0.244206	0.244206	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	18,724,737	1,012,014	19,736,751	0.141343	0.141343	0.141343	65
66	PHYSICAL THERAPY	14,722,924	6,488,889	21,211,813	0.255912	0.255912	0.255912	66
66.01	RNRC PHYSICAL THERAPY	6,589,390		6,589,390	0.070119	0.070119	0.070119	66.01
66.02	DAY REHABILITATION FACILITY		2,747,130	2,747,130	0.381740	0.381740	0.381740	66.02
67	OCCUPATIONAL THERAPY	9,048,322	1,886,600	10,934,922	0.266912	0.266912	0.266912	67
68	SPEECH PATHOLOGY	3,202,374	2,115,750	5,318,124	0.286680	0.286680	0.286680	68
69	ELECTROCARDIOLOGY	15,845,488	17,188,082	33,033,570	0.127799	0.127799	0.127799	69
70	ELECTROENCEPHALOGRAPHY	367,837	715,055	1,082,892	1.094237	1.094237	1.094237	70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,001,580	14,536,901	51,538,481	0.327969	0.327969	0.327969	71
72	IMPL. DEV. CHARGED TO PATIENTS	29,163,277	10,841,221	40,004,498	0.408508	0.408508	0.408508	72
73	DRUGS CHARGED TO PATIENTS	103,987,987	40,715,486	144,703,473	0.151866	0.151866	0.151866	73
74	RENAL DIALYSIS	2,507,833	7,205,597	9,713,430	0.223190	0.223190	0.223190	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	5,100,736	16,711,047	21,811,783	0.237509	0.237509	0.237509	90
90.01	WELLNESS PROGRAM		90,882	90,882	3.474296	3.474296	3.474296	90.01
91	EMERGENCY	26,911,725	48,037,941	74,949,666	0.110244	0.110244	0.110244	91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		19,084,221	19,084,221	0.266829	0.266829	0.266829	92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	730,608,983	434,644,557	1,165,253,540				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	730,608,983	434,644,557	1,165,253,540				202



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	6,062,081		6,062,081	49,827	121.66	27,699	3,369,860	30
31	INTENSIVE CARE UNIT	558,072		558,072	8,829	63.21	5,091	321,802	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	478,047		478,047	14,873	32.14	11,544	371,024	41
42	SUBPROVIDER I								42
43	NURSERY	71,241		71,241	3,378	21.09			43
44	SKILLED NURSING FACILITY	445,474		445,474	77,766	5.73	17,050	97,697	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	7,614,915		7,614,915	154,673		61,384	4,160,383	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0117

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	2,374,909	83,203,862	0.028543	24,674,787	704,292	50
51	RECOVERY ROOM	63,379	16,872,041	0.003756	4,671,375	17,546	51
52	DELIVERY ROOM & LABOR ROOM	442,996	204,623	2.164937			52
53	ANESTHESIOLOGY	346,676	24,662,712	0.014057	6,619,530	93,051	53
54	RADIOLOGY-DIAGNOSTIC	1,337,296	47,627,172	0.028078	10,210,329	286,686	54
55	RADIOLOGY-THERAPEUTIC	1,193,580	19,554,043	0.061040	736,538	44,958	55
56	RADIOISOTOPE	327,707	27,990,149	0.011708	5,110,077	59,829	56
57	CT SCAN	68,926	48,557,256	0.001419	11,383,537	16,153	57
58	MRI	959,382	19,442,439	0.049345	2,430,994	119,957	58
59	CARDIAC CATHETERIZATION	968,346	63,040,706	0.015361	19,223,060	295,285	59
60	LABORATORY	569,816	128,248,045	0.004443	43,750,605	194,384	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,133	8,463,611	0.003915	3,740,468	14,644	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	189,775	19,736,751	0.009615	11,302,992	108,678	65
66	PHYSICAL THERAPY	169,995	21,211,813	0.008014	3,611,818	28,945	66
66.01	RNRC PHYSICAL THERAPY	8,232	6,589,390	0.001249	1,904	2	66.01
66.02	DAY REHABILITATION FACILITY	99,409	2,747,130	0.036186			66.02
67	OCCUPATIONAL THERAPY	96,108	10,934,922	0.008789	741,300	6,515	67
68	SPEECH PATHOLOGY	49,003	5,318,124	0.009214	980,344	9,033	68
69	ELECTROCARDIOLOGY	511,348	33,033,570	0.015480	10,647,625	164,825	69
70	ELECTROENCEPHALOGRAPHY	483,393	1,082,892	0.446391	188,608	84,193	70
70.01	ELECTROPHYSIOLOGY						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,824	51,538,481	0.010998	19,760,737	217,329	71
72	IMPL. DEV. CHARGED TO PATIENTS	538,499	40,004,498	0.013461	16,695,760	224,742	72
73	DRUGS CHARGED TO PATIENTS	536,378	144,703,473	0.003707	54,069,932	200,437	73
74	RENAL DIALYSIS	115,860	9,713,430	0.011928	1,387,558	16,551	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	483,644	21,811,783	0.022174	3,134,635	69,507	90
90.01	WELLNESS PROGRAM	24,751	90,882	0.272342			90.01
91	EMERGENCY	594,176	74,949,666	0.007928	16,201,718	128,447	91
91.01	FAMILY PRACTICE	179,179					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	683,743	19,084,221	0.035828			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	14,016,463	950,417,685		271,276,231	3,105,989	200

(A) Worksheet A line numbers



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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

	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.)	
(A)		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 RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	49,827		27,699		30
31	INTENSIVE CARE UNIT	8,829		5,091		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	14,873		11,544		41
42	SUBPROVIDER I					42
43	NURSERY	3,378				43
44	SKILLED NURSING FACILITY	77,766		17,050		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	154,673		61,384		200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0117

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
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
66.01	RNRC PHYSICAL THERAPY							66.01
66.02	DAY REHABILITATION FACILITY							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	WELLNESS PROGRAM							90.01
91	EMERGENCY							91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0117

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	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	83,203,862			24,674,787		10,547,536	50	
51	RECOVERY ROOM	16,872,041			4,671,375		2,312,996	51	
52	DELIVERY ROOM & LABOR ROOM	204,623						52	
53	ANESTHESIOLOGY	24,662,712			6,619,530		3,708,938	53	
54	RADIOLOGY-DIAGNOSTIC	47,627,172			10,210,329		13,073,687	54	
55	RADIOLOGY-THERAPEUTIC	19,554,043			736,538		9,102,515	55	
56	RADIOISOTOPE	27,990,149			5,110,077		7,386,736	56	
57	CT SCAN	48,557,256			11,383,537		12,682,790	57	
58	MRI	19,442,439			2,430,994		5,313,637	58	
59	CARDIAC CATHETERIZATION	63,040,706			19,223,060		17,272,994	59	
60	LABORATORY	128,248,045			43,750,605		2,579,036	60	
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,463,611			3,740,468		882,047	62	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65	RESPIRATORY THERAPY	19,736,751			11,302,992		354,614	65	
66	PHYSICAL THERAPY	21,211,813			3,611,818		3,019	66	
66.01	RNRC PHYSICAL THERAPY	6,589,390			1,904			66.01	
66.02	DAY REHABILITATION FACILITY	2,747,130					2,563	66.02	
67	OCCUPATIONAL THERAPY	10,934,922			741,300		273	67	
68	SPEECH PATHOLOGY	5,318,124			980,344		100,268	68	
69	ELECTROCARDIOLOGY	33,033,570			10,647,625		6,772,972	69	
70	ELECTROENCEPHALOGRAPHY	1,082,892			188,608		218,864	70	
70.01	ELECTROPHYSIOLOGY							70.01	
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,538,481			19,760,737		5,525,948	71	
72	IMPL. DEV. CHARGED TO PATIENTS	40,004,498			16,695,760		6,231,496	72	
73	DRUGS CHARGED TO PATIENTS	144,703,473			54,069,932		20,901,918	73	
74	RENAL DIALYSIS	9,713,430			1,387,558		66,780	74	
76.97	CARDIAC REHABILITATION							76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
90	CLINIC	21,811,783			3,134,635		6,266,196	90	
90.01	WELLNESS PROGRAM	90,882					613	90.01	
91	EMERGENCY	74,949,666			16,201,718		11,216,670	91	
91.01	FAMILY PRACTICE							91.01	
92	OBSERVATION BEDS (NON-DISTINCT PART)	19,084,221					6,793,060	92	
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	950,417,685			271,276,231		149,318,166	200	

