



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY		1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 05/28/2014	TIME: 10:11
		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 MERCY MEDICAL CENTER (14-0174) ((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.

ECR Encryption: 05/28/2014 10:11
J1cJLfrwCl.ZF0Q:IH88JQbjXudx0
bEjju0geyRRPeZ4YQQCRMPfKDCM4F
e43D1nl5Fy04rTov

(SIGNED) *Anthony K...*
OFFICER OR ADMINISTRATOR OF PROVIDER(S)
Chief Financial Officer
TITLE
May 28, 2014
DATE

PI Encryption: 05/28/2014 10:11
tX9dIHhNEtBuz.ZzlynlsmU0Ym2RP0
XXPWv0m::B7AuAFT3gfpnYfhx18Pqz
OOZb0Im.K0YDj71

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIT	TITLE XIX
		PART A	PART B		
	1	2	3	4	5
1 HOSPITAL		-68,500	169,610	-20,160	1
2 SUBPROVIDER - IPF		55,068	-457		2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FOHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-13,432	169,153	-20,160	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.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:																			
1	STREET: 1325 NORTH HIGHLAND AVENUE		P.O. BOX:						1										
2	CITY: AURORA		STATE: IL		ZIP CODE: 60506		COUNTY: KANE		2										
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:																			
0	COMPONENT	1	COMPONENT NAME	2	CCN NUMBER	3	CBSA NUMBER	4	PROV-IDER TYPE	5	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)			6	7	8	9	
												V	XVIII	XIX					
3	HOSPITAL		PRESENCE MERCY MEDICAL CENTER		14-0174		16974		1		07/01/1966	N	P	O					3
4	SUBPROVIDER - IPF		PRESENCE PSYCH UNIT		14-S174		16974		4		07/01/1985	N	P	O					4
5	SUBPROVIDER - IRF																		5
6	SUBPROVIDER - (OTHER)																		6
7	SWING BEDS - SNF																		7
8	SWING BEDS - NF																		8
9	HOSPITAL-BASED SNF																		9
10	HOSPITAL-BASED NF																		10
11	HOSPITAL-BASED OLTG																		11
12	HOSPITAL-BASED HHA																		12
13	SEPARATELY CERTIFIED ASC																		13
14	HOSPITAL-BASED HOSPICE																		14
15	HOSPITAL-BASED HEALTH CLINIC - RHC																		15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC																		16
17	HOSPITAL-BASED (CMHC)																		17
18	RENAL DIALYSIS																		18
19	OTHER																		19
20	COST REPORTING PERIOD (mm/dd/yyyy)		FROM: 01 / 01 / 2013		TO: 12 / 31 / 2013														20
21	TYPE OF CONTROL (see instructions)		1																21
INPATIENT PPS INFORMATION											1	2							
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.										Y	N	22						
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)										N	Y	22.01						
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.										3	N	23						
					IN-STATE MEDICAID PAID DAYS	1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	2	OUT-OF-STATE MEDICAID PAID DAYS	3	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	4	MEDICAID HMO DAYS	5	OTHER MEDICAID DAYS	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.				4,282		1,150						1,624				24		
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.																25		
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.								1									26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.								1									27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.																35		
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.								BEGINNING:		ENDING:						36		
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.																37		
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.								BEGINNING:		ENDING:						38		
											1	2							



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		I	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	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 L (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



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WORKSHEET S-2
PART I

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



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WORKSHEET S-2
PART I

TITLE V AND XIX SERVICES		V	XIX		
		1	2		
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90	
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91	
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92	
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93	
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94	
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95	
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96	
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97	
RURAL PROVIDERS		1	2		
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105	
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106	
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107	
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108	
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	N	N	N
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:		290,616	1,076,991	
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02	
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120	
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121	
TRANSPLANT CENTER INFORMATION					
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.	N		125	
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126	
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127	
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128	
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129	
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130	
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131	
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132	
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133	
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS						
		1	2			
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	148003			140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.						
141	NAME: PRESENCE HEALTH PRV	CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES		CONTRACTOR'S NUMBER: 06101		141
142	STREET: 9223 W. ST FRANCIS ROAD	P.O. BOX:				142
143	CITY: FRANKFORT	STATE: IL	ZIP CODE: 60423			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y				144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y				145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N				146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				149
DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)						
		TITLE XVIII		TITLE V	TITLE XIX	
		PART A	PART B	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N		N	156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10
MULTICAMPUS						
165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					166
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5
HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT						
167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y				167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)					168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00				169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	05/01/2013	07/30/2013			170



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N		1	
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	Y		3	
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	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N	Y/N		
		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.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
BAD DEBTS					
		Y/N			
		Y		12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.	N		13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.	N		14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	05/01/2014	Y	05/01/2014
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS.	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART IIGENERAL 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 RELIEFED 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: JENNIFER	LAST NAME: HANES	TITLE: REIMBURSEMENT MGR
42	EMPLOYER: PRESENCE HEALTH		
43	PHONE NUMBER: (815) 806-2333	E-MAIL ADDRESS: JENNIFER.HANES@PRESENCEHEALTH.ORG	



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	51,714,587	16,250	51,730,837	1,718,679.00	30.10	1
2							2
3							3
4							4
4.01							4.01
5		242,840		242,840	3,502.00	69.34	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		5,497,828	-361,048	5,136,780	165,150.00	31.10	10
OTHER WAGES & RELATED COSTS							
11		2,536,470		2,536,470	68,842.00	36.84	11
12							12
13		366,487		366,487	2,689.00	136.29	13
14		9,944,716		9,944,716	180,706.00	55.03	14
15							15
16							16
WAGE-RELATED COSTS							
17		12,185,935		12,185,935			17
18							18
19		1,327,284		1,327,284			19
20							20
21							21
22							22
22.01							22.01
23		20,473		20,473			23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		137,490	16,250	153,740	4,349.00	35.35	26
27		6,017,514		6,017,514	189,333.00	31.78	27
28		25,623		25,623	547.00	46.84	28
29		457,644		457,644	19,394.00	23.60	29
30		1,145,346		1,145,346	37,724.00	30.36	30
31		6,870		6,870	583.00	11.78	31
32		1,287,336		1,287,336	90,583.00	14.21	32
33							33
34		725,391	-383,119	342,272	25,697.00	13.32	34
35		747,324		747,324	23,177.00	32.24	35
36			383,119	383,119	28,763.00	13.32	36
37							37
38		1,844,112		1,844,112	40,594.00	45.43	38
39		401,289		401,289	22,787.00	17.61	39
40		1,860,482		1,860,482	42,840.00	43.43	40
41		1,300,477		1,300,477	53,421.00	24.34	41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	52,244,694	16,250	52,260,944	1,738,901.00	30.05	1
2	EXCLUDED AREA SALARIES (see instructions)	5,497,828	-361,048	5,136,780	165,150.00	31.10	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	46,746,866	377,298	47,124,164	1,573,751.00	29.94	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	12,847,673		12,847,673	252,237.00	50.93	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	12,185,935		12,185,935		25.86%	5
6	TOTAL (sum of lines 3 through 5)	71,780,474	377,298	72,157,772	1,825,988.00	39.52	6
7	TOTAL OVERHEAD COST (see instructions)	15,956,898	16,250	15,973,148	579,792.00	27.55	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	1,934,828	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	-127,462	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,802,772	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)	5,213,589	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	118,805	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	11,846	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	211,341	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)	-139	14
15	WORKERS' COMPENSATION INSURANCE	664,037	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	3,697,835	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	-155,144	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)	-16,250	21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	177,636	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	13,533,694	24

PART B - OTHER THAN CORE RELATED COST

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

EXHIBIT 3

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

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

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD				
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	1/01/2012		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	1/01/2015		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S)	11
11.01		07/01/2012		11.01
11.02		07/01/2013		11.02
11.03		07/01/2014		11.03
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX				
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)	1,802,772		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	1,802,772		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	1,802,772		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

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



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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part 1, line 202, column 3 divided by line 202, column 8)	0.177896	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	28,094,250	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	146,099,080	6
7	MEDICAID COST (line 1 times line 6)	25,990,442	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.		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	309,309	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		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	33,370,572	1,061,619	34,432,191	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	5,936,491	188,858	6,125,349	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	242,863	225,240	468,103	22
23	COST OF CHARITY CARE (line 21 minus line 22)	5,693,628	-36,382	5,657,246	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)	16,428,021	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	640,668	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	15,787,353	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	2,808,507	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	8,465,753	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	8,465,753	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		9,558,262	9,558,262	-4,089,636	5,468,626	-2,045,693	3,422,933	1
2	00200	CAP REL COSTS-MVBLE EQUIP				6,046,505	6,046,505	-1,293	6,045,212	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	137,490	11,695,792	11,833,282	-13	11,833,269	2,027,593	13,860,862	4
5	00500	ADMINISTRATIVE & GENERAL	6,017,514	34,895,522	40,913,036	52,702	40,965,738	-7,744,483	33,221,255	5
6	00600	MAINTENANCE & REPAIRS	457,644	1,589,057	2,046,681	-197	2,046,484		2,046,484	6
7	00700	OPERATION OF PLANT	1,145,346	3,576,418	4,721,764	-161	4,721,603	-15,485	4,706,118	7
8	00800	LAUNDRY & LINEN SERVICE	6,870	450,146	457,016	-658	456,358		456,358	8
9	00900	HOUSEKEEPING	1,287,336	333,475	1,620,811	-1,200	1,619,611		1,619,611	9
10	01000	DIETARY	725,391	1,603,371	2,328,762	-1,229,980	1,098,782	-560,051	538,731	10
11	01100	CAFETERIA				1,229,948	1,229,948		1,229,948	11
13	01300	NURSING ADMINISTRATION	1,844,112	104,215	1,948,327	-6	1,948,321	-17,547	1,930,774	13
14	01400	CENTRAL SERVICES & SUPPLY	401,289	367,251	768,540	-442,920	325,620	-17	325,603	14
15	01500	PHARMACY	1,860,482	3,909,685	5,770,167	-3,516,931	2,253,236	-1,100	2,252,136	15
16	01600	MEDICAL RECORDS & LIBRARY	1,300,477	1,239,158	2,539,635	-24	2,539,611	-6,092	2,533,519	16
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	9,640,608	857,268	10,497,876	-533,765	9,964,111	-9,640	9,954,471	30
31	03100	INTENSIVE CARE UNIT	2,329,736	771,228	3,100,964	-143,795	2,957,169	-549,670	2,407,499	31
40	04000	SUBPROVIDER - IPF	4,820,297	336,372	5,156,669	-460,795	4,695,874	-207,401	4,488,473	40
43	04300	NURSERY	303,753	385,043	688,796	-13,483	675,313	-367,500	307,813	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	1,812,252	7,315,451	9,127,703	-5,735,089	3,392,614	-13,020	3,379,594	50
51	05100	RECOVERY ROOM	1,204,058	94,347	1,298,405	-21,964	1,276,441		1,276,441	51
52	05200	DELIVERY ROOM & LABOR ROOM	1,864,002	367,648	2,231,650	-48,064	2,183,586	-263,670	1,919,916	52
53	05300	ANESTHESIOLOGY	79,263	1,269,030	1,348,293	-128,427	1,219,866	-1,093,665	126,201	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,769,123	438,223	2,207,346	-272,733	1,934,613	-2,125	1,932,488	54
54.02	03630	ULTRASOUND	539,194	152,278	691,472	-25,556	665,916	-446	665,470	54.02
57	05700	CT SCAN	576,815	140,809	717,624	-120,304	597,320	-6,393	590,927	57
58	05800	MRI	254,991	60,342	315,333	-51,707	263,626	-4,114	259,512	58
59	05900	CARDIAC CATHETERIZATION	1,004,318	4,647,319	5,651,637	-4,619,568	1,032,069		1,032,069	59
60	06000	LABORATORY	18,311	4,594,295	4,612,606	-124,517	4,488,089	-11,443	4,476,646	60
63	06300	BLOOD STORING, PROCESSING & TRANS.		844,795	844,795		844,795		844,795	63
65	06500	RESPIRATORY THERAPY	870,488	115,604	986,092	-76,067	910,025		910,025	65
66	06600	PHYSICAL THERAPY	680,161	125,577	805,738	-1,331	804,407		804,407	66
67	06700	OCCUPATIONAL THERAPY	213,084	25,043	238,127	-1,598	236,529		236,529	67
68	06800	SPEECH PATHOLOGY	309,663	30,143	339,806	-1,770	338,036		338,036	68
69	06900	ELECTROCARDIOLOGY	403,162	21,432	424,594	-5,283	419,311	-2,155	417,156	69
70.01	03320	ECT	36,934	3,882	40,816		45,076		45,076	70.01
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				6,018,687	6,018,687		6,018,687	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				7,232,623	7,232,623		7,232,623	72
73	07300	DRUGS CHARGED TO PATIENTS				3,513,701	3,513,701		3,513,701	73
74	07400	RENAL DIALYSIS		539,963	539,963		539,963		539,963	74
75.01	03550	PSYCHOLOGY	578,779	16,062	594,841	117,859	712,700	-5,665	707,035	75.01
76	03950	OCCUPATIONAL HEALTH	416,394	945,411	1,361,805	-22,263	1,339,542	-453,810	885,732	76
76.97	07697	CARDIAC REHABILITATION	239,144	6,710	245,854	-2,698	243,156	-45	243,111	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	622,500	360,949	983,449	-13,254	970,195	-2,200	967,995	90
90.01	09001	OUTPATIENT PROCEDURES	13,179	90,773	103,952	441,673	545,625	-75,426	470,199	90.01
90.02	09002	PRCC	2,234,994	28,574,021	30,809,015	-532,204	30,276,811	-7,351,069	22,925,742	90.02
91	09100	EMERGENCY	3,017,902	1,918,132	4,936,034	-528,996	4,407,038	-798,841	3,608,197	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		3,581,105	3,581,105	-1,898,287	1,682,818	-1,682,818		113
118		SUBTOTALS (sum of lines 1-117)	51,037,056	127,951,587	178,988,643	-7,286	178,981,357	-21,265,284	157,716,073	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,184	69,459	73,643		73,643		73,643	190
192.01	19201	PHYSICIAN PRACTICE MANAGEMENT		2,464	2,464		2,464		2,464	192.01
193.01	19301	MASSAGE THERAPY	25,775	711	26,486	75	26,561		26,561	193.01
193.02	19302	IDOL SPACE/HOME HEALTH								193.02
193.03	19303	ADOL SCHOOL	35,227		35,227	7,242	42,469	-35,227	7,242	193.03
193.04	19304	FOUNDATION	170,245	46,704	216,949	-31	216,918	-86,387	130,531	193.04
193.05	19305	LEASED BLDG		48,451	48,451		48,451		48,451	193.05
193.07	19307	PARISH NURSING	208,507	463	208,970		208,970	-31,772	177,198	193.07
194	07950	OP PHARMACY	233,593	1,139,588	1,373,181		1,373,181		1,373,181	194
200		TOTAL (sum of lines 118-199)	51,714,587	129,259,427	180,974,014		180,974,014	-21,418,670	159,555,344	200