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0117

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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.210734	10,547,536			2,222,724			50
51	RECOVERY ROOM	0.113809	2,312,996			263,240			51
52	DELIVERY ROOM & LABOR ROOM	10.738886							52
53	ANESTHESIOLOGY	0.036102	3,708,938			133,900			53
54	RADIOLOGY-DIAGNOSTIC	0.225479	13,073,687			2,947,842			54
55	RADIOLOGY-THERAPEUTIC	0.291928	9,102,515			2,657,279			55
56	RADIOISOTOPE	0.156017	7,386,736			1,152,456			56
57	CT SCAN	0.035187	12,682,790			446,269			57
58	MRI	0.136455	5,313,637			725,072			58
59	CARDIAC CATHETERIZATION	0.072058	17,272,994	6		1,244,657			59
60	LABORATORY	0.129002	2,579,036			332,701			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206	882,047			215,401			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.141343	354,614			50,122			65
66	PHYSICAL THERAPY	0.255912	3,019			773			66
66.01	RNRC PHYSICAL THERAPY	0.070119							66.01
66.02	DAY REHABILITATION FACILITY	0.381740	2,563			978			66.02
67	OCCUPATIONAL THERAPY	0.266912	273			73			67
68	SPEECH PATHOLOGY	0.286680	100,268			28,745			68
69	ELECTROCARDIOLOGY	0.127799	6,772,972			865,579			69
70	ELECTROENCEPHALOGRAPHY	1.094237	218,864			239,489			70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969	5,525,948			1,812,340			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508	6,231,496			2,545,616			72
73	DRUGS CHARGED TO PATIENTS	0.151866	20,901,918			3,174,291		2,359	73
74	RENAL DIALYSIS	0.223190	66,780			14,905			74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.237509	6,266,196			1,488,278			90
90.01	WELLNESS PROGRAM	3.474296	613			2,130			90.01
91	EMERGENCY	0.110244	11,216,670			1,236,571			91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829	6,793,060			1,812,585			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		149,318,166	6	15,532	25,614,016		2,359	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		149,318,166	6	15,532	25,614,016		2,359	202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T117

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX [XX] 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	2,374,909	83,203,862	0.028543	905	26	50
51	RECOVERY ROOM	63,379	16,872,041	0.003756	1,630	6	51
52	DELIVERY ROOM & LABOR ROOM	442,996	204,623	2.164937			52
53	ANESTHESIOLOGY	346,676	24,662,712	0.014057	3,913	55	53
54	RADIOLOGY-DIAGNOSTIC	1,337,296	47,627,172	0.028078	273,029	7,666	54
55	RADIOLOGY-THERAPEUTIC	1,193,580	19,554,043	0.061040	172,668	10,540	55
56	RADIOISOTOPE	327,707	27,990,149	0.011708	191,573	2,243	56
57	CT SCAN	68,926	48,557,256	0.001419	247,568	351	57
58	MRI	959,382	19,442,439	0.049345	42,969	2,120	58
59	CARDIAC CATHETERIZATION	968,346	63,040,706	0.015361	24,431	375	59
60	LABORATORY	569,816	128,248,045	0.004443	3,409,434	15,148	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,133	8,463,611	0.003915	79,355	311	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	189,775	19,736,751	0.009615	1,256,432	12,081	65
66	PHYSICAL THERAPY	169,995	21,211,813	0.008014	7,425,696	59,510	66
66.01	RNRC PHYSICAL THERAPY	8,232	6,589,390	0.001249			66.01
66.02	DAY REHABILITATION FACILITY	99,409	2,747,130	0.036186			66.02
67	OCCUPATIONAL THERAPY	96,108	10,934,922	0.008789	6,251,586	54,945	67
68	SPEECH PATHOLOGY	49,003	5,318,124	0.009214	1,276,180	11,759	68
69	ELECTROCARDIOLOGY	511,348	33,033,570	0.015480	106,920	1,655	69
70	ELECTROENCEPHALOGRAPHY	483,393	1,082,892	0.446391	3,956	1,766	70
70.01	ELECTROPHYSIOLOGY						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,824	51,538,481	0.010998	1,031,294	11,342	71
72	IMPL. DEV. CHARGED TO PATIENTS	538,499	40,004,498	0.013461	52,574	708	72
73	DRUGS CHARGED TO PATIENTS	536,378	144,703,473	0.003707	6,212,998	23,032	73
74	RENAL DIALYSIS	115,860	9,713,430	0.011928	259,685	3,098	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	483,644	21,811,783	0.022174	2,226	49	90
90.01	WELLNESS PROGRAM	24,751	90,882	0.272342			90.01
91	EMERGENCY	594,176	74,949,666	0.007928	6,779	54	91
91.01	FAMILY PRACTICE	179,179					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		19,084,221				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	13,332,720	950,417,685		28,333,801	218,840	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T117

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	NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
66.01	RNRC PHYSICAL THERAPY							66.01
66.02	DAY REHABILITATION FACILITY							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	WELLNESS PROGRAM							90.01
91	EMERGENCY							91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T117

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)
7	8	9	10	11	12	13		
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	83,203,862			905			50
51	RECOVERY ROOM	16,872,041			1,630			51
52	DELIVERY ROOM & LABOR ROOM	204,623						52
53	ANESTHESIOLOGY	24,662,712			3,913			53
54	RADIOLOGY-DIAGNOSTIC	47,627,172			273,029		1,632	54
55	RADIOLOGY-THERAPEUTIC	19,554,043			172,668			55
56	RADIOISOTOPE	27,990,149			191,573			56
57	CT SCAN	48,557,256			247,568		4,300	57
58	MRI	19,442,439			42,969			58
59	CARDIAC CATHETERIZATION	63,040,706			24,431			59
60	LABORATORY	128,248,045			3,409,434			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,463,611			79,355			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	19,736,751			1,256,432			65
66	PHYSICAL THERAPY	21,211,813			7,425,696			66
66.01	RNRC PHYSICAL THERAPY	6,589,390						66.01
66.02	DAY REHABILITATION FACILITY	2,747,130						66.02
67	OCCUPATIONAL THERAPY	10,934,922			6,251,586			67
68	SPEECH PATHOLOGY	5,318,124			1,276,180		303	68
69	ELECTROCARDIOLOGY	33,033,570			106,920		322	69
70	ELECTROENCEPHALOGRAPHY	1,082,892			3,956			70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,538,481			1,031,294			71
72	IMPL. DEV. CHARGED TO PATIENTS	40,004,498			52,574			72
73	DRUGS CHARGED TO PATIENTS	144,703,473			6,212,998		9,687	73
74	RENAL DIALYSIS	9,713,430			259,685			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	21,811,783			2,226			90
90.01	WELLNESS PROGRAM	90,882						90.01
91	EMERGENCY	74,949,666			6,779		15	91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	19,084,221						92
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	950,417,685			28,333,801		16,259	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T117

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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.210734							50
51	RECOVERY ROOM	0.113809							51
52	DELIVERY ROOM & LABOR ROOM	10.738886							52
53	ANESTHESIOLOGY	0.036102							53
54	RADIOLOGY-DIAGNOSTIC	0.225479	1,632			368			54
55	RADIOLOGY-THERAPEUTIC	0.291928							55
56	RADIOISOTOPE	0.156017							56
57	CT SCAN	0.035187	4,300			151			57
58	MRI	0.136455							58
59	CARDIAC CATHETERIZATION	0.072058							59
60	LABORATORY	0.129002							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.141343							65
66	PHYSICAL THERAPY	0.255912							66
66.01	RNRC PHYSICAL THERAPY	0.070119							66.01
66.02	DAY REHABILITATION FACILITY	0.381740							66.02
67	OCCUPATIONAL THERAPY	0.266912							67
68	SPEECH PATHOLOGY	0.286680	303			87			68
69	ELECTROCARDIOLOGY	0.127799	322			41			69
70	ELECTROENCEPHALOGRAPHY	1.094237							70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508							72
73	DRUGS CHARGED TO PATIENTS	0.151866	9,687			105	1,471	16	73
74	RENAL DIALYSIS	0.223190							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.237509							90
90.01	WELLNESS PROGRAM	3.474296							90.01
91	EMERGENCY	0.110244	15			2			91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		16,259		105	2,120		16	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		16,259		105	2,120		16	202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5324

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
66.01	RNRC PHYSICAL THERAPY							66.01
66.02	DAY REHABILITATION FACILITY							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	WELLNESS PROGRAM							90.01
91	EMERGENCY							91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5324

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [XX] SNF [] TEFRA
 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)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	83,203,862							50
51	RECOVERY ROOM	16,872,041							51
52	DELIVERY ROOM & LABOR ROOM	204,623							52
53	ANESTHESIOLOGY	24,662,712							53
54	RADIOLOGY-DIAGNOSTIC	47,627,172			6,960				54
55	RADIOLOGY-THERAPEUTIC	19,554,043							55
56	RADIOISOTOPE	27,990,149							56
57	CT SCAN	48,557,256							57
58	MRI	19,442,439							58
59	CARDIAC CATHETERIZATION	63,040,706							59
60	LABORATORY	128,248,045			26,197				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,463,611			12,276				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	19,736,751							65
66	PHYSICAL THERAPY	21,211,813							66
66.01	RNRC PHYSICAL THERAPY	6,589,390			2,334,455				66.01
66.02	DAY REHABILITATION FACILITY	2,747,130							66.02
67	OCCUPATIONAL THERAPY	10,934,922			1,998,432				67
68	SPEECH PATHOLOGY	5,318,124			320,059				68
69	ELECTROCARDIOLOGY	33,033,570			117				69
70	ELECTROENCEPHALOGRAPHY	1,082,892							70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,538,481			33,480				71
72	IMPL. DEV. CHARGED TO PATIENTS	40,004,498							72
73	DRUGS CHARGED TO PATIENTS	144,703,473			894,628				73
74	RENAL DIALYSIS	9,713,430							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	CLINIC	21,811,783							90
90.01	WELLNESS PROGRAM	90,882							90.01
91	EMERGENCY	74,949,666							91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	19,084,221							92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	950,417,685			5,626,604				200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5324