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (I)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
1	RECLASS SUPPLY COSTS	A	MEDICAL SUPPLIES CHARGED TO P	71		6,018,687	1
2	RECLASS SUPPLY COSTS	A	IMPL. DEV. CHARGED TO PATIENT	72		7,232,623	2
3	RECLASS SUPPLY COSTS	A	MASSAGE THERAPY	193.01		75	3
4	RECLASS SUPPLY COSTS	A					4
5	RECLASS SUPPLY COSTS	A					5
6	RECLASS SUPPLY COSTS	A					6
7	RECLASS SUPPLY COSTS	A					7
8	RECLASS SUPPLY COSTS	A					8
9	RECLASS SUPPLY COSTS	A					9
10	RECLASS SUPPLY COSTS	A					10
11	RECLASS SUPPLY COSTS	A					11
12	RECLASS SUPPLY COSTS	A					12
13	RECLASS SUPPLY COSTS	A					13
14	RECLASS SUPPLY COSTS	A					14
15	RECLASS SUPPLY COSTS	A					15
16	RECLASS SUPPLY COSTS	A					16
17	RECLASS SUPPLY COSTS	A					17
18	RECLASS SUPPLY COSTS	A					18
19	RECLASS SUPPLY COSTS	A					19
20	RECLASS SUPPLY COSTS	A					20
21	RECLASS SUPPLY COSTS	A					21
22	RECLASS SUPPLY COSTS	A					22
23	RECLASS SUPPLY COSTS	A					23
24	RECLASS SUPPLY COSTS	A					24
25	RECLASS SUPPLY COSTS	A					25
26	RECLASS SUPPLY COSTS	A					26
27	RECLASS SUPPLY COSTS	A					27
28	RECLASS SUPPLY COSTS	A					28
29	RECLASS SUPPLY COSTS	A					29
30	RECLASS SUPPLY COSTS	A					30
31	RECLASS SUPPLY COSTS	A					31
32	RECLASS SUPPLY COSTS	A					32
33	RECLASS SUPPLY COSTS	A					33
34	RECLASS SUPPLY COSTS	A					34
35	RECLASS SUPPLY COSTS	A					35
36	RECLASS SUPPLY COSTS	A					36
37	RECLASS SUPPLY COSTS	A					37
38	RECLASS SUPPLY COSTS	A					38
39							39
500	TOTAL RECLASSIFICATIONS					13,251,385	500
	CODE LETTER - A						
1							1
2							2
3	PHARMACY	B	DRUGS CHARGED TO PATIENTS	73		3,513,701	3
500	TOTAL RECLASSIFICATIONS					3,513,701	500
	CODE LETTER -						
1							1
2							2
3	INTEREST	C	CAP REL COSTS-BLDG & FIXT	1		1,898,287	3
500	TOTAL RECLASSIFICATIONS					1,898,287	500
	CODE LETTER -						
1							1
2							2
3	PSYCH ADMIN RECLASS	D	ADULTS & PEDIATRICS	30	253,553	45,013	3
4	PSYCH ADMIN RECLASS	D	ECT	70.01	6,448	1,145	4
5	PSYCH ADMIN RECLASS	D	PSYCHOLOGY	75.01	101,047	17,939	5
6	PSYCH ADMIN RECLASS	D	ADOL SCHOOL	193.03	6,150	1,092	6
500	TOTAL RECLASSIFICATIONS				367,198	65,189	500
	CODE LETTER -						
1							1
2							2
3	DEFERRED COMP	E	EMPLOYEE BENEFITS DEPARTMENT	4	16,250		3
500	TOTAL RECLASSIFICATIONS				16,250		500
	CODE LETTER -						
1							1
2							2
3	CAFETERIA	F	CAFETERIA	11	383,119	846,829	3
500	TOTAL RECLASSIFICATIONS				383,119	846,829	500
	CODE LETTER -						
1							1



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
2							2
3	OP PROCEDURES	G	OUTPATIENT PROCEDURES	90.01	405,650	36,071	3
500	TOTAL RECLASSIFICATIONS				405,650	36,071	500
	CODE LETTER -						
1							1
2							2
3	EQUIP DEPR	I	CAP REL COSTS-MVBLE EQUIP	2		5,933,844	3
4			ADMINISTRATIVE & GENERAL	5		54,079	4
500	TOTAL RECLASSIFICATIONS					5,987,923	500
	CODE LETTER -						
1							1
2							2
3							3
4	LAB EQUIPMENT	J	CAP REL COSTS-MVBLE EQUIP	2		112,661	4
500	TOTAL RECLASSIFICATIONS					112,661	500
	CODE LETTER -						
	GRAND TOTAL (INCREASES)				1,172,217	25,712,046	

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



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RECLASSIFICATIONS

WORKSHEET A-6

(1)	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.	
			COST CENTER	LINE #	SALARY	OTHER		
		I	6	7	8	9	10	
1	RECLASS SUPPLY COSTS	A	EMPLOYEE BENEFITS DEPARTMENT	4		13		1
2	RECLASS SUPPLY COSTS	A	ADMINISTRATIVE & GENERAL	5		1,377		2
3	RECLASS SUPPLY COSTS	A	MAINTENANCE & REPAIRS	6		197		3
4	RECLASS SUPPLY COSTS	A	OPERATION OF PLANT	7		161		4
5	RECLASS SUPPLY COSTS	A	HOUSEKEEPING	9		1,200		5
6	RECLASS SUPPLY COSTS	A	DIETARY	10		32		6
7	RECLASS SUPPLY COSTS	A	NURSING ADMINISTRATION	13		6		7
8	RECLASS SUPPLY COSTS	A	CENTRAL SERVICES & SUPPLY	14		442,920		8
9	RECLASS SUPPLY COSTS	A	PHARMACY	15		3,230		9
10	RECLASS SUPPLY COSTS	A	MEDICAL RECORDS & LIBRARY	16		24		10
11	RECLASS SUPPLY COSTS	A	ADULTS & PEDIATRICS	30		390,610		11
12	RECLASS SUPPLY COSTS	A	INTENSIVE CARE UNIT	31		143,795		12
13	RECLASS SUPPLY COSTS	A	SUBPROVIDER - IPF	40		28,408		13
14	RECLASS SUPPLY COSTS	A	NURSERY	43		13,483		14
15	RECLASS SUPPLY COSTS	A	OPERATING ROOM	50		5,735,089		15
16	RECLASS SUPPLY COSTS	A	RECOVERY ROOM	51		21,964		16
17	RECLASS SUPPLY COSTS	A	DELIVERY ROOM & LABOR ROOM	52		48,064		17
18	RECLASS SUPPLY COSTS	A	ANESTHESIOLOGY	53		128,427		18
19	RECLASS SUPPLY COSTS	A	RADIOLOGY-DIAGNOSTIC	54		272,733		19
20	RECLASS SUPPLY COSTS	A	ULTRASOUND	54.02		25,556		20
21	RECLASS SUPPLY COSTS	A	CT SCAN	57		120,304		21
22	RECLASS SUPPLY COSTS	A	MRI	58		51,707		22
23	RECLASS SUPPLY COSTS	A	CARDIAC CATHETERIZATION	59		4,619,568		23
24	RECLASS SUPPLY COSTS	A	LABORATORY	60		11,856		24
25	RECLASS SUPPLY COSTS	A	RESPIRATORY THERAPY	65		76,067		25
26	RECLASS SUPPLY COSTS	A	PHYSICAL THERAPY	66		1,331		26
27	RECLASS SUPPLY COSTS	A	OCCUPATIONAL THERAPY	67		1,598		27
28	RECLASS SUPPLY COSTS	A	SPEECH PATHOLOGY	68		1,770		28
29	RECLASS SUPPLY COSTS	A	ELECTROCARDIOLOGY	69		5,283		29
30	RECLASS SUPPLY COSTS	A	ECT	70.01		3,333		30
31	RECLASS SUPPLY COSTS	A	PSYCHOLOGY	75.01		1,127		31
32	RECLASS SUPPLY COSTS	A	OCCUPATIONAL HEALTH	76		22,263		32
33	RECLASS SUPPLY COSTS	A	CARDIAC REHABILITATION	76.97		2,698		33
34	RECLASS SUPPLY COSTS	A	CLINIC	90		13,254		34
35	RECLASS SUPPLY COSTS	A	OUTPATIENT PROCEDURES	90.01		48		35
36	RECLASS SUPPLY COSTS	A	PRCC	90.02		532,204		36
37	RECLASS SUPPLY COSTS	A	EMERGENCY	91		528,996		37
38	RECLASS SUPPLY COSTS	A	FOUNDATION	193.04		31		38
39	RECLASS SUPPLY COSTS	A	LAUNDRY & LINEN SERVICE	8		658		39
500	TOTAL RECLASSIFICATIONS					13,251,385		500
	CODE LETTER - A							
1								1
2								2
3	PHARMACY	B	PHARMACY	15		3,513,701		3
500	TOTAL RECLASSIFICATIONS					3,513,701		500
	CODE LETTER -							
1								1
2								2
3	INTEREST	C	INTEREST EXPENSE	113		1,898,287	11	3
500	TOTAL RECLASSIFICATIONS					1,898,287		500
	CODE LETTER -							
1								1
2								2
3	PSYCH ADMIN RECLASS	D	SUBPROVIDER - IPF	40	367,198	65,189		3
4	PSYCH ADMIN RECLASS	D						4
5	PSYCH ADMIN RECLASS	D						5
6	PSYCH ADMIN RECLASS	D						6
500	TOTAL RECLASSIFICATIONS				367,198	65,189		500
	CODE LETTER -							
1								1
2								2
3	DEFERRED COMP	E	EMPLOYEE BENEFITS DEPARTMENT	4		16,250		3
500	TOTAL RECLASSIFICATIONS					16,250		500
	CODE LETTER -							
1								1
2								2
3	CAFETERIA	F	DIETARY	10	383,119	846,829		3
500	TOTAL RECLASSIFICATIONS				383,119	846,829		500
	CODE LETTER -							



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1							1	
2							2	
3	OP PROCEDURES	G	ADULTS & PEDIATRICS	30	405,650	36,071	3	
500	TOTAL RECLASSIFICATIONS				405,650	36,071	500	
	CODE LETTER -							
1							1	
2							2	
3	EQUIP DEPR	I	CAP REL COSTS-BLDG & FIXT	1		5,987,923	9	
4							4	
500	TOTAL RECLASSIFICATIONS					5,987,923	500	
	CODE LETTER -							
1							1	
2							2	
3							3	
4	LAB EQUIPMENT	J	LABORATORY	60		112,661	9	
500	TOTAL RECLASSIFICATIONS					112,661	500	
	CODE LETTER -							
	GRAND TOTAL (DECREASES)				1,155,967	25,728,296		

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



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
			PURCHASES	DONATION	TOTAL			
		1	2	3	4	5	6	7
1	LAND	4,545,766					4,545,766	1
2	LAND IMPROVEMENTS	4,381,101	11,895		11,895		4,392,996	2
3	BUILDINGS AND FIXTURES	114,203,120	5,360,787		5,360,787	2,881	119,561,026	3
4	BUILDING IMPROVEMENTS	896,639	5,573		5,573		902,212	4
5	FIXED EQUIPMENT	5,035,008	69,026		69,026		5,104,034	5
6	MOVABLE EQUIPMENT	45,301,377	532,827		532,827	1,327,007	44,507,197	6
7	HIT DESIGNATED ASSETS							7
8	SUBTOTAL (sum of lines 1-7)	174,363,011	5,980,108		5,980,108	1,329,888	179,013,231	8
9	RECONCILING ITEMS	7,292,597				4,477,287	2,815,310	9
10	TOTAL (line 7 minus line 9)	167,070,414	5,980,108		5,980,108	3,147,399	176,197,921	10

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

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	9,558,262						9,558,262	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)	9,558,262						9,558,262	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	129,960,268		129,960,268	0.744897					1
2	CAP REL COSTS-MVBLE EQUIP	44,507,197		44,507,197	0.255103					2
3	TOTAL (sum of lines 1-2)	174,467,465		174,467,465	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	3,102,452		404,610			-84,129	3,422,933	1
2	CAP REL COSTS-MVBLE EQUIP	6,046,505					-1,293	6,045,212	2
3	TOTAL (sum of lines 1-2)	9,148,957		404,610			-85,422	9,468,145	3

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



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			WKST A-7 REF. 5
				COST CENTER	LINE#		
		1	2	3	4		
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-1,493,677	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-6,564	ADMINISTRATIVE & GENERAL	5		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)	B	-29,610	ADMINISTRATIVE & GENERAL	5		6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	B	-144,000	ADMINISTRATIVE & GENERAL	5		7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-11,137,742				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-7,515,965				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS						14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-6,092	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	MISC MEDICAL STAFF INCOME	B	-20,500	ADMINISTRATIVE & GENERAL	5		33
34	HR ABSTRACT REVENUE	B	-85	EMPLOYEE BENEFITS DEPARTMENT	4		34
35	MISC A&G INCOME OFFSET	B	-62,785	ADMINISTRATIVE & GENERAL	5		35
36							36
37	MISC OPERATION OF PLANT INCOME	B	-15,485	OPERATION OF PLANT	7		37
38	CAFETERIA AND VENDING SALES	B	-544,905	DIETARY	10		38
38.01	MEALS ON WHEELS INCOME OFFSET	B	-15,145	DIETARY	10		38.01
39	MISC CAFETERIA INCOME OFFSET	B	-1	DIETARY	10		39
40	MISC INCOME SUBPROVIDER	B	-62,133	SUBPROVIDER - IPF	40		40
41	MISC RADIOLOGY INCOME	B	-203	RADIOLOGY-DIAGNOSTIC	54		41
42	MISC INCOME DELIVERY	B	-520	DELIVERY ROOM & LABOR ROOM	52		42
43	MISC INCOME - EKG	B	-45	CARDIAC REHABILITATION	76.97		43
44							44
44.02	ADOL SCHOOL MISC REVENUE	B	-35,227	ADOL SCHOOL	193.03		44.02
44.03	MISC INCOME PSYCHOLOGY	B	-550	PSYCHOLOGY	75.01		44.03
44.04	MISC INCOME CLINIC	B	-2,200	CLINIC	90		44.04
44.05	MISC INCOME NURSING ADMIN	B	-17,547	NURSING ADMINISTRATION	13		44.05
44.06	MISC INCOME MATERIALS MGMT	B	-17	CENTRAL SERVICES & SUPPLY	14		44.06
45							45
45.03	FAITH COM NURSING MISC INCOME	B	-31,772	PARISH NURSING	193.07		45.03
45.04	RENT INCOME CARDIO PULMONARY	B	-2,155	ELECTROCARDIOLOGY	69		45.04
45.06	NON-ALLOW DONATIONS, SPONSORSHI	A	-86,387	FOUNDATION	193.04		45.06
45.07	NON-ALLOW DONATIONS, SPONSORSHI	A	-19,602	ADMINISTRATIVE & GENERAL	5		45.07
45.10	REMOVE PHYSICIAN LOAN AMORTIZAT	A	-84,129	CAP REL COSTS-BLDG & FIXT	1	14	45.10
45.13	MISC PHARMACY REVENUE	B	-1,100	PHARMACY	15		45.13
45.16	MISC ER INCOME	B	-41,485	EMERGENCY	91		45.16
45.18	NON ALLOWABLE LOBBYING DUES	A	-35,277	ADMINISTRATIVE & GENERAL	5		45.18
45.19	OFFSET UNUSED BUILDING DEPR	A	-1,293	CAP REL COSTS-MVBLE EQUIP	2	14	45.19
46							46
47	OTHER MINISTRY EXPENSES	A	-4,472	ADMINISTRATIVE & GENERAL	5		47
48							48



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.	
				COST CENTER	LINE#		
		1	2	3	4	5	
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-21,418,670				50

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

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



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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
1	2	3	4	5	6	7	
1	1	CAP REL COSTS-BLDG & FIXT	CAPITAL	2,392,967	2,860,854	-467,887	9
2	4	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	2,564,253	536,575	2,027,678	2
3	5	ADMINISTRATIVE & GENERAL	A&G	9,592,984	16,985,922	-7,392,938	3
3.01	10	DIETARY	DIETARY	753,381	753,381		3.01
3.02	59	CARDIAC CATHETERIZATION	CARDIAC CATH LAB	-26,112	-26,112		3.02
3.03	90	CLINIC	DIABETIC HEALTH	37,474	37,474		3.03
3.04	90.02	PRCC	PRCC	59,556	59,556		3.04
3.05	113	INTEREST EXPENSE	INTEREST	1,891,940	3,574,758	-1,682,818	11
4			EMM				4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			17,266,443	24,782,408	-7,515,965	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
B	PRESENCE HEALTH PRV		PRESENCE HEALTH PRV	100.00	HEALTHCARE CHAIN

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GEN ADMINISTRATIVE	57,258		57,258	154,100	385	28,523	1,426	1
2	31	INTENSIVE CARE UNIT INTENSIVE CARE	552,481	547,736	4,745	177,200	33	2,811	141	2
3	30	ADULTS & PEDIATRICS ADULTS & PEDIAT	23,420		23,420	154,100	186	13,780	689	3
4	40	SUBPROVIDER - IPF SUBPROVIDER - I	178,977	124,898	54,079	154,100	455	33,709	1,685	4
5	43	NURSERY NURSERY	367,500	367,500						5
6	52	DELIVERY ROOM & LABO DELIVERY ROOM &	263,150	263,150						6
7	53	ANESTHESIOLOGY ANESTHESIOLOGY	1,093,665	1,093,665						7
8	54	RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN	1,922	1,922						8
9	54.02	ULTRASOUND ULTRASOUND	446	446						9
10	57	CT SCAN COMPUTED TOMOGR	6,393	6,393						10
11	58	MRI MAGNETIC RESONA	4,114	4,114						11
12	76	OCCUPATIONAL HEALTH OCCUPATIONAL HE	453,810	453,810						12
13	90.01	OUTPATIENT PROCEDURE OUTPATIENT PROC	75,426	75,426						13
14	90.02	PRCC PRCC	7,351,069	7,351,069						14
15	91	EMERGENCY EMERGENCY	841,100	700,048	141,052	177,200	983	83,744	4,187	15
16	50	OPERATING ROOM OPERATING ROOM	19,750		19,750	177,200	79	6,730	337	16
17	60	LABORATORY LABORATORY	109,441		109,441	215,700	945	97,998	4,900	17
18	75.01	PSYCHOLOGY PSYCHOLOGY	10,820		10,820	154,100	77	5,705	285	18
200		TOTAL	11,410,742	10,990,177	420,565		3,143	273,000	13,650	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING 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 ADMINISTRATIVE & GEN ADMINISTRATIVE					28,523	28,735	28,735	1
2	31 INTENSIVE CARE UNIT INTENSIVE CARE					2,811	1,934	549,670	2
3	30 ADULTS & PEDIATRICS ADULTS & PEDIAT					13,780	9,640	9,640	3
4	40 SUBPROVIDER - IPF SUBPROVIDER - I					33,709	20,370	145,268	4
5	43 NURSERY NURSERY							367,500	5
6	52 DELIVERY ROOM & LABO DELIVERY ROOM &							263,150	6
7	53 ANESTHESIOLOGY ANESTHESIOLOGY							1,093,665	7
8	54 RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGN							1,922	8
9	54.02 ULTRASOUND ULTRASOUND							446	9
10	57 CT SCAN COMPUTED TOMOGR							6,393	10
11	58 MRI MAGNETIC RESONA							4,114	11
12	76 OCCUPATIONAL HEALTH OCCUPATIONAL HE							453,810	12
13	90.01 OUTPATIENT PROCEDURE OUTPATIENT PROC							75,426	13
14	90.02 PRCC PRCC							7,351,069	14
15	91 EMERGENCY EMERGENCY					83,744	57,308	757,356	15
16	50 OPERATING ROOM OPERATING ROOM					6,730	13,020	13,020	16
17	60 LABORATORY LABORATORY					97,998	11,443	11,443	17
18	75.01 PSYCHOLOGY PSYCHOLOGY					5,705	5,115	5,115	18
200	TOTAL					273,000	147,565	11,137,742	200



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART I - GENERAL INFORMATION

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

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



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		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