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [XX] SNF [] SWING BED NF
 BOXES: [] 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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.210734							50
51	RECOVERY ROOM	0.113809							51
52	DELIVERY ROOM & LABOR ROOM	10.738886							52
53	ANESTHESIOLOGY	0.036102							53
54	RADIOLOGY-DIAGNOSTIC	0.225479							54
55	RADIOLOGY-THERAPEUTIC	0.291928							55
56	RADIOISOTOPE	0.156017							56
57	CT SCAN	0.035187							57
58	MRI	0.136455							58
59	CARDIAC CATHETERIZATION	0.072058							59
60	LABORATORY	0.129002							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.141343							65
66	PHYSICAL THERAPY	0.255912							66
66.01	RNRC PHYSICAL THERAPY	0.070119							66.01
66.02	DAY REHABILITATION FACILITY	0.381740							66.02
67	OCCUPATIONAL THERAPY	0.266912							67
68	SPEECH PATHOLOGY	0.286680							68
69	ELECTROCARDIOLOGY	0.127799							69
70	ELECTROENCEPHALOGRAPHY	1.094237							70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508							72
73	DRUGS CHARGED TO PATIENTS	0.151866							73
74	RENAL DIALYSIS	0.223190							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.237509							90
90.01	WELLNESS PROGRAM	3.474296							90.01
91	EMERGENCY	0.110244							91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829							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 RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 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)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	6,062,081		6,062,081	49,827	121.66	3,448	419,484	30
31	INTENSIVE CARE UNIT	558,072		558,072	8,829	63.21	631	39,886	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	478,047		478,047	14,873	32.14	254	8,164	41
42	SUBPROVIDER I								42
43	NURSERY	71,241		71,241	3,378	21.09	1,516	31,972	43
44	SKILLED NURSING FACILITY	445,474		445,474	77,766	5.73	43,251	247,828	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	7,614,915		7,614,915	154,673		49,100	747,334	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0117

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,374,909	83,203,862	0.028543			50
51	RECOVERY ROOM	63,379	16,872,041	0.003756			51
52	DELIVERY ROOM & LABOR ROOM	442,996	204,623	2.164937			52
53	ANESTHESIOLOGY	346,676	24,662,712	0.014057			53
54	RADIOLOGY-DIAGNOSTIC	1,337,296	47,627,172	0.028078			54
55	RADIOLOGY-THERAPEUTIC	1,193,580	19,554,043	0.061040			55
56	RADIOISOTOPE	327,707	27,990,149	0.011708			56
57	CT SCAN	68,926	48,557,256	0.001419			57
58	MRI	959,382	19,442,439	0.049345			58
59	CARDIAC CATHETERIZATION	968,346	63,040,706	0.015361			59
60	LABORATORY	569,816	128,248,045	0.004443			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,133	8,463,611	0.003915			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	189,775	19,736,751	0.009615			65
66	PHYSICAL THERAPY	169,995	21,211,813	0.008014			66
66.01	RNRC PHYSICAL THERAPY	8,232	6,589,390	0.001249			66.01
66.02	DAY REHABILITATION FACILITY	99,409	2,747,130	0.036186			66.02
67	OCCUPATIONAL THERAPY	96,108	10,934,922	0.008789			67
68	SPEECH PATHOLOGY	49,003	5,318,124	0.009214			68
69	ELECTROCARDIOLOGY	511,348	33,033,570	0.015480			69
70	ELECTROENCEPHALOGRAPHY	483,393	1,082,892	0.446391			70
70.01	ELECTROPHYSIOLOGY						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,824	51,538,481	0.010998			71
72	IMPL. DEV. CHARGED TO PATIENTS	538,499	40,004,498	0.013461			72
73	DRUGS CHARGED TO PATIENTS	536,378	144,703,473	0.003707			73
74	RENAL DIALYSIS	115,860	9,713,430	0.011928			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	483,644	21,811,783	0.022174			90
90.01	WELLNESS PROGRAM	24,751	90,882	0.272342			90.01
91	EMERGENCY	594,176	74,949,666	0.007928			91
91.01	FAMILY PRACTICE	179,179					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	683,743	19,084,221	0.035828			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	14,016,463	950,417,685				200

(A) Worksheet A line numbers



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	49,827		3,448		30
31	INTENSIVE CARE UNIT	8,829		631		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	14,873		254		41
42	SUBPROVIDER I					42
43	NURSERY	3,378		1,516		43
44	SKILLED NURSING FACILITY	77,766		43,251		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	154,673		49,100		200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0117

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
66.01	RNRC PHYSICAL THERAPY							66.01
66.02	DAY REHABILITATION FACILITY							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	WELLNESS PROGRAM							90.01
91	EMERGENCY							91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0117

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)	
7		8		9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	83,203,862							50
51	RECOVERY ROOM	16,872,041							51
52	DELIVERY ROOM & LABOR ROOM	204,623							52
53	ANESTHESIOLOGY	24,662,712							53
54	RADIOLOGY-DIAGNOSTIC	47,627,172							54
55	RADIOLOGY-THERAPEUTIC	19,554,043							55
56	RADIOISOTOPE	27,990,149							56
57	CT SCAN	48,557,256							57
58	MRI	19,442,439							58
59	CARDIAC CATHETERIZATION	63,040,706							59
60	LABORATORY	128,248,045							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,463,611							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	19,736,751							65
66	PHYSICAL THERAPY	21,211,813							66
66.01	RNRC PHYSICAL THERAPY	6,589,390							66.01
66.02	DAY REHABILITATION FACILITY	2,747,130							66.02
67	OCCUPATIONAL THERAPY	10,934,922							67
68	SPEECH PATHOLOGY	5,318,124							68
69	ELECTROCARDIOLOGY	33,033,570							69
70	ELECTROENCEPHALOGRAPHY	1,082,892							70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,538,481							71
72	IMPL. DEV. CHARGED TO PATIENTS	40,004,498							72
73	DRUGS CHARGED TO PATIENTS	144,703,473							73
74	RENAL DIALYSIS	9,713,430							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	CLINIC	21,811,783							90
90.01	WELLNESS PROGRAM	90,882							90.01
91	EMERGENCY	74,949,666							91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	19,084,221							92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	950,417,685							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0117

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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.210734							50
51	RECOVERY ROOM	0.113809							51
52	DELIVERY ROOM & LABOR ROOM	10.738886							52
53	ANESTHESIOLOGY	0.036102							53
54	RADIOLOGY-DIAGNOSTIC	0.225479							54
55	RADIOLOGY-THERAPEUTIC	0.291928							55
56	RADIOISOTOPE	0.156017							56
57	CT SCAN	0.035187							57
58	MRI	0.136455							58
59	CARDIAC CATHETERIZATION	0.072058							59
60	LABORATORY	0.129002							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.141343							65
66	PHYSICAL THERAPY	0.255912							66
66.01	RNRC PHYSICAL THERAPY	0.070119							66.01
66.02	DAY REHABILITATION FACILITY	0.381740							66.02
67	OCCUPATIONAL THERAPY	0.266912							67
68	SPEECH PATHOLOGY	0.286680							68
69	ELECTROCARDIOLOGY	0.127799							69
70	ELECTROENCEPHALOGRAPHY	1.094237							70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508							72
73	DRUGS CHARGED TO PATIENTS	0.151866							73
74	RENAL DIALYSIS	0.223190							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.237509							90
90.01	WELLNESS PROGRAM	3.474296							90.01
91	EMERGENCY	0.110244							91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829							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 RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T117