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	3,422,933	3,422,933					1
2	CAP REL COSTS-MVBLE EQUIP	6,045,212		6,045,212				2
4	EMPLOYEE BENEFITS DEPARTMENT	13,860,862	31,940	56,408	13,949,210			4
5	ADMINISTRATIVE & GENERAL	33,221,255	625,465	1,104,629	1,627,461	36,578,810	36,578,810	5
6	MAINTENANCE & REPAIRS	2,046,484	487,068	860,207	123,772	3,517,531	1,046,272	6
7	OPERATION OF PLANT	4,706,118	148,804	262,802	309,763	5,427,487	1,614,379	7
8	LAUNDRY & LINEN SERVICE	456,358	4,944	8,732	1,858	471,892	140,362	8
9	HOUSEKEEPING	1,619,611	55,043	97,211	348,165	2,120,030	630,592	9
10	DIETARY	538,731	125,948	222,436	196,185	1,083,300	322,222	10
11	CAFETERIA	1,229,948				1,229,948	365,842	11
13	NURSING ADMINISTRATION	1,930,774	36,406	64,295	498,747	2,530,222	752,602	13
14	CENTRAL SERVICES & SUPPLY	325,603	117,487	207,492	108,530	759,112	225,794	14
15	PHARMACY	2,252,136	85,595	151,168	503,175	2,992,074	889,977	15
16	MEDICAL RECORDS & LIBRARY	2,533,519	58,831	103,901	351,719	3,047,970	906,603	16
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	9,954,471	132,687	234,337	2,607,324	12,928,819	3,845,613	30
31	INTENSIVE CARE UNIT	2,407,499	159,299	281,337	630,086	3,478,221	1,034,579	31
40	SUBPROVIDER - IPF	4,488,473	316,620	559,181	1,303,666	6,667,940	1,983,345	40
43	NURSERY	307,813	9,275	16,380	82,151	415,619	123,624	43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	3,379,594	229,630	405,547	490,131	4,504,902	1,339,961	50
51	RECOVERY ROOM	1,276,441	180,624	318,999	325,642	2,101,706	625,142	51
52	DELIVERY ROOM & LABOR ROOM	1,919,916	146,930	259,492	504,127	2,830,465	841,908	52
53	ANESTHESIOLOGY	126,201	5,048	8,915	21,437	161,601	48,067	53
54	RADIOLOGY-DIAGNOSTIC	1,932,488	99,623	175,943	478,466	2,686,520	799,092	54
54.02	ULTRASOUND	665,470	22,784	40,239	145,827	874,320	260,062	54.02
57	CT SCAN	590,927	11,269	19,901	156,002	778,099	231,442	57
58	MRI	259,512	20,376	35,986	68,963	384,837	114,468	58
59	CARDIAC CATHETERIZATION	1,032,069	26,349	46,535	271,622	1,376,575	409,455	59
60	LABORATORY	4,476,646	5,247	9,268	4,952	4,496,113	1,337,346	60
63	BLOOD STORING, PROCESSING & TRANS.	844,795	4,298	7,592		856,685	254,817	63
65	RESPIRATORY THERAPY	910,025	8,350	14,746	235,427	1,168,548	347,579	65
66	PHYSICAL THERAPY	804,407	28,989	51,197	183,952	1,068,545	317,833	66
67	OCCUPATIONAL THERAPY	236,529			57,629	294,158	87,496	67
68	SPEECH PATHOLOGY	338,036	2,464	4,352	83,750	428,602	127,486	68
69	ELECTROCARDIOLOGY	417,156	25,879	45,704	109,037	597,776	177,805	69
70.01	ECT	45,076			9,989	55,065	16,379	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,018,687				6,018,687	1,790,228	71
72	IMPL. DEV. CHARGED TO PATIENTS	7,232,623				7,232,623	2,151,308	72
73	DRUGS CHARGED TO PATIENTS	3,513,701				3,513,701	1,045,133	73
74	RENAL DIALYSIS	539,963	4,179	7,380		551,522	164,047	74
75.01	PSYCHOLOGY	707,035	39,372	69,535	156,533	972,475	289,258	75.01
76	OCCUPATIONAL HEALTH	885,732	3,254	5,746	112,615	1,007,347	299,630	76
76.97	CARDIAC REHABILITATION	243,111	22,465	39,676	64,677	369,929	110,034	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	967,995	3,182	5,620	168,358	1,145,155	340,621	90
90.01	OUTPATIENT PROCEDURES	470,199			3,564	473,763	140,918	90.01
90.02	PRCC	22,925,742			604,463	23,530,205	6,998,997	90.02
91	EMERGENCY	3,608,197	129,377	228,492	816,204	4,782,270	1,422,462	91
92	OBSERVATION BEDS (NON-DISTINCT PAR'T)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	157,716,073	3,415,101	6,031,381	13,765,969	157,511,169	35,970,780	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	73,643			1,132	74,775	22,241	190
192.01	PHYSICIAN PRACTICE MANAGEMENT	2,464				2,464	733	192.01
193.01	MASSAGE THERAPY	26,561			6,971	33,532	9,974	193.01
193.02	IDOL SPACE/HOME HEALTH							193.02
193.03	ADOL SCHOOL	7,242			9,527	16,769	4,988	193.03
193.04	FOUNDATION	130,531	5,559	9,817	46,043	191,950	57,095	193.04
193.05	LEASED BLDG	48,451				48,451	14,412	193.05
193.07	PARISH NURSING	177,198	2,273	4,014	56,392	239,877	71,350	193.07
194	OP PHARMACY	1,373,181			63,176	1,436,357	427,237	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	159,555,344	3,422,933	6,045,212	13,949,210	159,555,344	36,578,810	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS	4,563,803						6
7	OPERATION OF PLANT	298,058	7,339,924					7
8	LAUNDRY & LINEN SERVICE	9,904	17,041	639,199				8
9	HOUSEKEEPING	110,252	189,707		3,050,581			9
10	DIETARY	252,276	434,084	12,367	185,641	2,289,890		10
11	CAFETERIA						1,595,790	11
13	NURSING ADMINISTRATION	72,921	125,473		53,660			13
14	CENTRAL SERVICES & SUPPLY	235,328	404,921		173,169			14
15	PHARMACY	171,448	295,005		126,162			15
16	MEDICAL RECORDS & LIBRARY	117,840	202,763		86,714			16
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	265,774	457,309	254,493	195,573	1,243,296	866,435	30
31	INTENSIVE CARE UNIT	319,079	549,029	48,227	234,798	149,313	104,054	31
40	SUBPROVIDER - IPF	634,198	1,091,241	41,043	466,681	825,715	575,429	40
43	NURSERY	18,578	31,966	11,641	13,671			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	459,954	791,427	25,300	338,462			50
51	RECOVERY ROOM	361,794	622,526	44,469	266,230	11,962	8,336	51
52	DELIVERY ROOM & LABOR ROOM	294,304	506,399	34,924	216,567	45,064	31,404	52
53	ANESTHESIOLOGY	10,112	17,399		7,441			53
54	RADIOLOGY-DIAGNOSTIC	199,546	343,353	22,582	146,839			54
54.02	ULTRASOUND	45,638	78,527	11,008	33,583			54.02
57	CT SCAN	22,571	38,837		16,609			57
58	MRI	40,813	70,226		30,033			58
59	CARDIAC CATHETERIZATION	52,778	90,813	6,160	38,837			59
60	LABORATORY	10,511	18,086		7,735			60
63	BLOOD STORING, PROCESSING & TRANS.	8,610	14,815		6,336			63
65	RESPIRATORY THERAPY	16,725	28,778		12,307			65
66	PHYSICAL THERAPY	58,065	99,911		42,728			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY	4,936	8,493		3,632			68
69	ELECTROCARDIOLOGY	51,835	89,191		38,144			69
70.01	ECT							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	8,370	14,403		6,159			74
75.01	PSYCHOLOGY	78,863	135,698		58,033			75.01
76	OCCUPATIONAL HEALTH	6,517	11,214		4,796			76
76.97	CARDIAC REHABILITATION	44,999	77,428		33,113			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	6,374	10,967		4,690			90
90.01	OUTPATIENT PROCEDURES							90.01
90.02	PRCC							90.02
91	EMERGENCY	259,145	445,903	126,985	190,695	14,540	10,132	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	4,548,116	7,312,933	639,199	3,039,038	2,289,890	1,595,790	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192.01	PHYSICIAN PRACTICE MANAGEMENT							192.01
193.01	MASSAGE THERAPY							193.01
193.02	IDOL SPACE/HOME HEALTH							193.02
193.03	ADOL SCHOOL							193.03
193.04	FOUNDATION	11,134	19,158		8,193			193.04
193.05	LEASED BLDG							193.05
193.07	PARISH NURSING	4,553	7,833		3,350			193.07
194	OP PHARMACY							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,563,803	7,339,924	639,199	3,050,581	2,289,890	1,595,790	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 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	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	3,534,878						13
14	CENTRAL SERVICES & SUPPLY		1,798,324					14
15	PHARMACY	127,175	3,819	4,605,660				15
16	MEDICAL RECORDS & LIBRARY		4,862		4,366,752			16
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	999,821	29,932	34,316	390,727	21,512,108		30
31	INTENSIVE CARE UNIT	199,036	2,666	7,806	90,118	6,216,926		31
40	SUBPROVIDER - IPF	446,636	3,651	68	119,767	12,855,714		40
43	NURSERY	23,499	100	361	3,608	642,667		43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	151,446	19,836	8,798	679,196	8,319,282		50
51	RECOVERY ROOM	93,847	4,227	7,187	166,893	4,314,319		51
52	DELIVERY ROOM & LABOR ROOM	149,849	2,860	2,390	28,629	4,984,763		52
53	ANESTHESIOLOGY	11,848	600	2,003	52,146	311,217		53
54	RADIOLOGY-DIAGNOSTIC	165,230	1,862	825	126,487	4,492,336		54
54.02	ULTRASOUND	37,496	21	11	69,178	1,409,844		54.02
57	CT SCAN	44,479	97	75	239,853	1,372,062		57
58	MRI	18,776	346	294	58,350	718,143		58
59	CARDIAC CATHETERIZATION	68,984		1,580	311,578	2,356,760		59
60	LABORATORY	1,392	305		321,896	6,193,384		60
63	BLOOD STORING, PROCESSING & TRANS.		103,976		12,425	1,257,664		63
65	RESPIRATORY THERAPY	88,254	229		73,991	1,736,411		65
66	PHYSICAL THERAPY	57,362	1,090		27,786	1,673,320		66
67	OCCUPATIONAL THERAPY	13,059	190		7,569	402,472		67
68	SPEECH PATHOLOGY	22,425	745		6,318	602,637		68
69	ELECTROCARDIOLOGY	39,854	392	1,233	92,354	1,088,584		69
70.01	ECT	4,512	44	55	4,212	80,267		70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		678,594		54,924	8,542,433		71
72	IMPL. DEV. CHARGED TO PATIENTS		890,171			10,274,102		72
73	DRUGS CHARGED TO PATIENTS			995,853	375,610	5,930,297		73
74	RENAL DIALYSIS				23,471	767,972		74
75.01	PSYCHOLOGY	61,480	413		21,084	1,617,304		75.01
76	OCCUPATIONAL HEALTH	46,147	3,914	3,954	7,403	1,390,922		76
76.97	CARDIAC REHABILITATION	21,050	388		9,975	666,916		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	58,701	2,017	2,149	12,110	1,582,784		90
90.01	OUTPATIENT PROCEDURES	43,790			1,911	660,382		90.01
90.02	PRCC	244,800	26,898	3,483,831	550,480	34,835,211		90.02
91	EMERGENCY	293,930	12,647	24,917	426,703	8,010,329		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	3,534,878	1,796,892	4,577,706	4,366,752	156,819,532		118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		362			97,378		190
192.01	PHYSICIAN PRACTICE MANAGEMENT					3,197		192.01
193.01	MASSAGE THERAPY		59			43,565		193.01
193.02	IDOL SPACE/HOME HEALTH							193.02
193.03	ADOL SCHOOL					21,757		193.03
193.04	FOUNDATION		547			288,077		193.04
193.05	LEASED BLDG					62,863		193.05
193.07	PARISH NURSING					326,963		193.07
194	OP PHARMACY		464	27,954		1,892,012		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,534,878	1,798,324	4,605,660	4,366,752	159,555,344		202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

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	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	21,512,108				30
31	INTENSIVE CARE UNIT	6,216,926				31
40	SUBPROVIDER - IPF	12,855,714				40
43	NURSERY	642,667				43
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,319,282				50
51	RECOVERY ROOM	4,314,319				51
52	DELIVERY ROOM & LABOR ROOM	4,984,763				52
53	ANESTHESIOLOGY	311,217				53
54	RADIOLOGY-DIAGNOSTIC	4,492,336				54
54.02	ULTRASOUND	1,409,844				54.02
57	CT SCAN	1,372,062				57
58	MRI	718,143				58
59	CARDIAC CATHETERIZATION	2,356,760				59
60	LABORATORY	6,193,384				60
63	BLOOD STORING, PROCESSING & TRANS.	1,257,664				63
65	RESPIRATORY THERAPY	1,736,411				65
66	PHYSICAL THERAPY	1,673,320				66
67	OCCUPATIONAL THERAPY	402,472				67
68	SPEECH PATHOLOGY	602,637				68
69	ELECTROCARDIOLOGY	1,088,584				69
70.01	ECT	80,267				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,542,433				71
72	IMPL. DEV. CHARGED TO PATIENTS	10,274,102				72
73	DRUGS CHARGED TO PATIENTS	5,930,297				73
74	RENAL DIALYSIS	767,972				74
75.01	PSYCHOLOGY	1,617,304				75.01
76	OCCUPATIONAL HEALTH	1,390,922				76
76.97	CARDIAC REHABILITATION	666,916				76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,582,784				90
90.01	OUTPATIENT PROCEDURES	660,382				90.01
90.02	PRCC	34,835,211				90.02
91	EMERGENCY	8,010,329				91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE					113
118	SUBTOTALS (sum of lines 1-117)	156,819,532				118
NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	97,378				190
192.01	PHYSICIAN PRACTICE MANAGEMENT	3,197				192.01
193.01	MASSAGE THERAPY	43,565				193.01
193.02	IDOL SPACE/HOME HEALTH					193.02
193.03	ADOL SCHOOL	21,757				193.03
193.04	FOUNDATION	288,077				193.04
193.05	LEASED BLDG	62,863				193.05
193.07	PARISH NURSING	326,963				193.07
194	OP PHARMACY	1,892,012				194
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (sum of lines 118-201)	159,555,344				202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		31,940	56,408	88,348	88,348		4
5	ADMINISTRATIVE & GENERAL	625,465		1,104,629	1,730,094	10,308	1,740,402	5
6	MAINTENANCE & REPAIRS	487,068		860,207	1,347,275	784	49,780	6
7	OPERATION OF PLANT	148,804		262,802	411,606	1,962	76,810	7
8	LAUNDRY & LINEN SERVICE	4,944		8,732	13,676	12	6,678	8
9	HOUSEKEEPING	55,043		97,211	152,254	2,205	30,003	9
10	DIETARY	125,948		222,436	348,384	1,243	15,331	10
11	CAFETERIA						17,406	11
13	NURSING ADMINISTRATION		36,406	64,295	100,701	3,159	35,808	13
14	CENTRAL SERVICES & SUPPLY	117,487		207,492	324,979	687	10,743	14
15	PHARMACY	85,595		151,168	236,763	3,187	42,344	15
16	MEDICAL RECORDS & LIBRARY		58,831	103,901	162,732	2,228	43,135	16
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		132,687	234,337	367,024	16,511	182,969	30
31	INTENSIVE CARE UNIT		159,299	281,337	440,636	3,991	49,224	31
40	SUBPROVIDER - IPF		316,620	559,181	875,801	8,257	94,365	40
43	NURSERY		9,275	16,380	25,655	520	5,882	43
	ANCHLLARY SERVICE COST CENTERS							
50	OPERATING ROOM		229,630	405,547	635,177	3,104	63,753	50
51	RECOVERY ROOM		180,624	318,999	499,623	2,063	29,743	51
52	DELIVERY ROOM & LABOR ROOM		146,930	259,492	406,422	3,193	40,057	52
53	ANESTHESIOLOGY		5,048	8,915	13,963	136	2,287	53
54	RADIOLOGY-DIAGNOSTIC		99,623	175,943	275,566	3,031	38,020	54
54.02	ULTRASOUND		22,784	40,239	63,023	924	12,373	54.02
57	CT SCAN		11,269	19,901	31,170	988	11,012	57
58	MRI		20,376	35,986	56,362	437	5,446	58
59	CARDIAC CATHETERIZATION		26,349	46,535	72,884	1,720	19,481	59
60	LABORATORY		5,247	9,268	14,515	31	63,629	60
63	BLOOD STORING, PROCESSING & TRANS.		4,298	7,592	11,890		12,124	63
65	RESPIRATORY THERAPY		8,350	14,746	23,096	1,491	16,537	65
66	PHYSICAL THERAPY		28,989	51,197	80,186	1,165	15,122	66
67	OCCUPATIONAL THERAPY					365	4,163	67
68	SPEECH PATHOLOGY		2,464	4,352	6,816	530	6,066	68
69	ELECTROCARDIOLOGY		25,879	45,704	71,583	691	8,460	69
70.01	ECT					63	779	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						85,176	71
72	IMPL. DEV. CHARGED TO PATIENTS						102,356	72
73	DRUGS CHARGED TO PATIENTS						49,726	73
74	RENAL DIALYSIS		4,179	7,380	11,559		7,805	74
75.01	PSYCHOLOGY		39,372	69,535	108,907	991	13,762	75.01
76	OCCUPATIONAL HEALTH		3,254	5,746	9,000	713	14,256	76
76.97	CARDIAC REHABILITATION		22,465	39,676	62,141	410	5,235	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		3,182	5,620	8,802	1,066	16,206	90
90.01	OUTPATIENT PROCEDURES					23	6,705	90.01
90.02	PRCC					3,829	333,037	90.02
91	EMERGENCY		129,377	228,492	357,869	5,170	67,679	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		3,415,101	6,031,381	9,446,482	87,188	1,711,473	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					7	1,058	190
192.01	PHYSICIAN PRACTICE MANAGEMENT						35	192.01
193.01	MASSAGE THERAPY					44	475	193.01
193.02	IDOL SPACE/HOME HEALTH							193.02
193.03	ADOL SCHOOL					60	237	193.03
193.04	FOUNDATION		5,559	9,817	15,376	292	2,716	193.04
193.05	LEASED BLDG						686	193.05
193.07	PARISH NURSING		2,273	4,014	6,287	357	3,395	193.07
194	OP PHARMACY					400	20,327	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		3,422,933	6,045,212	9,468,145	88,348	1,740,402	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS	1,397,839						6
7	OPERATION OF PLANT	91,292	581,670					7
8	LAUNDRY & LINEN SERVICE	3,033		24,749				8
9	HOUSEKEEPING	33,769	15,034		233,265			9
10	DIETARY	77,269	34,400	479	14,195	491,301		10
11	CAFETERIA						17,406	11
13	NURSING ADMINISTRATION	22,335	9,943		4,103			13
14	CENTRAL SERVICES & SUPPLY	72,078	32,089		13,242			14
15	PHARMACY	52,513	23,378		9,647			15
16	MEDICAL RECORDS & LIBRARY	36,093	16,068		6,631			16
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	81,404	36,241	9,853	14,955	266,751	9,450	30
31	INTENSIVE CARE UNIT	97,730	43,509	1,867	17,954	32,036	1,135	31
40	SUBPROVIDER - IPF	194,247	86,477	1,589	35,683	177,159	6,276	40
43	NURSERY	5,690	2,533	451	1,045			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	140,878	62,719	980	25,881			50
51	RECOVERY ROOM	110,813	49,334	1,722	20,358	2,567	91	51
52	DELIVERY ROOM & LABOR ROOM	90,142	40,131	1,352	16,560	9,669	343	52
53	ANESTHESIOLOGY	3,097	1,379		569			53
54	RADIOLOGY-DIAGNOSTIC	61,119	27,210	874	11,228			54
54.02	ULTRASOUND	13,978	6,223	426	2,568			54.02
57	CT SCAN	6,913	3,078		1,270			57
58	MRI	12,501	5,565		2,297			58
59	CARDIAC CATHETERIZATION	16,165	7,197	239	2,970			59
60	LABORATORY	3,219	1,433		591			60
63	BLOOD STORING, PROCESSING & TRANS.	2,637	1,174		484			63
65	RESPIRATORY THERAPY	5,123	2,281		941			65
66	PHYSICAL THERAPY	17,785	7,918		3,267			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY	1,512	673		278			68
69	ELECTROCARDIOLOGY	15,877	7,068		2,917			69
70.01	ECT							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	2,564	1,141		471			74
75.01	PSYCHOLOGY	24,155	10,754		4,438			75.01
76	OCCUPATIONAL HEALTH	1,996	889		367			76
76.97	CARDIAC REHABILITATION	13,783	6,136		2,532			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,952	869		359			90
90.01	OUTPATIENT PROCEDURES							90.01
90.02	PRCC							90.02
91	EMERGENCY	79,373	35,337	4,917	14,582	3,119	111	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,393,035	579,531	24,749	232,383	491,301	17,406	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192.01	PHYSICIAN PRACTICE MANAGEMENT							192.01
193.01	MASSAGE THERAPY							193.01
193.02	IDOL SPACE/HOME HEALTH							193.02
193.03	ADOL SCHOOL							193.03
193.04	FOUNDATION	3,410	1,518		626			193.04
193.05	LEASED BLDG							193.05
193.07	PARISH NURSING	1,394	621		256			193.07
194	QP PHARMACY							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,397,839	581,670	24,749	233,265	491,301	17,406	202