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	2,374,909	83,203,862	0.028543			50
51	RECOVERY ROOM	63,379	16,872,041	0.003756			51
52	DELIVERY ROOM & LABOR ROOM	442,996	204,623	2.164937			52
53	ANESTHESIOLOGY	346,676	24,662,712	0.014057			53
54	RADIOLOGY-DIAGNOSTIC	1,337,296	47,627,172	0.028078			54
55	RADIOLOGY-THERAPEUTIC	1,193,580	19,554,043	0.061040			55
56	RADIOISOTOPE	327,707	27,990,149	0.011708			56
57	CT SCAN	68,926	48,557,256	0.001419			57
58	MRI	959,382	19,442,439	0.049345			58
59	CARDIAC CATHETERIZATION	968,346	63,040,706	0.015361			59
60	LABORATORY	569,816	128,248,045	0.004443			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,133	8,463,611	0.003915			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	189,775	19,736,751	0.009615			65
66	PHYSICAL THERAPY	169,995	21,211,813	0.008014			66
66.01	RNRC PHYSICAL THERAPY	8,232	6,589,390	0.001249			66.01
66.02	DAY REHABILITATION FACILITY	99,409	2,747,130	0.036186			66.02
67	OCCUPATIONAL THERAPY	96,108	10,934,922	0.008789			67
68	SPEECH PATHOLOGY	49,003	5,318,124	0.009214			68
69	ELECTROCARDIOLOGY	511,348	33,033,570	0.015480			69
70	ELECTROENCEPHALOGRAPHY	483,393	1,082,892	0.446391			70
70.01	ELECTROPHYSIOLOGY						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,824	51,538,481	0.010998			71
72	IMPL. DEV. CHARGED TO PATIENTS	538,499	40,004,498	0.013461			72
73	DRUGS CHARGED TO PATIENTS	536,378	144,703,473	0.003707			73
74	RENAL DIALYSIS	115,860	9,713,430	0.011928			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	483,644	21,811,783	0.022174			90
90.01	WELLNESS PROGRAM	24,751	90,882	0.272342			90.01
91	EMERGENCY	594,176	74,949,666	0.007928			91
91.01	FAMILY PRACTICE	179,179					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		19,084,221				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	13,332,720	950,417,685				200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T117

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 ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
66.01	RNRC PHYSICAL THERAPY							66.01
66.02	DAY REHABILITATION FACILITY							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	WELLNESS PROGRAM							90.01
91	EMERGENCY							91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T117

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF
 BOXES: [XX] 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)	
7		8		9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	83,203,862							50
51	RECOVERY ROOM	16,872,041							51
52	DELIVERY ROOM & LABOR ROOM	204,623							52
53	ANESTHESIOLOGY	24,662,712							53
54	RADIOLOGY-DIAGNOSTIC	47,627,172							54
55	RADIOLOGY-THERAPEUTIC	19,554,043							55
56	RADIOISOTOPE	27,990,149							56
57	CT SCAN	48,557,256							57
58	MRI	19,442,439							58
59	CARDIAC CATHETERIZATION	63,040,706							59
60	LABORATORY	128,248,045							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,463,611							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	19,736,751							65
66	PHYSICAL THERAPY	21,211,813							66
66.01	RNRC PHYSICAL THERAPY	6,589,390							66.01
66.02	DAY REHABILITATION FACILITY	2,747,130							66.02
67	OCCUPATIONAL THERAPY	10,934,922							67
68	SPEECH PATHOLOGY	5,318,124							68
69	ELECTROCARDIOLOGY	33,033,570							69
70	ELECTROENCEPHALOGRAPHY	1,082,892							70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,538,481							71
72	IMPL. DEV. CHARGED TO PATIENTS	40,004,498							72
73	DRUGS CHARGED TO PATIENTS	144,703,473							73
74	RENAL DIALYSIS	9,713,430							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	CLINIC	21,811,783							90
90.01	WELLNESS PROGRAM	90,882							90.01
91	EMERGENCY	74,949,666							91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	19,084,221							92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	950,417,685							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T117

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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.210734							50
51	RECOVERY ROOM	0.113809							51
52	DELIVERY ROOM & LABOR ROOM	10.738886							52
53	ANESTHESIOLOGY	0.036102							53
54	RADIOLOGY-DIAGNOSTIC	0.225479							54
55	RADIOLOGY-THERAPEUTIC	0.291928							55
56	RADIOISOTOPE	0.156017							56
57	CT SCAN	0.035187							57
58	MRI	0.136455							58
59	CARDIAC CATHETERIZATION	0.072058							59
60	LABORATORY	0.129002							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.141343							65
66	PHYSICAL THERAPY	0.255912							66
66.01	RNRC PHYSICAL THERAPY	0.070119							66.01
66.02	DAY REHABILITATION FACILITY	0.381740							66.02
67	OCCUPATIONAL THERAPY	0.266912							67
68	SPEECH PATHOLOGY	0.286680							68
69	ELECTROCARDIOLOGY	0.127799							69
70	ELECTROENCEPHALOGRAPHY	1.094237							70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508							72
73	DRUGS CHARGED TO PATIENTS	0.151866							73
74	RENAL DIALYSIS	0.223190							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.237509							90
90.01	WELLNESS PROGRAM	3.474296							90.01
91	EMERGENCY	0.110244							91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829							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 RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5324

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [XX] SNF
 BOXES: [XX] 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)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
66.01	RNRC PHYSICAL THERAPY							66.01
66.02	DAY REHABILITATION FACILITY							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	WELLNESS PROGRAM							90.01
91	EMERGENCY							91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5324

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [XX] SNF
 BOXES: [XX] 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)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	83,203,862							50
51	RECOVERY ROOM	16,872,041							51
52	DELIVERY ROOM & LABOR ROOM	204,623							52
53	ANESTHESIOLOGY	24,662,712							53
54	RADIOLOGY-DIAGNOSTIC	47,627,172							54
55	RADIOLOGY-THERAPEUTIC	19,554,043							55
56	RADIOISOTOPE	27,990,149							56
57	CT SCAN	48,557,256							57
58	MRI	19,442,439							58
59	CARDIAC CATHETERIZATION	63,040,706							59
60	LABORATORY	128,248,045							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,463,611							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	19,736,751							65
66	PHYSICAL THERAPY	21,211,813							66
66.01	RNRC PHYSICAL THERAPY	6,589,390							66.01
66.02	DAY REHABILITATION FACILITY	2,747,130							66.02
67	OCCUPATIONAL THERAPY	10,934,922							67
68	SPEECH PATHOLOGY	5,318,124							68
69	ELECTROCARDIOLOGY	33,033,570							69
70	ELECTROENCEPHALOGRAPHY	1,082,892							70
70.01	ELECTROPHYSIOLOGY								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,538,481							71
72	IMPL. DEV. CHARGED TO PATIENTS	40,004,498							72
73	DRUGS CHARGED TO PATIENTS	144,703,473							73
74	RENAL DIALYSIS	9,713,430							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90	CLINIC	21,811,783							90
90.01	WELLNESS PROGRAM	90,882							90.01
91	EMERGENCY	74,949,666							91
91.01	FAMILY PRACTICE								91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	19,084,221							92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	950,417,685							200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5324

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [XX] 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.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.210734						50
51	RECOVERY ROOM	0.113809						51
52	DELIVERY ROOM & LABOR ROOM	10.738886						52
53	ANESTHESIOLOGY	0.036102						53
54	RADIOLOGY-DIAGNOSTIC	0.225479						54
55	RADIOLOGY-THERAPEUTIC	0.291928						55
56	RADIOISOTOPE	0.156017						56
57	CT SCAN	0.035187						57
58	MRI	0.136455						58
59	CARDIAC CATHETERIZATION	0.072058						59
60	LABORATORY	0.129002						60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.141343						65
66	PHYSICAL THERAPY	0.255912						66
66.01	RNRC PHYSICAL THERAPY	0.070119						66.01
66.02	DAY REHABILITATION FACILITY	0.381740						66.02
67	OCCUPATIONAL THERAPY	0.266912						67
68	SPEECH PATHOLOGY	0.286680						68
69	ELECTROCARDIOLOGY	0.127799						69
70	ELECTROENCEPHALOGRAPHY	1.094237						70
70.01	ELECTROPHYSIOLOGY							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508						72
73	DRUGS CHARGED TO PATIENTS	0.151866						73
74	RENAL DIALYSIS	0.223190						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	0.237509						90
90.01	WELLNESS PROGRAM	3.474296						90.01
91	EMERGENCY	0.110244						91
91.01	FAMILY PRACTICE							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829						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 RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0117

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)	49,827	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	49,827	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)	44,207	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)	27,699	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)	45,147,770	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	45,147,770	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)	45,147,770	37



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0117

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)					906.09	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					25,097,787	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)					25,097,787	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	12,152,434	8,829	1,376.42	5,091	7,007,354	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					46,907,712	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					79,012,853	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					3,691,662	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					3,105,989	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					6,797,651	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					72,215,202	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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0117

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)					5,620	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					906.09	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					5,092,226	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	6,062,081	45,147,770	0.134272	5,092,226	683,743	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T117

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	14,873	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	14,873	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)	14,873	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,544	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)	9,183,834	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	9,183,834	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)	9,183,834	37



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T117

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)	617.48	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	7,128,189	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)	7,128,189	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	6,112,881	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	13,241,070	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	371,024	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	218,840	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	589,864	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	12,651,206	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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5324

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	77,766	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	77,766	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)	77,766	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)	17,050	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)	17,521,627	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	17,521,627	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)	17,521,627	37



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5324

WORKSHEET D-1
PARTS III & IV

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	17,521,627	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	225.31	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	3,841,536	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (line 14 x line 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (line 72 + line 73)	3,841,536	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 26, line 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (line 75 ÷ line 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (line 9 x line 76)		77
78	INPATIENT ROUTINE SERVICE COST (line 74 minus line 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (from provider records)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (line 78 minus line 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (line 9 x line 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (see instructions)	3,841,536	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	943,655	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	4,785,191	86