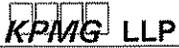
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 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	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
13	NURSING ADMINISTRATION	176,049						13
14	CENTRAL SERVICES & SUPPLY		453,818					14
15	PHARMACY	6,334	964	375,130				15
16	MEDICAL RECORDS & LIBRARY		1,227		268,114			16
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	49,794	7,553	2,795	23,977	1,069,277		30
31	INTENSIVE CARE UNIT	9,913	673	636	5,530	704,834		31
40	SUBPROVIDER - IPF	22,244	921	6	7,349	1,510,374		40
43	NURSERY	1,170	25	29	221	43,221		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	7,543	5,006	717	41,833	987,591		50
51	RECOVERY ROOM	4,674	1,067	585	10,241	732,881		51
52	DELIVERY ROOM & LABOR ROOM	7,463	722	195	1,757	618,006		52
53	ANESTHESIOLOGY	590	152	163	3,200	25,536		53
54	RADIOLOGY-DIAGNOSTIC	8,229	470	67	7,762	433,576		54
54.02	ULTRASOUND	1,867	5	1	4,245	105,633		54.02
57	CT SCAN	2,215	24	6	14,718	71,394		57
58	MRI	935	87	24	3,581	87,235		58
59	CARDIAC CATHETERIZATION	3,436		129	19,120	143,341		59
60	LABORATORY	69	77		19,753	103,317		60
63	BLOOD STORING, PROCESSING & TRANS.		26,238		762	55,309		63
65	RESPIRATORY THERAPY	4,395	58		4,540	58,462		65
66	PHYSICAL THERAPY	2,857	275		1,705	130,280		66
67	OCCUPATIONAL THERAPY	650	48		464	5,690		67
68	SPEECH PATHOLOGY	1,117	188		388	17,568		68
69	ELECTROCARDIOLOGY	1,985	99	100	5,667	114,447		69
70.01	ECT	225	11	4	258	1,340		70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		171,245		3,370	259,791		71
72	IMPL. DEV. CHARGED TO PATIENTS		224,643			326,999		72
73	DRUGS CHARGED TO PATIENTS			81,114	23,049	153,889		73
74	RENAL DIALYSIS				1,440	24,980		74
75.01	PSYCHOLOGY	3,062	104		1,294	167,467		75.01
76	OCCUPATIONAL HEALTH	2,298	988	322	454	31,283		76
76.97	CARDIAC REHABILITATION	1,048	98		612	91,995		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	2,924	509	175	743	33,605		90
90.01	OUTPATIENT PROCEDURES	2,181			117	9,026		90.01
90.02	PRCC	12,192	6,788	283,755	33,780	673,381		90.02
91	EMERGENCY	14,639	3,192	2,030	26,184	614,202		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	176,049	453,457	372,853	268,114	9,405,930		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		91			1,156		190
192.01	PHYSICIAN PRACTICE MANAGEMENT					35		192.01
193.01	MASSAGE THERAPY		15			534		193.01
193.02	IDOL SPACE/HOME HEALTH							193.02
193.03	ADOL SCHOOL					297		193.03
193.04	FOUNDATION		138			24,076		193.04
193.05	LEASED BLDG					686		193.05
193.07	PARISH NURSING					12,310		193.07
194	OP PHARMACY		117	2,277		23,121		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	176,049	453,818	375,130	268,114	9,468,145		202



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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	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,069,277				30
31	INTENSIVE CARE UNIT	704,834				31
40	SUBPROVIDER - IPF	1,510,374				40
43	NURSERY	43,221				43
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	987,591				50
51	RECOVERY ROOM	732,881				51
52	DELIVERY ROOM & LABOR ROOM	618,006				52
53	ANESTHESIOLOGY	25,536				53
54	RADIOLOGY-DIAGNOSTIC	433,576				54
54.02	ULTRASOUND	105,633				54.02
57	CT SCAN	71,394				57
58	MRI	87,235				58
59	CARDIAC CATHETERIZATION	143,341				59
60	LABORATORY	103,317				60
63	BLOOD STORING, PROCESSING & TRANS.	55,309				63
65	RESPIRATORY THERAPY	58,462				65
66	PHYSICAL THERAPY	130,280				66
67	OCCUPATIONAL THERAPY	5,690				67
68	SPEECH PATHOLOGY	17,568				68
69	ELECTROCARDIOLOGY	114,447				69
70.01	ECT	1,340				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	259,791				71
72	IMPL. DEV. CHARGED TO PATIENTS	326,999				72
73	DRUGS CHARGED TO PATIENTS	153,889				73
74	RENAL DIALYSIS	24,980				74
75.01	PSYCHOLOGY	167,467				75.01
76	OCCUPATIONAL HEALTH	31,283				76
76.97	CARDIAC REHABILITATION	91,995				76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	33,605				90
90.01	OUTPATIENT PROCEDURES	9,026				90.01
90.02	PRCC	673,381				90.02
91	EMERGENCY	614,202				91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE					113
118	SUBTOTALS (sum of lines 1-117)	9,405,930				118
NONREIMBURSABLE COST CENTERS						
190	GIFT FLOWER, COFFEE SHOP & CANTEN	1,156				190
192.01	PHYSICIAN PRACTICE MANAGEMENT	35				192.01
193.01	MASSAGE THERAPY	534				193.01
193.02	IDOL SPACE/HOME HEALTH					193.02
193.03	ADOL SCHOOL	297				193.03
193.04	FOUNDATION	24,076				193.04
193.05	LEASED BLDG	686				193.05
193.07	PARISH NURSING	12,310				193.07
194	OP PHARMACY	23,121				194
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (sum of lines 118-201)	9,468,145				202



COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS SQUARE FEET	
		1	2	4	5A	5	6	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	429,212						1
2	CAP REL COSTS-MVBLE EQUIP		429,212					2
4	EMPLOYEE BENEFITS DEPARTMENT	4,005	4,005	51,577,087				4
5	ADMINISTRATIVE & GENERAL	78,429	78,429	6,017,514	-36,578,810	122,976,534		5
6	MAINTENANCE & REPAIRS	61,075	61,075	457,644		3,517,531	285,703	6
7	OPERATION OF PLANT	18,659	18,659	1,145,346		5,427,487	18,659	7
8	LAUNDRY & LINEN SERVICE	620	620	6,870		471,892	620	8
9	HOUSEKEEPING	6,902	6,902	1,287,336		2,120,030	6,902	9
10	DIETARY	15,793	15,793	725,391		1,083,300	15,793	10
11	CAFETERIA					1,229,948		11
13	NURSING ADMINISTRATION	4,565	4,565	1,844,112		2,530,222	4,565	13
14	CENTRAL SERVICES & SUPPLY	14,732	14,732	401,289		759,112	14,732	14
15	PHARMACY	10,733	10,733	1,860,482		2,992,074	10,733	15
16	MEDICAL RECORDS & LIBRARY	7,377	7,377	1,300,477		3,047,970	7,377	16
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	16,638	16,638	9,640,608		12,928,819	16,638	30
31	INTENSIVE CARE UNIT	19,975	19,975	2,329,736		3,478,221	19,975	31
40	SUBPROVIDER - IPF	39,702	39,702	4,820,287		6,667,940	39,702	40
43	NURSERY	1,163	1,163	303,753		415,619	1,163	43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	28,794	28,794	1,812,252		4,504,902	28,794	50
51	RECOVERY ROOM	22,649	22,649	1,204,058		2,101,706	22,649	51
52	DELIVERY ROOM & LABOR ROOM	18,424	18,424	1,864,002		2,830,465	18,424	52
53	ANESTHESIOLOGY	633	633	79,263		161,601	633	53
54	RADIOLOGY-DIAGNOSTIC	12,492	12,492	1,769,123		2,686,520	12,492	54
54.02	ULTRASOUND	2,857	2,857	539,194		874,320	2,857	54.02
57	CT SCAN	1,413	1,413	576,815		778,099	1,413	57
58	MRI	2,555	2,555	254,991		384,837	2,555	58
59	CARDIAC CATHETERIZATION	3,304	3,304	1,004,318		1,376,575	3,304	59
60	LABORATORY	658	658	18,311		4,496,113	658	60
63	BLOOD STORING, PROCESSING & TRANS.	539	539			856,685	539	63
65	RESPIRATORY THERAPY	1,047	1,047	870,488		1,168,548	1,047	65
66	PHYSICAL THERAPY	3,635	3,635	680,161		1,068,545	3,635	66
67	OCCUPATIONAL THERAPY			213,084		294,158		67
68	SPEECH PATHOLOGY	309	309	309,663		428,602	309	68
69	ELECTROCARDIOLOGY	3,245	3,245	403,162		597,776	3,245	69
70.01	ECT			36,934		55,065		70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					6,018,687		71
72	IMPL. DEV. CHARGED TO PATIENTS					7,232,623		72
73	DRUGS CHARGED TO PATIENTS					3,513,701		73
74	RENAL DIALYSIS	524	524			551,522	524	74
75.01	PSYCHOLOGY	4,937	4,937	578,779		972,475	4,937	75.01
76	OCCUPATIONAL HEALTH	408	408	416,394		1,007,347	408	76
76.97	CARDIAC REHABILITATION	2,817	2,817	239,144		369,929	2,817	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	399	399	622,500		1,145,155	399	90
90.01	OUTPATIENT PROCEDURES			13,179		473,763		90.01
90.02	PRCC			2,234,994		23,530,205		90.02
91	EMERGENCY	16,223	16,223	3,017,902		4,782,270	16,223	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	428,230	428,230	50,899,556	-36,578,810	120,932,359	284,721	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			4,184		74,775		190
192.01	PHYSICIAN PRACTICE MANAGEMENT					2,464		192.01
193.01	MASSAGE THERAPY			25,775		33,532		193.01
193.02	IDOL SPACE/HOME HEALTH							193.02
193.03	ADOL SCHOOL			35,227		16,769		193.03
193.04	FOUNDATION	697	697	170,245		191,950	697	193.04
193.05	LEASED BLDG					48,451		193.05
193.07	PARISH NURSING	285	285	208,507		239,877	285	193.07
194	OP PHARMACY			233,593		1,436,357		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,422,933	6,045,212	13,949,210		36,578,810	4,563,803	202
203	UNIT COST MULT-WS B PT I	7.974924	14.084443	0.270454		0.297445	15.973941	203
204	COST TO BE ALLOC PER B PT II			88,348		1,740,402	1,397,839	204
205	UNIT COST MULT-WS B PT II			0.001713		0.014152	4.892630	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	MEALS SERVED	DIRECT NRSGING HRS	
		7	8	9	10	11	13	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	267,044						7
8	LAUNDRY & LINEN SERVICE	620	892,076					8
9	HOUSEKEEPING	6,902		259,522				9
10	DIETARY	15,793	17,259	15,793	153,714			10
11	CAFETERIA					153,714		11
13	NURSING ADMINISTRATION	4,565		4,565			1,190,754	13
14	CENTRAL SERVICES & SUPPLY	14,732		14,732				14
15	PHARMACY	10,733		10,733			42,840	15
16	MEDICAL RECORDS & LIBRARY	7,377		7,377				16
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	16,638	355,176	16,638	83,459	83,459	336,798	30
31	INTENSIVE CARE UNIT	19,975	67,306	19,975	10,023	10,023	67,047	31
40	SUBPROVIDER - IPF	39,702	57,280	39,702	55,428	55,428	150,453	40
43	NURSERY	1,163	16,247	1,163			7,916	43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	28,794	35,309	28,794			51,016	50
51	RECOVERY ROOM	22,649	62,061	22,649	803	803	31,613	51
52	DELIVERY ROOM & LABOR ROOM	18,424	48,740	18,424	3,025	3,025	50,478	52
53	ANESTHESIOLOGY	633		633			3,991	53
54	RADIOLOGY-DIAGNOSTIC	12,492	31,516	12,492			55,659	54
54.02	ULTRASOUND	2,857	15,363	2,857			12,631	54.02
57	CT SCAN	1,413		1,413			14,983	57
58	MRI	2,555		2,555			6,325	58
59	CARDIAC CATHETERIZATION	3,304	8,597	3,304			23,238	59
60	LABORATORY	658		658			469	60
63	BLOOD STORING, PROCESSING & TRANS.	539		539				63
65	RESPIRATORY THERAPY	1,047		1,047			29,729	65
66	PHYSICAL THERAPY	3,635		3,635			19,323	66
67	OCCUPATIONAL THERAPY						4,399	67
68	SPEECH PATHOLOGY	309		309			7,554	68
69	ELECTROCARDIOLOGY	3,245		3,245			13,425	69
70.01	ECT						1,520	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	524		524				74
75.01	PSYCHOLOGY	4,937		4,937			20,710	75.01
76	OCCUPATIONAL HEALTH	408		408			15,545	76
76.97	CARDIAC REHABILITATION	2,817		2,817			7,091	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	399		399			19,774	90
90.01	OUTPATIENT PROCEDURES						14,751	90.01
90.02	PRCC						82,463	90.02
91	EMERGENCY	16,223	177,222	16,223	976	976	99,013	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	266,062	892,076	258,540	153,714	153,714	1,190,754	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192.01	PHYSICIAN PRACTICE MANAGEMENT							192.01
193.01	MASSAGE THERAPY							193.01
193.02	IDOL SPACE/HOME HEALTH							193.02
193.03	ADOL SCHOOL							193.03
193.04	FOUNDATION	697		697				193.04
193.05	LEASED BLDG							193.05
193.07	PARISH NURSING	285		285				193.07
194	OP PHARMACY							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	7,339,924	639,199	3,050,581	2,289,890	1,595,790	3,534,878	202
203	UNIT COST MULT-WS B PT I	27,485,823	0.716530	11,754,614	14,897,082	10,381,553	2,968,605	203
204	COST TO BE ALLOC PER B PT II	581,670	24,749	233,265	491,301	17,406	176,049	204
205	UNIT COST MULT-WS B PT II	2,178,180	0.027743	0.898826	3.196202	0.113236	0.147847	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHARGES				
	14	15	16				