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0117

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	49,827	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	49,827	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)	44,207	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)	3,448	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)	3,378	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	1,516	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)	45,147,770	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	45,147,770	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)	45,147,770	37



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0117

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

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					906.09	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					3,124,198	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)					3,124,198	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	2,035,868	3,378	602.68	1,516	913,663	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	12,152,434	8,829	1,376.42	631	868,521	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

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)					4,906,382	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					491,342	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)					491,342	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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0117

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)					5,620	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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T117

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: [XX] TITLE XIX - I/P [XX] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	14,873	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	14,873	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)	14,873	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)	254	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)	9,183,834	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	9,183,834	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)	9,183,834	37



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T117

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	617.48	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	156,840	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)	156,840	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)	156,840	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	8,164	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)	8,164	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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5324

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	77,766	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	77,766	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)	77,766	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)	43,251	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)	17,521,627	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	17,521,627	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)	17,521,627	37



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5324

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	17,521,627	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	225.31	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	9,744,883	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (line 14 x line 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (line 72 + line 73)	9,744,883	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 26, line 45)	445,474	75
76	PER DIEM CAPITAL-RELATED COSTS (line 75 ÷ line 2)	5.73	76
77	PROGRAM CAPITAL-RELATED COSTS (line 9 x line 76)	247,828	77
78	INPATIENT ROUTINE SERVICE COST (line 74 minus line 77)	9,497,055	78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (from provider records)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (line 78 minus line 79)	9,497,055	80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (line 9 x line 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (see instructions)	247,828	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)		84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	247,828	86



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0117

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [] 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		75,262,781		30
31	INTENSIVE CARE UNIT		20,149,228		31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.210734	24,674,787	5,199,817	50
51	RECOVERY ROOM	0.113809	4,671,375	531,645	51
52	DELIVERY ROOM & LABOR ROOM	10.738886			52
53	ANESTHESIOLOGY	0.036102	6,619,530	238,978	53
54	RADIOLOGY-DIAGNOSTIC	0.225479	10,210,329	2,302,215	54
55	RADIOLOGY-THERAPEUTIC	0.291928	736,538	215,016	55
56	RADIOISOTOPE	0.156017	5,110,077	797,259	56
57	CT SCAN	0.035187	11,383,537	400,553	57
58	MRI	0.136455	2,430,994	331,721	58
59	CARDIAC CATHETERIZATION	0.072058	19,223,060	1,385,175	59
60	LABORATORY	0.129617	43,750,605	5,670,822	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206	3,740,468	913,445	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.141343	11,302,992	1,597,599	65
66	PHYSICAL THERAPY	0.255912	3,611,818	924,308	66
66.01	RNRC PHYSICAL THERAPY	0.070119	1,904	134	66.01
66.02	DAY REHABILITATION FACILITY	0.381740			66.02
67	OCCUPATIONAL THERAPY	0.266912	741,300	197,862	67
68	SPEECH PATHOLOGY	0.286680	980,344	281,045	68
69	ELECTROCARDIOLOGY	0.127799	10,647,625	1,360,756	69
70	ELECTROENCEPHALOGRAPHY	1.094237	188,608	206,382	70
70.01	ELECTROPHYSIOLOGY				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969	19,760,737	6,480,909	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508	16,695,760	6,820,352	72
73	DRUGS CHARGED TO PATIENTS	0.151866	54,069,932	8,211,384	73
74	RENAL DIALYSIS	0.223190	1,387,558	309,689	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.237509	3,134,635	744,504	90
90.01	WELLNESS PROGRAM	3.474296			90.01
91	EMERGENCY	0.110244	16,201,718	1,786,142	91
91.01	FAMILY PRACTICE				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		271,276,231	46,907,712	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		271,276,231		202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T117

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [XX] 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
41	SUBPROVIDER - IRF		21,410,907		41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.210734	905	191	50
51	RECOVERY ROOM	0.113809	1,630	186	51
52	DELIVERY ROOM & LABOR ROOM	10.738886			52
53	ANESTHESIOLOGY	0.036102	3,913	141	53
54	RADIOLOGY-DIAGNOSTIC	0.225479	273,029	61,562	54
55	RADIOLOGY-THERAPEUTIC	0.291928	172,668	50,407	55
56	RADIOISOTOPE	0.156017	191,573	29,889	56
57	CT SCAN	0.035187	247,568	8,711	57
58	MRI	0.136455	42,969	5,863	58
59	CARDIAC CATHETERIZATION	0.072058	24,431	1,760	59
60	LABORATORY	0.129617	3,409,434	441,921	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206	79,355	19,379	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.141343	1,256,432	177,588	65
66	PHYSICAL THERAPY	0.255912	7,425,696	1,900,325	66
66.01	RNRC PHYSICAL THERAPY	0.070119			66.01
66.02	DAY REHABILITATION FACILITY	0.381740			66.02
67	OCCUPATIONAL THERAPY	0.266912	6,251,586	1,668,623	67
68	SPEECH PATHOLOGY	0.286680	1,276,180	365,855	68
69	ELECTROCARDIOLOGY	0.127799	106,920	13,664	69
70	ELECTROENCEPHALOGRAPHY	1.094237	3,956	4,329	70
70.01	ELECTROPHYSIOLOGY				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969	1,031,294	338,232	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508	52,574	21,477	72
73	DRUGS CHARGED TO PATIENTS	0.151866	6,212,998	943,543	73
74	RENAL DIALYSIS	0.223190	259,685	57,959	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.237509	2,226	529	90
90.01	WELLNESS PROGRAM	3.474296			90.01
91	EMERGENCY	0.110244	6,779	747	91
91.01	FAMILY PRACTICE				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		28,333,801	6,112,881	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		28,333,801		202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-5324

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [XX] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [] 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
41	SUBPROVIDER - IRF				41
43	NURSERY				43
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	0.210734			50
51	RECOVERY ROOM	0.113809			51
52	DELIVERY ROOM & LABOR ROOM	10.738886			52
53	ANESTHESIOLOGY	0.036102			53
54	RADIOLOGY-DIAGNOSTIC	0.225479	6,960	1,569	54
55	RADIOLOGY-THERAPEUTIC	0.291928			55
56	RADIOISOTOPE	0.156017			56
57	CT SCAN	0.035187			57
58	MRI	0.136455			58
59	CARDIAC CATHETERIZATION	0.072058			59
60	LABORATORY	0.129002	26,197	3,379	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206	12,276	2,998	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.141343			65
66	PHYSICAL THERAPY	0.255912			66
66.01	RNRC PHYSICAL THERAPY	0.070119	2,334,455	163,690	66.01
66.02	DAY REHABILITATION FACILITY	0.381740			66.02
67	OCCUPATIONAL THERAPY	0.266912	1,998,432	533,405	67
68	SPEECH PATHOLOGY	0.286680	320,059	91,755	68
69	ELECTROCARDIOLOGY	0.127799	117	15	69
70	ELECTROENCEPHALOGRAPHY	1.094237			70
70.01	ELECTROPHYSIOLOGY				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969	33,480	10,980	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508			72
73	DRUGS CHARGED TO PATIENTS	0.151866	894,628	135,864	73
74	RENAL DIALYSIS	0.223190			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90	CLINIC	0.237509			90
90.01	WELLNESS PROGRAM	3.474296			90.01
91	EMERGENCY	0.110244			91
91.01	FAMILY PRACTICE				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829			92
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (sum of lines 50-94, and 96-98)		5,626,604	943,655	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		5,626,604		202

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0117

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX 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
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.210734			50
51	RECOVERY ROOM	0.113809			51
52	DELIVERY ROOM & LABOR ROOM	10.738886			52
53	ANESTHESIOLOGY	0.036102			53
54	RADIOLOGY-DIAGNOSTIC	0.225479			54
55	RADIOLOGY-THERAPEUTIC	0.291928			55
56	RADIOISOTOPE	0.156017			56
57	CT SCAN	0.035187			57
58	MRI	0.136455			58
59	CARDIAC CATHETERIZATION	0.072058			59
60	LABORATORY	0.129002			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.141343			65
66	PHYSICAL THERAPY	0.255912			66
66.01	RNRC PHYSICAL THERAPY	0.070119			66.01
66.02	DAY REHABILITATION FACILITY	0.381740			66.02
67	OCCUPATIONAL THERAPY	0.266912			67
68	SPEECH PATHOLOGY	0.286680			68
69	ELECTROCARDIOLOGY	0.127799			69
70	ELECTROENCEPHALOGRAPHY	1.094237			70
70.01	ELECTROPHYSIOLOGY				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508			72
73	DRUGS CHARGED TO PATIENTS	0.151866			73
74	RENAL DIALYSIS	0.223190			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.237509			90
90.01	WELLNESS PROGRAM	3.474296			90.01
91	EMERGENCY	0.110244			91
91.01	FAMILY PRACTICE				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829			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 RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T117