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	14,611,292					14
15	PHARMACY	31,030	16,250,277				15
16	MEDICAL RECORDS & LIBRARY	39,504		881,480,168			16
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	243,195	121,078	78,870,999			30
31	INTENSIVE CARE UNIT	21,664	27,543	18,190,887			31
40	SUBPROVIDER - IPF	29,667	241	24,175,778			40
43	NURSERY	811	1,275	728,298			43
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	161,163	31,041	137,121,115			50
51	RECOVERY ROOM	34,345	25,358	33,688,599			51
52	DELIVERY ROOM & LABOR ROOM	23,236	8,431	5,778,928			52
53	ANESTHESIOLOGY	4,879	7,069	10,526,077			53
54	RADIOLOGY-DIAGNOSTIC	15,127	2,910	25,532,332			54
54.02	ULTRASOUND	167	39	13,263,992			54.02
57	CT SCAN	787	264	48,416,033			57
58	MRI	2,813	1,039	11,778,364			58
59	CARDIAC CATHETERIZATION		5,575	62,894,293			59
60	LABORATORY	2,476		64,976,915			60
63	BLOOD STORING, PROCESSING & TRANS.	844,795		2,507,984			63
65	RESPIRATORY THERAPY	1,863		14,935,652			65
66	PHYSICAL THERAPY	8,859		5,608,804			66
67	OCCUPATIONAL THERAPY	1,543		1,527,913			67
68	SPEECH PATHOLOGY	6,052		1,275,264			68
69	ELECTROCARDIOLOGY	3,185	4,350	18,642,304			69
70.01	ECT	354	194	850,204			70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,513,531		11,086,779			71
72	IMPL. DEV. CHARGED TO PATIENTS	7,232,623					72
73	DRUGS CHARGED TO PATIENTS		3,513,701	75,819,535			73
74	RENAL DIALYSIS			4,737,750			74
75.01	PSYCHOLOGY	3,354		4,255,958			75.01
76	OCCUPATIONAL HEALTH	31,799	13,952	1,494,411			76
76.97	CARDIAC REHABILITATION	3,149		2,013,533			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	16,386	7,582	2,444,413			90
90.01	OUTPATIENT PROCEDURES			385,792			90.01
90.02	PRCC	218,547	12,292,086	111,118,304			90.02
91	EMERGENCY	102,759	87,917	86,132,958			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	14,599,663	16,151,645	881,480,168			118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,938					190
192.01	PHYSICIAN PRACTICE MANAGEMENT						192.01
193.01	MASSAGE THERAPY	480					193.01
193.02	IDOL SPACE/HOME HEALTH						193.02
193.03	ADOL SCHOOL						193.03
193.04	FOUNDATION	4,443					193.04
193.05	LEASED BLDG						193.05
193.07	PARISH NURSING						193.07
194	OP PHARMACY	3,768	98,632				194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,798,324	4,605,660	4,366,752			202
203	UNIT COST MULT-WS B PT I	0.123078	0.283420	0.004954			203
204	COST TO BE ALLOC PER B PT II	453,818	375,130	268,114			204
205	UNIT COST MULT-WS B PT II	0.031059	0.023085	0.000304			205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT
		PART	LINE NO.	
	1	2	3	4



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	21,512,108		21,512,108	9,640	21,521,748	30
31	INTENSIVE CARE UNIT	6,216,926		6,216,926	1,934	6,218,860	31
40	SUBPROVIDER - IPF	12,855,714		12,855,714	20,370	12,876,084	40
43	NURSERY	642,667		642,667		642,667	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,319,282		8,319,282	13,020	8,332,302	50
51	RECOVERY ROOM	4,314,319		4,314,319		4,314,319	51
52	DELIVERY ROOM & LABOR ROOM	4,984,763		4,984,763		4,984,763	52
53	ANESTHESIOLOGY	311,217		311,217		311,217	53
54	RADIOLOGY-DIAGNOSTIC	4,492,336		4,492,336		4,492,336	54
54.02	ULTRASOUND	1,409,844		1,409,844		1,409,844	54.02
57	CT SCAN	1,372,062		1,372,062		1,372,062	57
58	MRI	718,143		718,143		718,143	58
59	CARDIAC CATHETERIZATION	2,356,760		2,356,760		2,356,760	59
60	LABORATORY	6,193,384		6,193,384	11,443	6,204,827	60
63	BLOOD STORING, PROCESSING & TRANS.	1,257,664		1,257,664		1,257,664	63
65	RESPIRATORY THERAPY	1,736,411		1,736,411		1,736,411	65
66	PHYSICAL THERAPY	1,673,320		1,673,320		1,673,320	66
67	OCCUPATIONAL THERAPY	402,472		402,472		402,472	67
68	SPEECH PATHOLOGY	602,637		602,637		602,637	68
69	ELECTROCARDIOLOGY	1,088,584		1,088,584		1,088,584	69
70.01	ECT	80,267		80,267		80,267	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,542,433		8,542,433		8,542,433	71
72	IMPL. DEV. CHARGED TO PATIENTS	10,274,102		10,274,102		10,274,102	72
73	DRUGS CHARGED TO PATIENTS	5,930,297		5,930,297		5,930,297	73
74	RENAL DIALYSIS	767,972		767,972		767,972	74
75.01	PSYCHOLOGY	1,617,304		1,617,304	5,115	1,622,419	75.01
76	OCCUPATIONAL HEALTH	1,390,922		1,390,922		1,390,922	76
76.97	CARDIAC REHABILITATION	666,916		666,916		666,916	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,582,784		1,582,784		1,582,784	90
90.01	OUTPATIENT PROCEDURES	660,382		660,382		660,382	90.01
90.02	PRCC	34,835,211		34,835,211		34,835,211	90.02
91	EMERGENCY	8,010,329		8,010,329	57,308	8,067,637	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,597,527		3,597,527		3,597,527	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	160,417,059		160,417,059	118,830	160,535,889	200
201	LESS OBSERVATION BEDS	3,597,527		3,597,527		3,597,527	201
202	TOTAL (SEE INSTRUCTIONS)	156,819,532		156,819,532		156,938,362	202



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES		TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT					
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	63,399,091		63,399,091				30
31	INTENSIVE CARE UNIT	16,445,318		16,445,318				31
40	SUBPROVIDER - IPF	24,170,072		24,170,072				40
43	NURSERY	723,358		723,358				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	55,702,918	47,116,877	102,819,795	0.080911	0.080911	0.081038	50
51	RECOVERY ROOM	14,341,001	19,339,043	33,680,044	0.128097	0.128097	0.128097	51
52	DELIVERY ROOM & LABOR ROOM	4,951,386	670,429	5,621,815	0.886682	0.886682	0.886682	52
53	ANESTHESIOLOGY	4,167,064	6,312,516	10,479,580	0.029697	0.029697	0.029697	53
54	RADIOLOGY-DIAGNOSTIC	7,224,020	18,308,311	25,532,331	0.175947	0.175947	0.175947	54
54.02	ULTRASOUND	3,514,304	10,444,950	13,959,254	0.100997	0.100997	0.100997	54.02
57	CT SCAN	13,841,435	34,574,598	48,416,033	0.028339	0.028339	0.028339	57
58	MRI	2,857,655	8,920,710	11,778,365	0.060971	0.060971	0.060971	58
59	CARDIAC CATHETERIZATION	21,477,806	23,121,443	44,599,249	0.052843	0.052843	0.052843	59
60	LABORATORY	33,053,192	31,923,723	64,976,915	0.095317	0.095317	0.095493	60
63	BLOOD STORING, PROCESSING & TRANS.	1,952,997	554,987	2,507,984	0.501464	0.501464	0.501464	63
65	RESPIRATORY THERAPY	8,218,652	1,353,056	9,571,708	0.181411	0.181411	0.181411	65
66	PHYSICAL THERAPY	2,804,970	2,803,833	5,608,803	0.298338	0.298338	0.298338	66
67	OCCUPATIONAL THERAPY	980,940	545,937	1,526,877	0.263592	0.263592	0.263592	67
68	SPEECH PATHOLOGY	469,269	805,995	1,275,264	0.472559	0.472559	0.472559	68
69	ELECTROCARDIOLOGY	8,304,178	10,338,126	18,642,304	0.058393	0.058393	0.058393	69
70.01	ECT	416,387	433,817	850,204	0.094409	0.094409	0.094409	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,897,382	19,325,593	48,222,975	0.177144	0.177144	0.177144	71
72	IMPL. DEV. CHARGED TO PATIENTS	13,217,709	9,655,165	22,872,874	0.449183	0.449183	0.449183	72
73	DRUGS CHARGED TO PATIENTS	54,071,253	21,736,882	75,808,135	0.078228	0.078228	0.078228	73
74	RENAL DIALYSIS	4,432,788	304,962	4,737,750	0.162096	0.162096	0.162096	74
75.01	PSYCHOLOGY	8,108	4,253,556	4,261,664	0.379501	0.379501	0.380701	75.01
76	OCCUPATIONAL HEALTH	2,614	1,439,517	1,442,131	0.964491	0.964491	0.964491	76
76.97	CARDIAC REHABILITATION	5,513	2,008,020	2,013,533	0.331217	0.331217	0.331217	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	12,071	2,432,342	2,444,413	0.647511	0.647511	0.647511	90
90.01	OUTPATIENT PROCEDURES	9,608	3,713,716	3,723,324	0.177364	0.177364	0.177364	90.01
90.02	PRCC		110,777,883	110,777,883	0.314460	0.314460	0.314460	90.02
91	EMERGENCY	19,361,324	65,987,112	85,348,436	0.093854	0.093854	0.094526	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,854,393	10,430,280	13,284,673	0.270803	0.270803	0.270803	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	411,888,776	469,633,379	881,522,155				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	411,888,776	469,633,379	881,522,155				202



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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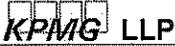
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK [] TITLE V [XX] PPS
 APPLICABLE [XX] 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)	1,069,277		1,069,277	31,204	34.27	10,488	359,424	30
31	INTENSIVE CARE UNIT	704,834		704,834	3,289	214.30	1,561	334,522	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	1,510,374		1,510,374	12,859	117.46	4,532	532,329	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	43,221		43,221	850	50.85			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	3,327,706		3,327,706	48,202		16,581	1,226,275	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0174

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

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 + col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	987,591	102,819,795	0.009605	24,719,791	217,434	50
51	RECOVERY ROOM	732,881	33,680,044	0.021760	6,388,830	139,021	51
52	DELIVERY ROOM & LABOR ROOM	618,006	5,621,815	0.109930	32,701	3,595	52
53	ANESTHESIOLOGY	25,536	10,479,580	0.002437	1,721,764	4,196	53
54	RADIOLOGY-DIAGNOSTIC	433,576	25,532,331	0.016981	3,939,326	66,894	54
54.02	ULTRASOUND	105,633	13,959,254	0.007567	1,670,777	12,643	54.02
57	CT SCAN	71,394	48,416,033	0.001475	6,926,509	10,217	57
58	MRI	87,235	11,778,365	0.007406	1,265,962	9,376	58
59	CARDIAC CATHETERIZATION	143,341	44,599,249	0.003214	9,881,566	31,759	59
60	LABORATORY	103,317	64,976,915	0.001590	14,135,163	22,475	60
63	BLOOD STORING, PROCESSING & TRANS.	55,309	2,507,984	0.022053	988,104	21,791	63
65	RESPIRATORY THERAPY	58,462	9,571,798	0.006108	4,529,681	27,667	65
66	PHYSICAL THERAPY	130,280	5,608,803	0.023228	1,667,167	38,725	66
67	OCCUPATIONAL THERAPY	5,690	1,526,877	0.003727	577,118	2,151	67
68	SPEECH PATHOLOGY	17,568	1,275,264	0.013776	271,588	3,741	68
69	ELECTROCARDIOLOGY	114,447	18,642,304	0.006139	4,376,068	26,865	69
70.01	ECT	1,340	850,204	0.001576	1,571	2	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	259,791	48,222,975	0.005387	13,689,591	73,746	71
72	IMPL. DEV. CHARGED TO PATIENTS	326,999	22,872,874	0.014296	6,972,935	99,685	72
73	DRUGS CHARGED TO PATIENTS	153,889	75,808,135	0.002030	23,002,368	46,695	73
74	RENAL DIALYSIS	24,980	4,737,750	0.005273	2,529,813	13,340	74
75.01	PSYCHOLOGY	167,467	4,261,664	0.039296	236	9	75.01
76	OCCUPATIONAL HEALTH	31,283	1,442,131	0.021692	1,599	35	76
76.97	CARDIAC REHABILITATION	91,995	2,013,533	0.045688	2,555	117	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	33,605	2,444,413	0.013748	8,860	122	90
90.01	OUTPATIENT PROCEDURES	9,026	3,723,324	0.002424	159		90.01
90.02	PRCC	673,381	110,777,883	0.006079			90.02
91	EMERGENCY	614,202	85,348,436	0.007196	8,904,793	64,079	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	178,740	13,284,673	0.013455	1,342,877	18,068	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,256,964	776,784,316		139,549,472	974,448	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM (col. 5+ col. 6) 7	INPATIENT PROGRAM DAYS 8	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8) 9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	31,204		10,488		30
31	INTENSIVE CARE UNIT	3,289		1,561		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	12,859		4,532		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	850				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	48,202		16,581		200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0174

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
54.02	ULTRASOUND						54.02
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
70.01	ECT						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
75.01	PSYCHOLOGY						75.01
76	OCCUPATIONAL HEALTH						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	OUTPATIENT PROCEDURES						90.01
90.02	PRCC						90.02
91	EMERGENCY						91
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 MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0174

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)	OUTPUT- IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPUT- IENT PROGRAM CHARGES	OUTPUT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	102,819,795			24,719,791		9,715,362		50
51	RECOVERY ROOM	33,680,044			6,388,830		4,447,995		51
52	DELIVERY ROOM & LABOR ROOM	5,621,815			32,701		597		52
53	ANESTHESIOLOGY	10,479,580			1,721,764		1,429,136		53
54	RADIOLOGY-DIAGNOSTIC	25,532,331			3,939,326		3,924,499		54
54.02	ULTRASOUND	13,959,254			1,670,777		1,585,101		54.02
57	CT SCAN	48,416,033			6,926,509		7,539,768		57
58	MRI	11,778,265			1,265,962		1,966,718		58
59	CARDIAC CATHETERIZATION	44,599,249			9,881,566		7,798,280		59
60	LABORATORY	64,976,915			14,135,163		935,734		60
63	BLOOD STORING, PROCESSING & TRANS.	2,507,984			988,104		80,280		63
65	RESPIRATORY THERAPY	9,571,708			4,529,681		167,014		65
66	PHYSICAL THERAPY	5,608,803			1,667,167				66
67	OCCUPATIONAL THERAPY	1,526,877			577,118				67
68	SPEECH PATHOLOGY	1,275,264			271,588				68
69	ELECTROCARDIOLOGY	18,642,304			4,376,068		2,627,263		69
70.01	ECT	850,204			1,571		307,882		70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,222,975			13,689,591		4,810,695		71
72	IMPL. DEV. CHARGED TO PATIENTS	22,872,874			6,972,935		3,371,123		72
73	DRUGS CHARGED TO PATIENTS	75,808,135			23,002,368		5,479,749		73
74	RENAL DIALYSIS	4,737,750			2,529,813		84,589		74
75.01	PSYCHOLOGY	4,261,664			236		97,832		75.01
76	OCCUPATIONAL HEALTH	1,442,131			1,599		5,039		76
76.97	CARDIAC REHABILITATION	2,013,533			2,555		835,861		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,444,413			8,860		715,232		90
90.01	OUTPATIENT PROCEDURES	3,723,324			159		672,321		90.01
90.02	PRCC	110,777,883					51,617,768		90.02
91	EMERGENCY	85,348,436			8,904,793		9,496,665		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	13,284,673			1,342,877		2,996,381		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	776,784,316			139,549,472		122,708,884		200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

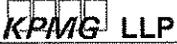
COMPONENT CCN: 14-0174

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	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	0.080911	9,715,362			786,080		50	
51	RECOVERY ROOM	0.128097	4,447,995	12,491		569,775	1,600	51	
52	DELIVERY ROOM & LABOR ROOM	0.886682	597			529		52	
53	ANESTHESIOLOGY	0.029697	1,429,136	2		42,441		53	
54	RADIOLOGY-DIAGNOSTIC	0.175947	3,924,499			690,504		54	
54.02	ULTRASOUND	0.100997	1,585,101	925		160,090	93	54.02	
57	CT SCAN	0.028339	7,539,768			213,669		57	
58	MRI	0.060971	1,966,718			119,913		58	
59	CARDIAC CATHETERIZATION	0.052843	7,798,280	55		412,085	3	59	
60	LABORATORY	0.095317	935,734	97		89,191	9	60	
63	BLOOD STORING, PROCESSING & TRANS.	0.501464	80,280			40,258		63	
65	RESPIRATORY THERAPY	0.181411	167,014			30,298		65	
66	PHYSICAL THERAPY	0.298338						66	
67	OCCUPATIONAL THERAPY	0.263592						67	
68	SPEECH PATHOLOGY	0.472559						68	
69	ELECTROCARDIOLOGY	0.058393	2,627,263			153,414		69	
70.01	ECT	0.094409	307,882			29,067		70.01	
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177144	4,810,695	7,619		852,186	1,350	71	
72	IMPL. DEV. CHARGED TO PATIENTS	0.449183	3,371,123			1,514,251		72	
73	DRUGS CHARGED TO PATIENTS	0.078228	5,479,749	1,658	207,511	428,670	130	16,233	
74	RENAL DIALYSIS	0.162096	84,589			13,712		74	
75.01	PSYCHOLOGY	0.379501	97,832			37,127		75.01	
76	OCCUPATIONAL HEALTH	0.964491	5,039			4,860		76	
76.97	CARDIAC REHABILITATION	0.331217	835,861			276,851		76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.647511	715,232			463,121		90	
90.01	OUTPATIENT PROCEDURES	0.177364	672,321	62		119,246	11	90.01	
90.02	PRCC	0.314460	51,617,768	5,707		16,231,723	1,795	90.02	
91	EMERGENCY	0.093854	9,496,665			891,300		91	
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.270803	2,996,381			811,429		92	
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		122,708,884	28,616	207,511	24,981,790	4,991	16,233	
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201	
202	NET CHARGES (line 200 - line 201)		122,708,884	28,616	207,511	24,981,790	4,991	16,233	

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S174

WORKSHEET D
PART II

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

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 + col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	987,591	102,819,795	0.009605	2,958	28	50
51	RECOVERY ROOM	732,881	33,680,044	0.021760	343	7	51
52	DELIVERY ROOM & LABOR ROOM	618,006	5,621,815	0.109930	10	1	52
53	ANESTHESIOLOGY	25,536	10,479,580	0.002437	39,504	96	53
54	RADIOLOGY-DIAGNOSTIC	433,576	25,532,331	0.016981	57,194	971	54
54.02	ULTRASOUND	105,633	13,959,254	0.007567	21,635	164	54.02
57	CT SCAN	71,394	48,416,033	0.001475	153,760	227	57
58	MRI	87,235	11,778,365	0.007406	46,559	345	58
59	CARDIAC CATHETERIZATION	143,341	44,599,249	0.003214	4,960	16	59
60	LABORATORY	103,317	64,976,915	0.001590	932,400	1,483	60
63	BLOOD STORING, PROCESSING & TRANS.	55,309	2,507,984	0.022053	14,672	324	63
65	RESPIRATORY THERAPY	58,462	9,571,708	0.006108	70,510	431	65
66	PHYSICAL THERAPY	130,280	5,608,803	0.023228	45,889	1,066	66
67	OCCUPATIONAL THERAPY	5,690	1,526,877	0.003727	2,697	10	67
68	SPEECH PATHOLOGY	17,568	1,275,264	0.013776	8,075	111	68
69	ELECTROCARDIOLOGY	114,447	18,642,304	0.006139	52,844	324	69
70.01	ECT	1,340	850,204	0.001576	245,121	386	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	259,791	48,222,975	0.005387	7,015	38	71
72	IMPL. DEV. CHARGED TO PATIENTS	326,999	22,872,874	0.014296			72
73	DRUGS CHARGED TO PATIENTS	153,889	75,808,135	0.002030	2,696,158	5,473	73
74	RENAL DIALYSIS	24,980	4,737,750	0.005273	11,220	59	74
75.01	PSYCHOLOGY	167,467	4,261,664	0.039296	988	39	75.01
76	OCCUPATIONAL HEALTH	31,283	1,442,131	0.021692	21		76
76.97	CARDIAC REHABILITATION	91,995	2,013,533	0.045688			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	33,605	2,444,413	0.013748	203	3	90
90.01	OUTPATIENT PROCEDURES	9,026	3,723,324	0.002424			90.01
90.02	PRCC	673,381	110,777,883	0.006079			90.02
91	EMERGENCY	614,202	85,348,436	0.007196	733,344	5,277	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		13,284,673				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,078,224	776,784,316		5,148,080	16,879	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S174

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6
		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						
30	OPERATING ROOM						50
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.02	ULTRASOUND						54.02
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
70.01	ECT						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
75.01	PSYCHOLOGY						75.01
76	OCCUPATIONAL HEALTH						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	OUTPATIENT PROCEDURES						90.01
90.02	PRCC						90.02
91	EMERGENCY						91
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 MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S174

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] 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)
7	8	9	10	11	12	13		
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	102,819,795			2,958			50
51	RECOVERY ROOM	33,680,044			343			51
52	DELIVERY ROOM & LABOR ROOM	5,621,815			10			52
53	ANESTHESIOLOGY	10,479,580			39,504			53
54	RADIOLOGY-DIAGNOSTIC	25,532,331			57,194			54
54.02	ULTRASOUND	13,959,254			21,635			54.02
57	CT SCAN	48,416,033			153,760		2,498	57
58	MRI	11,778,365			46,559			58
59	CARDIAC CATHETERIZATION	44,599,249			4,960			59
60	LABORATORY	64,976,915			932,400			60
63	BLOOD STORING, PROCESSING & TRANS.	2,507,984			14,672			63
65	RESPIRATORY THERAPY	9,571,708			70,510			65
66	PHYSICAL THERAPY	5,608,803			45,889			66
67	OCCUPATIONAL THERAPY	1,526,877			2,697			67
68	SPEECH PATHOLOGY	1,275,264			8,075			68
69	ELECTROCARDIOLOGY	18,642,304			52,844			69
70.01	ECT	850,204			245,121			70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,222,975			7,015			71
72	IMPL. DEV. CHARGED TO PATIENTS	22,872,874						72
73	DRUGS CHARGED TO PATIENTS	75,808,135			2,696,158			73
74	RENAL DIALYSIS	4,737,750			11,220			74
75.01	PSYCHOLOGY	4,261,664			988			75.01
76	OCCUPATIONAL HEALTH	1,442,131			21			76
76.97	CARDIAC REHABILITATION	2,013,533						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,444,413			203			90
90.01	OUTPATIENT PROCEDURES	3,723,324						90.01
90.02	PRCC	110,777,883						90.02
91	EMERGENCY	85,348,436			733,344		673	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	13,284,673						92
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	776,784,316			5,148,080		3,171	200

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S174

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: 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	0.080911						50
51	RECOVERY ROOM	0.128097						51
52	DELIVERY ROOM & LABOR ROOM	0.886682						52
53	ANESTHESIOLOGY	0.029697						53
54	RADIOLOGY-DIAGNOSTIC	0.175947						54
54.02	ULTRASOUND	0.100997						54.02
57	CT SCAN	0.028339	2,498				71	57
58	MRI	0.060971						58
59	CARDIAC CATHETERIZATION	0.052843						59
60	LABORATORY	0.095317						60
63	BLOOD STORING, PROCESSING & TRANS.	0.501464						63
65	RESPIRATORY THERAPY	0.181411						65
66	PHYSICAL THERAPY	0.298338						66
67	OCCUPATIONAL THERAPY	0.263592						67
68	SPEECH PATHOLOGY	0.472559						68
69	ELECTROCARDIOLOGY	0.058393						69
70.01	ECT	0.094409						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177144						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.449183						72
73	DRUGS CHARGED TO PATIENTS	0.078228			1,799			141
74	RENAL DIALYSIS	0.162096						74
75.01	PSYCHOLOGY	0.379501						75.01
76	OCCUPATIONAL HEALTH	0.964491						76
76.97	CARDIAC REHABILITATION	0.331217						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.647511						90
90.01	OUTPATIENT PROCEDURES	0.177364						90.01
90.02	PRCC	0.314460						90.02
91	EMERGENCY	0.093854	673			63		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.270803						92
OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		3,171		1,799	134		141
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		3,171		1,799	134		141

(A) Worksheet A line numbers



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0174

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	31,204	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	31,204	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	25,988	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)	10,488	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)	21,521,748	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	21,521,748	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)	21,521,748	37



COMPU-MAX

PRESENCE MERCY MEDICAL CENTER Provider CCN: 14-0174	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 10:11 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0174