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX 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
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.210734			50
51	RECOVERY ROOM	0.113809			51
52	DELIVERY ROOM & LABOR ROOM	10.738886			52
53	ANESTHESIOLOGY	0.036102			53
54	RADIOLOGY-DIAGNOSTIC	0.225479			54
55	RADIOLOGY-THERAPEUTIC	0.291928			55
56	RADIOISOTOPE	0.156017			56
57	CT SCAN	0.035187			57
58	MRI	0.136455			58
59	CARDIAC CATHETERIZATION	0.072058			59
60	LABORATORY	0.129002			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.141343			65
66	PHYSICAL THERAPY	0.255912			66
66.01	RNRC PHYSICAL THERAPY	0.070119			66.01
66.02	DAY REHABILITATION FACILITY	0.381740			66.02
67	OCCUPATIONAL THERAPY	0.266912			67
68	SPEECH PATHOLOGY	0.286680			68
69	ELECTROCARDIOLOGY	0.127799			69
70	ELECTROENCEPHALOGRAPHY	1.094237			70
70.01	ELECTROPHYSIOLOGY				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508			72
73	DRUGS CHARGED TO PATIENTS	0.151866			73
74	RENAL DIALYSIS	0.223190			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.237509			90
90.01	WELLNESS PROGRAM	3.474296			90.01
91	EMERGENCY	0.110244			91
91.01	FAMILY PRACTICE				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829			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 RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-5324

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX 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
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.210734			50
51	RECOVERY ROOM	0.113809			51
52	DELIVERY ROOM & LABOR ROOM	10.738886			52
53	ANESTHESIOLOGY	0.036102			53
54	RADIOLOGY-DIAGNOSTIC	0.225479			54
55	RADIOLOGY-THERAPEUTIC	0.291928			55
56	RADIOISOTOPE	0.156017			56
57	CT SCAN	0.035187			57
58	MRI	0.136455			58
59	CARDIAC CATHETERIZATION	0.072058			59
60	LABORATORY	0.129002			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.244206			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.141343			65
66	PHYSICAL THERAPY	0.255912			66
66.01	RNRC PHYSICAL THERAPY	0.070119			66.01
66.02	DAY REHABILITATION FACILITY	0.381740			66.02
67	OCCUPATIONAL THERAPY	0.266912			67
68	SPEECH PATHOLOGY	0.286680			68
69	ELECTROCARDIOLOGY	0.127799			69
70	ELECTROENCEPHALOGRAPHY	1.094237			70
70.01	ELECTROPHYSIOLOGY				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.327969			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.408508			72
73	DRUGS CHARGED TO PATIENTS	0.151866			73
74	RENAL DIALYSIS	0.223190			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.237509			90
90.01	WELLNESS PROGRAM	3.474296			90.01
91	EMERGENCY	0.110244			91
91.01	FAMILY PRACTICE				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.266829			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



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	44,358,781			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	14,576,323			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	1,293,567			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	5,894,583			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	256.60			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)	47.57			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)	18.00			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				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002	4.36			8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)	69.93			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	72.45			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	69.93			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	70.64			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	68.19			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	69.59			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	69.59			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.271200			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.250817			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.250817			21
22	IME PAYMENT ADJUSTMENT (see instructions)	8,303,192			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)	2.52			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)	8,303,192			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)				30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)				31
32	SUM OF LINES 30 AND 31				32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)				33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)				34
		PRIOR TO OCTOBER 1	ON OR AFTER OCTOBER 1		
	UNCOMPENSATED CARE ADJUSTMENT				
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)				35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)				35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)				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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	68,531,863			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)	68,531,863			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	5,703,711			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)	3,647,622			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES	7,419			54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	77,890,615			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	77,890,615			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	5,019,048			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	298,312			63
64	ALLOWABLE BAD DEBTS (see instructions)	602,423			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	391,575			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	446,788			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	72,964,830			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	82,410			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-335,873			70.94
71	AMOUNT DUE PROVIDER (see instructions)	72,711,367			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,097,942			71.01
72	INTERIM PAYMENTS	71,632,518			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-19,093			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2				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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0117

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)	2,359			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	25,614,016			2
3	PPS PAYMENTS	24,043,512			3
4	OUTLIER PAYMENT (see instructions)	231,367			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)	2,359			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	15,538			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)	15,538			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)	15,538			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	13,179			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)	2,359			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)	24,274,879			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	5,267,410			26
27	SUBTOTAL ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	19,009,828			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	894,826			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	19,904,654			30
31	PRIMARY PAYER PAYMENTS	1,108			31
32	SUBTOTAL (line 30 minus line 31)	19,903,546			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)	688,826			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	447,737			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	587,548			36
37	SUBTOTAL (see instructions)	20,351,283			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-214			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	20,351,497			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	307,308			40.01
41	INTERIM PAYMENTS	19,923,544			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	120,645			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



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T117

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	16			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	2,120			2
3	PPS PAYMENTS	2,653			3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	16			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	105			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)	105			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)	105			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	89			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	16			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	2,653			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	704			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,965			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	1,965			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	1,965			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	1,965			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,965			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	30			40.01
41	INTERIM PAYMENTS	1,920			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	15			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



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-5324

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (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



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0117

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	AMOUNT	mm/dd/yyyy	AMOUNT		
		1	2	3	4		
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		66,825,226		18,716,358	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		3,015,971		915,870	2	
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT						
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)						
		.01	12/23/2013	2,460,307	12/23/2013	637,347	3.01
		.02					3.02
		PROGRAM					3.03
		TO					3.04
		PROVIDER					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50					3.50
		.51	07/10/2013	668,986	07/10/2013	346,031	3.51
		PROVIDER					3.52
		TO					3.53
		PROGRAM					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		1,791,321		291,316	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)			71,632,518		19,923,544	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)						
		.01					5.01
		.02					5.02
		PROGRAM					5.03
		TO					5.04
		PROVIDER					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
		PROVIDER					5.52
		TO					5.53
		PROGRAM					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		1,078,849		427,953	6.01
		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			72,711,367		20,351,497	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.



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-T117

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	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		15,750,419		1,920
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				
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT				
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
		.01	07/10/2013		
		.02			
		.03			
		.04			
		.05			
		.06			
		.07			
		.08			
		.09			
		.10			
		.50			
		.51			
		.52			
		.53			
		.54			
		.55			
		.56			
		.57			
		.58			
		.59			
		.99	10,790		
4	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		10,790		
	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15,761,209		1,920
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)				
		.01			
		.02			
		.03			
		.04			
		.05			
		.06			
		.07			
		.08			
		.09			
		.10			
		.50			
		.51			
		.52			
		.53			
		.54			
		.55			
		.56			
		.57			
		.58			
		.59			
		.99			
6	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				
	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		254,664		45
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		16,015,873		1,965
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.



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-5324

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	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		6,775,579		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				
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
					3.01
					3.02
					3.03
					3.04
					3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
					3.51
					3.52
					3.53
					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)				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)		6,775,579		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
					5.02
					5.03
					5.04
					5.05
					5.06
					5.07
					5.08
					5.09
					5.10
					5.50
					5.51
					5.52
					5.53
					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) BASED ON THE COST REPORT (1)		107,940		6.01
					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		6,883,519		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.



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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	11,589	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	32,790	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3,252	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	53,036	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,165,253,540	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	18,326,417	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	2,822,355	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	2,933,305	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-110,950	32



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T117

WORKSHEET E-3
PART III

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		J	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	15,961,710		1
2	MEDICARE SSI RATIO (see instructions)	0.011300		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	228,252		3
4	OUTLIER PAYMENTS	26,296		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)	40.747945		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	16,216,258		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	16,216,258		17
18	PRIMARY PAYER PAYMENTS			18
19	SUBTOTAL (line 17 less line 18)	16,216,258		19
20	DEDUCTIBLES	142,052		20
21	SUBTOTAL (line 19 minus line 20)	16,074,206		21
22	COINSURANCE	66,185		22
23	SUBTOTAL (line 21 minus line 22)	16,008,021		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	12,080		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	7,852		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	12,080		26
27	SUBTOTAL (sum of lines 23 and 25)	16,015,873		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	16,015,873		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	241,840		32.01
33	INTERIM PAYMENTS	15,761,209		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	12,824		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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	8,330,219	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (sum of lines 1-3)	8,330,219	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	DO NOT USE THIS LINE		5
6	DEDUCTIBLES		6
7	COINSURANCE	1,446,700	7
8	ALLOWABLE BAD DEBTS (see instructions)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	6,883,519	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		14
15	SUBTOTAL (line 12 minus 13 ± line 14)	6,883,519	15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	103,941	15.01
16	INTERIM PAYMENTS	6,775,579	16
17	TENTATIVE SETTLEMENT (for contractor use only)		17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)	3,999	18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0117

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	4,906,382		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	4,906,382		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	4,906,382		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)	4,906,382		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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T117

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	INPATIENT HOSPITAL SNF/NF SERVICES	156,840	1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (certified transplant centers only)		3
4	SUBTOTAL (sum of lines 1, 2 and 3)	156,840	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	156,840	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	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)	156,840	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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-5324