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					689.71	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					7,233,678	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)					7,233,678	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 + col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	6,218,860	3,289	1,890.81	1,561	2,951,554	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)					17,240,116	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					27,425,348	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					693,946	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					974,448	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					1,668,394	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					25,756,954	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0174

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)					5,216	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 + line 2)					689.71	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					3,597,527	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	1,069,277	21,521,748	0.049684	3,597,527	178,740	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S174

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	12,859	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	12,859	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)	12,859	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	4,532	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)	12,876,084	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	12,876,084	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)	12,876,084	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S174

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

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,001.33	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	4,538,028	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)	4,538,028	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	458,627	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	4,996,655	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	532,329	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	16,879	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	549,208	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	4,447,447	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0174

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	1 RATIO OF COST TO CHARGES	2 INPATIENT PROGRAM CHARGES	3 INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		27,179,891		30
31	INTENSIVE CARE UNIT		8,655,517		31
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.081038	24,719,791	2,003,242	50
51	RECOVERY ROOM	0.128097	6,388,830	818,390	51
52	DELIVERY ROOM & LABOR ROOM	0.886682	32,701	28,995	52
53	ANESTHESIOLOGY	0.029697	1,721,764	51,131	53
54	RADIOLOGY-DIAGNOSTIC	0.175947	3,939,326	693,113	54
54.02	ULTRASOUND	0.100997	1,670,777	168,743	54.02
57	CT SCAN	0.028339	6,926,509	196,290	57
58	MRI	0.060971	1,265,962	77,187	58
59	CARDIAC CATHETERIZATION	0.052843	9,881,566	522,172	59
60	LABORATORY	0.095493	14,135,163	1,349,809	60
63	BLOOD STORING, PROCESSING & TRANS.	0.501464	988,104	495,499	63
65	RESPIRATORY THERAPY	0.181411	4,529,681	821,734	65
66	PHYSICAL THERAPY	0.298338	1,667,167	497,379	66
67	OCCUPATIONAL THERAPY	0.263592	577,118	152,124	67
68	SPEECH PATHOLOGY	0.472559	271,588	128,341	68
69	ELECTROCARDIOLOGY	0.058393	4,376,068	255,532	69
70.01	ECT	0.094409	1,571	148	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177144	13,689,591	2,425,029	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.449183	6,972,935	3,132,124	72
73	DRUGS CHARGED TO PATIENTS	0.078228	23,002,368	1,799,429	73
74	RENAL DIALYSIS	0.162096	2,529,813	410,073	74
75.01	PSYCHOLOGY	0.380701	236	90	75.01
76	OCCUPATIONAL HEALTH	0.964491	1,599	1,542	76
76.97	CARDIAC REHABILITATION	0.331217	2,555	846	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.647511	8,860	5,737	90
90.01	OUTPATIENT PROCEDURES	0.177364	159	28	90.01
90.02	PRCC	0.314460			90.02
91	EMERGENCY	0.094526	8,904,793	841,734	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.270803	1,342,877	363,655	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		139,549,472	17,240,116	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		139,549,472		202

(A) Worksheet A line numbers



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S174

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
40	SUBPROVIDER - IPF		8,459,720		40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.081038	2,958	240	50
51	RECOVERY ROOM	0.128097	343	44	51
52	DELIVERY ROOM & LABOR ROOM	0.886682	10	9	52
53	ANESTHESIOLOGY	0.029697	39,504	1,173	53
54	RADIOLOGY-DIAGNOSTIC	0.175947	57,194	10,063	54
54.02	ULTRASOUND	0.100997	21,635	2,185	54.02
57	CT SCAN	0.028339	153,760	4,357	57
58	MRI	0.060971	46,559	2,839	58
59	CARDIAC CATHETERIZATION	0.052843	4,960	262	59
60	LABORATORY	0.095493	932,400	89,038	60
63	BLOOD STORING, PROCESSING & TRANS.	0.501464	14,672	7,357	63
65	RESPIRATORY THERAPY	0.181411	70,510	12,791	65
66	PHYSICAL THERAPY	0.298338	45,889	13,690	66
67	OCCUPATIONAL THERAPY	0.263592	2,697	711	67
68	SPEECH PATHOLOGY	0.472559	8,075	3,816	68
69	ELECTROCARDIOLOGY	0.058393	52,844	3,086	69
70.01	ECT	0.094409	245,121	23,142	70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.177144	7,015	1,243	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.449183			72
73	DRUGS CHARGED TO PATIENTS	0.078228	2,696,158	210,915	73
74	RENAL DIALYSIS	0.162096	11,220	1,819	74
75.01	PSYCHOLOGY	0.380701	988	376	75.01
76	OCCUPATIONAL HEALTH	0.964491	21	20	76
76.97	CARDIAC REHABILITATION	0.331217			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.647511	203	131	90
90.01	OUTPATIENT PROCEDURES	0.177364			90.01
90.02	PRCC	0.314460			90.02
91	EMERGENCY	0.094526	733,344	69,320	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.270803			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		5,148,080	458,627	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		5,148,080		202

(A) Worksheet A line numbers



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL
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)	17,971,295			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	6,000,507			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)	360,957			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	5,558,374			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	201.71			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(c)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(I)				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 50969, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0419			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2327			31
32	SUM OF LINES 30 AND 31	0.2746			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1187			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	2,311,258			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)		2,456,173		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		619,091		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	619,091			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL
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)	27,263,108			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)	27,263,108			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	2,058,339			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				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)	29,321,447			59
60	PRIMARY PAYER PAYMENTS	7,444			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	29,314,003			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,151,672			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	109,520			63
64	ALLOWABLE BAD DEBTS (see instructions)	359,997			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	233,998			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	92,979			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	27,286,809			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (NEW TECHNOLOGY)	8,979			70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-62,185			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-117,025			70.94
71	AMOUNT DUE PROVIDER (see instructions)	27,116,578			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	409,460			71.01
72	INTERIM PAYMENTS	26,775,618			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-68,500			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	99,303			75

TO BE COMPLETED BY CONTRACTOR

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0174

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)	21,224			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	24,981,790			2
3	PPS PAYMENTS	22,373,979			3
4	OUTLIER PAYMENT (see instructions)	121,760			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	21,224			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	236,127			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)	236,127			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)	236,127			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	214,903			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)	21,224			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)	22,495,739			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	344			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	4,285,363			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	18,231,256			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)	18,231,256			30
31	PRIMARY PAYER PAYMENTS	2,639			31
32	SUBTOTAL (line 30 minus line 31)	18,228,617			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)	538,787			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	350,212			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	261,104			36
37	SUBTOTAL (see instructions)	18,578,829			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (P RECON)	74			39
40	SUBTOTAL (see instructions)	18,578,903			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	280,541			40.01
41	INTERIM PAYMENTS	18,128,752			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	169,610			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S174

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1 MEDICAL AND OTHER SERVICES (see instructions)	141			1
2 MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	134			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)	141			11
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
12 ANCILLARY SERVICE CHARGES	1,799			12
13 ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14 TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	1,799			14
CUSTOMARY CHARGES				
15 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17 RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18 TOTAL CUSTOMARY CHARGES (see instructions)	1,799			18
19 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	1,658			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)	141			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)	69			26
27 SUBTOTAL (lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23 (see instructions)	72			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)	72			30
31 PRIMARY PAYER PAYMENTS				31
32 SUBTOTAL (line 30 minus line 31)	72			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)	72			37
38 MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39 OTHER ADJUSTMENTS ()				39
40 SUBTOTAL (see instructions)	72			40
40.01 SEQUESTRATION ADJUSTMENT (see instructions)	1			40.01
41 INTERIM PAYMENTS	528			41
42 TENTATIVE SETTLEMENT (for contractor use only)				42
43 BALANCE DUE PROVIDER/PROGRAM (see instructions)	-457			43
44 PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0174

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		27,153,378		18,171,613	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					3.01
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					3.02
	PROGRAM					3.03
	TO					3.04
	PROVIDER					3.05
						3.06
						3.07
						3.08
						3.09
						3.10
		07/11/2013	377,760	07/11/2013	42,861	3.50
						3.51
	PROVIDER					3.52
	TO					3.53
	PROGRAM					3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-377,760		-42,861	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)		26,775,618		18,128,752	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					5.03
	PROGRAM					5.04
	TO					5.05
	PROVIDER					5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
	PROVIDER					5.52
	TO					5.53
	PROGRAM					5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		340,960		450,151	6.01
						6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		27,116,578		18,578,903	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S174

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,407,958		528	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					3.01
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					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
						3.99
4	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,407,958		528	4
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
5	TO BE COMPLETED BY CONTRACTOR					
	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					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
						5.99
6	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		108,161			6.01
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)				-456	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		3,516,119		72	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK 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	7,158	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	12,049	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,310	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	29,277	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	881,522,155	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	34,432,191	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,634,199	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	32,684	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,601,515	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,621,675	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-20,160	32



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S174

WORKSHEET E-3
PART II

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

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	3,862,005	1
2	NET IPF PPS OUTLIER PAYMENT	21,135	2
3	NET IPF PPS ECT PAYMENT	47,530	3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
4.01	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)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	35,230137	9
10	TEACHING ADJUSTMENT FACTOR $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	3,930,670	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	3,930,670	16
17	PRIMARY PAYER PAYMENTS	4,427	17
18	SUBTOTAL (line 16 less line 17)	3,926,243	18
19	DEDUCTIBLES	399,996	19
20	SUBTOTAL (line 18 minus line 19)	3,526,247	20
21	COINSURANCE	66,304	21
22	SUBTOTAL (line 20 minus line 21)	3,459,943	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	86,858	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	56,458	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	86,858	25
26	SUBTOTAL (sum of lines 22 and 24)	3,516,401	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (OTHER)	-282	30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	3,516,119	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	53,093	31.01
32	INTERIM PAYMENTS	3,407,958	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	55,068	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (see instructions)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)		52
53	TIME VALUE OF MONEY (see instructions)		53



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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	6,486,000			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE	104,000			3
4	ACCOUNTS RECEIVABLE	32,982,000			4
5	OTHER RECEIVABLES	1,898,000			5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE				6
7	INVENTORY	4,303,000			7
8	PREPAID EXPENSES	843,000			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS	2,983,000			10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	49,599,000			11
FIXED ASSETS					
12	LAND	4,545,766			12
13	LAND IMPROVEMENTS	4,579,447			13
14	ACCUMULATED DEPRECIATION	-3,122,186			14
15	BUILDINGS	119,374,574			15
16	ACCUMULATED DEPRECIATION	-69,389,197			16
17	LEASEHOLD IMPROVEMENTS	902,212			17
18	ACCUMULATED AMORTIZATION	-581,703			18
19	FIXED EQUIPMENT	3,872,618			19
20	ACCUMULATED DEPRECIATION	-3,286,279			20
21	AUTOMOBILES AND TRUCKS	140,944			21
22	ACCUMULATED DEPRECIATION	-140,944			22
23	MAJOR MOVABLE EQUIPMENT	45,597,670			23
24	ACCUMULATED DEPRECIATION	-36,839,922			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)	65,653,000			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	7,375,000			34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	7,375,000			35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	122,627,000			36
LIABILITIES AND FUND BALANCES (Omit Cents)					
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	12,557,000			37
38	SALARIES, WAGES & FEES PAYABLE				38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (short term)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	9,529,000			43
44	OTHER CURRENT LIABILITIES	16,321,000			44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	38,407,000			45
LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	3,492,000			49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	3,492,000			50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	41,899,000			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	80,728,000			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)	80,728,000			59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	122,627,000			60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		84,051,000			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		11,385,950			2
3	TOTAL (sum of line 1 and line 2)		95,436,950			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		95,436,950			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14	NET ASSET TRANSFER	14,708,950				14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		14,708,950			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		80,728,000			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14	NET ASSET TRANSFER					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	63,496,706		63,496,706	1
2	SUBPROVIDER (PF)	24,170,072		24,170,072	2
3	SUBPROVIDER (RF)				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	87,666,778		87,666,778	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	87,666,778		87,666,778	17
18	ANCILLARY SERVICES	324,221,998	469,633,379	793,855,377	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FOHC				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)	411,888,776	469,633,379	881,522,155	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		180,974,014	29
30	ADD (SPECIFY)			30
31				31
32	RECONCILING ITEM			32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		180,974,014	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	881,522,155	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	701,886,428	2
3	NET PATIENT REVENUES (line 1 minus line 2)	179,635,727	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	180,974,014	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-1,338,287	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	1,966,026	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	6,564	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	550,900	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	1,196,069	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	6,208	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	10,028	21
22	RENTAL OF HOSPITAL SPACE	31,765	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER OPERATING REVENUE)	8,240,901	24
24.01	OTHER (JOINT VENTURE)	715,776	24.01
25	TOTAL OTHER INCOME (sum of lines 6-24)	12,724,237	25
26	TOTAL (line 5 plus line 25)	11,385,950	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	11,385,950	29



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0174

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	1,908,669	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	40,494	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)	80.75	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0419	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.2327	8
9	SUM OF LINES 7 AND 8	0.2746	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0572	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	109,176	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	2,058,339	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
40	SUBPROVIDER - IPF						40
43	NURSERY						43
	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
54.02	ULTRASOUND						54.02
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
70.01	ECT						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
75.01	PSYCHOLOGY						75.01
76	OCCUPATIONAL HEALTH						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	OUTPATIENT PROCEDURES						90.01
90.02	PRCC						90.02
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192.01	PHYSICIAN PRACTICE MANAGEMENT						192.01
193.01	MASSAGE THERAPY						193.01
193.02	IDOL SPACE/HOME HEALTH						193.02
193.03	ADOL SCHOOL						193.03
193.04	FOUNDATION						193.04
193.05	LEASED BLDG						193.05
193.07	PARISH NURSING						193.07
194	OP PHARMACY						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202