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX & Facility_Desc 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	247,828		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	247,828		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	247,828		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)	247,828		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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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					
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			48.41	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)			18.00	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)			0.05	3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))			3.28	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)			69.64	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			73.46	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			69.64	7
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	25.23	46.82	72.05	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	23.92	44.39	68.31	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	23.92	44.39		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	25.45	44.81		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	20.50	47.69		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	23.29	45.63		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	23.29	45.63		17
18	PER RESIDENT AMOUNT	95,749.43	93,014.79		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	2,230,004	4,244,265	6,474,269	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)			3.82	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)			6,474,269	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	44,334	3,857		26
27	TOTAL INPATIENT DAYS (see instructions)	67,909	67,909		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.652844	0.056797		28
29	PROGRAM DIRECT GME AMOUNT	4,226,688	367,719		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		51,959		30
31	NET PROGRAM DIRECT GME AMOUNT			4,542,448	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)			9,713,430	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)			104,425,678	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)			104,425,678	41
PART B REASONABLE COST					
42	REASONABLE COST (see instructions)			25,618,511	42
43	PRIMARY PAYER PAYMENTS (see instructions)			1,108	43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			25,617,403	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			130,043,081	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.803008	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			0.196992	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	TOTAL PROGRAM GME PAYMENT (line 31)			4,542,448	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			3,647,622	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			894,826	50



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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				
		PRIMARY CARE	OTHER	TOTAL
		1	2	3
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
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00
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
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00	
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00	
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00	
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00	
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00	
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00	
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00	
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00	
18	PER RESIDENT AMOUNT	0.00	0.00	
19	APPROVED AMOUNT FOR RESIDENT COSTS			
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)			
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)			
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)			
24	MULTIPLY LINE 22 TIMES LINE 23			
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			
COMPUTATION OF PROGRAM PATIENT LOAD				
		INPATIENT PART A	MANAGED CARE	
26	INPATIENT DAYS	4,333		26
27	TOTAL INPATIENT DAYS (see instructions)	67,909		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.063806	0.000000	28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE			30
31	NET PROGRAM DIRECT GME AMOUNT			31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)			38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)			39
40	PRIMARY PAYER PAYMENTS (see instructions)			40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			41
PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			42
43	PRIMARY PAYER PAYMENTS (see instructions)			43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)			47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (line 31)			48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)			49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)			50



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	32,105,975				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	137,369,584				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-93,240,098				6
7	INVENTORY	3,827,790				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	2,035,152				9
10	DUE FROM OTHER FUNDS	812,235,471				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	894,333,874				11
FIXED ASSETS						
12	LAND	580,293				12
13	LAND IMPROVEMENTS	308,710				13
14	ACCUMULATED DEPRECIATION	-271,256				14
15	BUILDINGS	10,809,326				15
16	ACCUMULATED DEPRECIATION	-10,602,233				16
17	LEASEHOLD IMPROVEMENTS	145,000				17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	170,545				19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS	518,038				21
22	ACCUMULATED DEPRECIATION	-429,573				22
23	MAJOR MOVABLE EQUIPMENT	126,320,214				23
24	ACCUMULATED DEPRECIATION	-102,252,761				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)	25,296,303				30
OTHER ASSETS						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	4,196,106				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	4,196,106				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	923,826,283				36
LIABILITIES AND FUND BALANCES						
	(Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	19,651,545				37
38	SALARIES, WAGES & FEES PAYABLE	69,374,677				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME	75,000				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	338,369,325				43
44	OTHER CURRENT LIABILITIES	182,818,255				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	610,288,802				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)					50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	610,288,802				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	313,537,481				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	313,537,481				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	923,826,283				60



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCES AT BEGINNING OF PERIOD		271,255,943		1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-1,709,711		2
3	TOTAL (sum of line 1 and line 2)		269,546,232		3
4	ADDITIONS (credit adjustments)				4
5					5
6	TRANSFERS TO AFFILIATES	43,991,230			6
7					7
8					8
9					9
10	TOTAL ADDITIONS (sum of lines 4-9)		43,991,230		10
11	SUBTOTAL (line 3 plus line 10)		313,537,462		11
12	DEDUCTIONS (debit adjustments)				12
13					13
14					14
15					15
16					16
17					17
18	TOTAL DEDUCTIONS (sum of lines 12-17)				18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		313,537,462		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	TRANSFERS TO AFFILIATES				6
7					7
8					8
9					9
10	TOTAL ADDITIONS (sum of lines 4-9)				10
11	SUBTOTAL (line 3 plus line 10)				11
12	DEDUCTIONS (debit adjustments)				12
13					13
14					14
15					15
16					16
17					17
18	TOTAL DEDUCTIONS (sum of lines 12-17)				18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)				19



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

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	160,057,788		160,057,788	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	27,935,843		27,935,843	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	21,572,519		21,572,519	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	209,566,150		209,566,150	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	36,048,804		36,048,804	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	36,048,804		36,048,804	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	245,614,954		245,614,954	17
18	ANCILLARY SERVICES	484,994,028	438,911,298	923,905,326	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	730,608,982	438,911,298	1,169,520,280	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		277,803,100	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39	RECONCILING ITEM			39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		277,803,100	43



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	1,169,520,280	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	903,963,006	2
3	NET PATIENT REVENUES (line 1 minus line 2)	265,557,274	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	277,803,100	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-12,245,826	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	7,519	6
7	INCOME FROM INVESTMENTS	5,622,549	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (REVENUE FROM OTHER SERVICES)	4,671,989	24
24.01	OTHER (NET ASSETS RELEASED FROM RESTRICTION)	234,058	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	10,536,115	25
26	TOTAL (line 5 plus line 25)	-1,709,711	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-1,709,711	29



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

WORKSHEET I-1

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

		TOTAL COSTS	BASIS	STATISTICS	FTEs PER 2080 HOURS	
		1	2	3	4	
1	REGISTERED NURSES	834,547	HOURS OF SERVICE	10,004.00	4.81	1
2	LICENSED PRACTICAL NURSES		HOURS OF SERVICE			2
3	NURSES AIDES		HOURS OF SERVICE			3
4	TECHNICIANS	121,443	HOURS OF SERVICE	3,248.00	1.56	4
5	SOCIAL WORKERS		HOURS OF SERVICE	620.00	0.30	5
6	DIETICIANS	37,117	HOURS OF SERVICE	622.00	0.30	6
7	PHYSICIANS		ACCUMULATED COST			7
8	NON-PATIENT CARE SALARY	48,101	ACCUMULATED COST			8
9	SUBTOTAL (sum of lines 1-8)	1,041,208				9
10	EMPLOYEE BENEFITS		SALARY			10
11	CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			11
12	CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			12
13	MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME			13
14	SUPPLIES		REQUISITIONS			14
15	DRUGS		REQUISITIONS			15
16	OTHER	432,939	ACCUMULATED COST			16
17	SUBTOTAL (sum of lines 9-16)	1,474,147				17
18	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	20,679	SQUARE FEET			18
19	CAPITAL RELATED COSTS-MOVABLE EQUIPMENT	50,883	PERCENTAGE OF TIME			19
20	EMPLOYEE BENEFITS DEPARTMENT		SALARY			20
21	ADMINISTRATIVE AND GENERAL	451,341	ACCUMULATED COST			21
22	MAINT./REPAIRS-OPERATION-HOUSEKEEPING	110,590	SQUARE FEET			22
23	MEDICAL EDUCATION PROGRAM COSTS					23
24	CENTRAL SERVICES & SUPPLIES		REQUISITIONS			24
25	PHARMACY		REQUISITIONS			25
26	OTHER ALLOCATED COSTS	60,297	ACCUMULATED COST			26
27	SUBTOTAL (sum of lines 17-26)	2,167,937				27
28	LABORATORY		CHARGES			28
29	RESPIRATORY THERAPY		CHARGES			29
30	OTHER ANCILLARY (SPECIFY)		CHARGES			30
30.97	CARDIAC REHABILITATION		CHARGES			30.97
30.98	HYPERBARIC OXYGEN THERAPY		CHARGES			30.98
30.99	LITHOTRIPSY		CHARGES			30.99
31	TOTAL COSTS (sum of lines 27-30)	2,167,937				31



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

WORKSHEET I-2

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT

HOME PROGRAM DIALYSIS

	OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS DEPARTMENT	DRUGS	
		BUILDING	EQUIPMENT	RNs	OTHER			
		1	2	3	4	5	6	
1	TOTAL RENAL DEPARTMENT COSTS	131,269	50,883	834,547	158,560			1
	MAINTENANCE							
2	HEMODIALYSIS	109,606	42,486	696,822	132,398			2
3	INTERMITTENT PERITONEAL							3
	TRAINING							
4	HEMODIALYSIS							4
5	INTERMITTENT PERITONEAL							5
6	CAPD							6
7	CCPD							7
	HOME							
8	HEMODIALYSIS							8
9	INTERMITTENT PERITONEAL							9
10	CAPD							10
11	CCPD							11
	OTHER BILLABLE SERVICES							
12	INPATIENT DIALYSIS	21,663	8,397	137,725	26,162			12
13	METHOD II HOME PATIENT							13
14	EPO (included in renal department)							14
15	ARANESP (included in renal department)							15
16	OTHER							16
17	TOTAL (sum of lines 2-16)	131,269	50,883	834,547	158,560			17
18	MEDICAL EDUCATION PROGRAM COSTS							18
19	TOTAL RENAL COSTS (line 17 + line 18)							19



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

WORKSHEET I-2

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

	OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	MEDICAL SUPPLIES	ROUTINE ANCILLARY SERVICES	SUBTOTAL (sum of cols. 1-8)	OVERHEAD	TOTAL (col. 9 + col. 10)	
		7	8	9	10	11	
1	TOTAL RENAL DEPARTMENT COSTS			1,175,259	992,678	2,167,937	1
	MAINTENANCE						
2	HEMODIALYSIS			981,312	828,861	1,810,173	2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS			193,947	163,817	357,764	12
13	METHOD II HOME PATIENT						13
14	EPO (included in renal department)						14
15	ARANESP (included in renal department)						15
16	OTHER						16
17	TOTAL (sum of lines 2-16)			1,175,259	992,678	2,167,937	17
18	MEDICAL EDUCATION PROGRAM COSTS						18
19	TOTAL RENAL COSTS (line 17 + line 18)					2,167,937	19



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

WORKSHEET I-3

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

	COMPOSITE PAYMENT SERVICES	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS DEPARTMENT (Salary)	
		BUILDING (Square Feet)	EQUIPMENT (% of Time)	RNs (Hours)	OTHERS (Hours)		
		1	2	3	4	5	
1	TOTAL RENAL DEPT COSTS	131,269	50,883	834,547	158,560		1
	MAINTENANCE						
2	HEMODIALYSIS	3,137	17,835.00	15,725.00	10,324.00	913,207	2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS TREATMENTS	620	3,525.00	3,108.00	2,040.00	180,479	12
13	METHOD II HOME PATIENT						13
14	EPO						14
15	ARANESP						15
16	OTHER						16
17	TOTAL STATISTICAL BASIS	3,757	21,360.00	18,833.00	12,364.00	1,093,686	17
18	UNIT COST MULTIPLIER (line 1 ÷ line 17)	34.939846	2.382163	44.313014	12.824329		18



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

WORKSHEET I-3

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT

HOME PROGRAM DIALYSIS

	COMPOSITE PAYMENT SERVICES	DRUGS (Requist.)	MEDICAL SUPPLIES (Requist.)	ROUTINE ANCILLARY SERVICES (Charges)	SUBTOTAL	OVERHEAD (Accum. Cost)	
		6	7	8	9	10	
1	TOTAL RENAL DEPT COSTS						1
	MAINTENANCE						
2	HEMODIALYSIS	432,492	276,378				2
3	INTERMITTENT PERITONEAL TRAINING						3
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS TREATMENTS	85,474	54,621				12
13	METHOD II HOME PATIENT						13
14	EPO						14
15	ARANESP						15
16	OTHER						16
17	TOTAL STATISTICAL BASIS	517,966	330,999			1,175,259	17
18	UNIT COST MULTIPLIER (line 1 ÷ line 17)					0.844646	18



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

WORKSHEET I-4

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

		NUMBER OF TOTAL TREATMENTS	TOTAL COST (from Wkst. 1-2, col. 11)	AVERAGE COST OF PROGRAM TREATMENTS (col. 2 ÷ col. 1)	NUMBER OF PROGRAM TREATMENTS	NUMBER OF PROGRAM TREATMENTS	NUMBER OF PROGRAM TREATMENTS	TOTAL PROGRAM EXPENSES (see instructions)	
		1	2	3	4	4.01	4.02	5	
1	MAINTENANCE - HEMODIALYSIS	6,183	1,810,173	292.77			6,183	1,810,197	1
2	MAINTENANCE - PERITONEAL DIALYSIS								2
3	TRAINING - HEMODIALYSIS								3
4	TRAINING - PERITONEAL DIALYSIS								4
5	TRAINING - CONTINUOUS AMBULATORY PERITONEAL DIALYSIS								5
6	TRAINING - CONTINUOUS CYCLING PERITONEAL DIALYSIS								6
7	HOME PROGRAM - HEMODIALYSIS								7
8	HOME PROGRAM - PERITONEAL DIALYSIS								8
		PATIENT WEEKS			PATIENT WEEKS	PATIENT WEEKS	PATIENT WEEKS		
9	HOME PROGRAM - CONTINUOUS AMBULATORY PERITONEAL DIALYSIS								9
10	HOME PROGRAM - CONTINUOUS CYCLING PERITONEAL DIALYSIS								10
11	TOTALS (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6)	6,183	1,810,173				6,183	1,810,197	11
12	TOTAL TREATMENTS (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))	6,183							12



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

WORKSHEET I-4

CHECK APPLICABLE BOX: RENAL DIALYSIS DEPARTMENT HOME PROGRAM DIALYSIS

		TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	TOTAL PROGRAM PAYMENT	AVERAGE PAYMENT RATE (col. 6 ÷ col. 4)	AVERAGE PAYMENT RATE (col. 6.01 ÷ col. 4.01)	AVERAGE PAYMENT RATE (col. 6.02 ÷ col. 4.02)	
		6	6.01	6.02	7	7.01	7.02	
1	MAINTENANCE - HEMODIALYSIS			1,606,449			259.82	1
2	MAINTENANCE - PERITONEAL DIALYSIS							2
3	TRAINING - HEMODIALYSIS							3
4	TRAINING - PERITONEAL DIALYSIS							4
5	TRAINING - CONTINUOUS AMBULATORY PERITONEAL DIALYSIS							5
6	TRAINING - CONTINUOUS CYCLING PERITONEAL DIALYSIS							6
7	HOME PROGRAM - HEMODIALYSIS							7
8	HOME PROGRAM - PERITONEAL DIALYSIS							8
9	HOME PROGRAM - CONTINUOUS AMBULATORY PERITONEAL DIALYSIS							9
10	HOME PROGRAM - CONTINUOUS CYCLING PERITONEAL DIALYSIS							10
11	TOTALS (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6)			1,606,449				11
12	TOTAL TREATMENTS (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))							12



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

WORKSHEET I-5

DESCRIPTION				
1		1	2	
1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (see instructions)		1,810,197	1
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11) (see instructions)			2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11) (see instructions)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11) (see instructions)	1,606,449	1,606,449	2.02
2.03	TOTAL PAYMENT DUE (see instructions)	1,606,449	1,606,449	2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			3.03
4	COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			4
4.01	COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)	321,257	321,257	4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)	321,257	321,257	4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (sum of line 5 through line 5.04)			5.05
6	ALLOWABLE BAD DEBTS (see instructions)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (Part B) PATIENTS (see instructions)		321,257	8
9	PROGRAM PAYMENT (see instructions)		1,285,159	9
10	UNRECOVERED FROM MEDICARE (Part B) PATIENTS (see instructions)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (transfer to Worksheet E, Part B, line 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12	TOTAL ALLOWABLE EXPENSES (see instructions)	1,810,173	12
13	TOTAL COMPOSITE COSTS (from Worksheet I-4, column 2, line 11)	1,810,173	13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (line 13 divided by line 12)	1.000000	14



PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0117

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

1	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	4,692,430	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	196,675	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)	145.30	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	69.59	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	14.47	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	678,995	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0194	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.1215	8
9	SUM OF LINES 7 AND 8	0.1409	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0289	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	135,611	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	5,703,711	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



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY 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
5.10	NON PATIENT PHONES						5.10
5.20	DATA PROCESSING						5.20
5.30	PURCHASING AND STORES						5.30
5.50	CASHIERS AR AND COLLECTIONS						5.50
5.60	ADMINISTRATION & GENERAL						5.60
5.90	RNP ADMINISTRATION						5.90
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
7.01	ELECTRICITY						7.01
7.02	RNP OPERATION OF PLANT						7.02
8	LAUNDRY & LINEN SERVICE						8
8.01	RNP LAUNDRY						8.01
9	HOUSEKEEPING						9
9.01	RNP HOSUEKEEPING						9.01
10	DIETARY						10
10.01	RNP DIETARY						10.01
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
17.01	RNP SOCIAL SERVICE						17.01
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
41	SUBPROVIDER - IRF						41
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
55	RADIOLOGY-THERAPEUTIC						55
56	RADIOISOTOPE						56
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
66.01	RNRC PHYSICAL THERAPY						66.01
66.02	DAY REHABILITATION FACILITY						66.02
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
70.01	ELECTROPHYSIOLOGY						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	WELLNESS PROGRAM						90.01
91	EMERGENCY						91
91.01	FAMILY PRACTICE						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)						92



COMPU-MAX

PRESENCE RESURRECTION MEDICAL CENTER Provider CCN: 14-0117	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/23/2014 Run Time: 10:33 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	OTHER							194
194.05	NON EMPLOYEE CHILD CARE							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202