

Presence Saints Mary and Elizabeth Medical Center

Medicare Cost Report

Six Months Ended 12.31.2012

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY Provider CCN: 140180 Period: From 07/01/2012 To 12/31/2012 Worksheet S Parts I-III Date/Time Prepared: 5/24/2013 9:31 am

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/24/2013 Time: 9:31 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received: 10. NPR Date:
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
 (2) Settled without Audit 8. Initial Report for this Provider CCN 12. If line 5, column 1 is 4: Enter
 (3) Settled with Audit 9. Final Report for this Provider CCN number of times reopened = 0-9.
 (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 certification 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 SAINTS MARY & ELIZABETH MED (140180) for the cost reporting period beginning 07/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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.

Encryption Information

ECR: Date: 5/24/2013 Time: 9:31 am
 . Tsi F3Ti pgX: pvM3y1VZxj TevyPJPO
 LjOsz01w: j UW6Fj nqBi TAdT4WesJ47
 J4KX17u00f0rQyxk
 PI: Date: 5/24/2013 Time: 9:31 am
 igvYKmkTgtUJMT.s.3d3SYe1Z1c1n0
 RD2dG0san8a1d54TA5mzsBl woKSI tW
 S: W60Sy8Wv0tBMgk

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	235,779	254,847	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	26,160	183		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	6,000	-17		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	267,939	255,013	0	0	200.00

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 and review the 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 the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 9:28 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 2233 WEST DIVISION STREET			PO Box:						1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60622		County: COOK		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		PRESENCE SAINTS MARY & ELIZABETH MED		140180	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		ST. MARY OF NAZARETH REHAB UNIT		14T180	16974	5	01/01/1984	N	P	O	5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF		ST. ELIZABETH'S SNF		145541	16974		01/28/1986	N	P	N	9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2012	12/31/2012		20.00		
21.00	Type of Control (see instructions)						1		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y		N		22.00	
23.00	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		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	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 column 5, and other Medicaid days in column 6.	22,856	4,938	0	0	0	0		24.00			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the 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.	373	175	0	0	0	0		25.00			
							Urban/Rural	S	Date of Geogr			
							1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00			
27.00	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		27.00			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00			

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	Y		45.00
46.00	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		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00
57.00	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				57.00
58.00	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				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	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				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	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)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1 / (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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)	0.00	40.48	0.000000		64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter 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)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 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)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in 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 that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000		67.00

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		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	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 or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) 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. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				75.00
76.00	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 or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) 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. (see instructions)	N	N		0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	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		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	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	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N			N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N			N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 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. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	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 no for each therapy.	N				109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	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" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	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.		0			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0		0
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	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	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	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. (see instructions)		Y		140.00
		1.00	2.00	3.00	
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.					
141.00	Name: PRESENCE HEALTH	Contractor's Name: NGS		Contractor's Number: 00131	
142.00	Street: 100 NORTH RIVER ROAD	PO Box:			
143.00	City: DES PLAINES	State: IL		Zip Code: 60016	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	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		145.00
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "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		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
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)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140180			Period: From 07/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 9:28 am	
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	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)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/24/2013 9:28 am	
		Y/N	Date		
		1.00	2.00		
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					
Provider Organization and Operation					
1.00	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			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	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			2.00
3.00	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			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	Y			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/02/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	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 this cost report? If yes, see instructions.	N		N	18.00
19.00	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	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/24/2013 9:28 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00	2.00	3.00
		N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	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.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
			1.00	2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ALICIA		JUMPER	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(847) 813-3713		ALICIA.JUMPER@PRESENCEHEALTH.ORG	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	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)	04/02/2013		16.00
17.00	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)			17.00
18.00	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 this cost report? If yes, see instructions.			18.00
19.00	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.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIR. OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	420	77,280	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		420	77,280	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	32	5,888	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		452	83,168	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	15	2,760		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	28	5,152		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		495				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	15,178	22,508	47,570			1.00
2.00 HMO	1,386	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	15,178	22,508	47,570			7.00
8.00 INTENSIVE CARE UNIT	1,499	2,987	4,943			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		1,100	1,431			13.00
14.00 Total (see instructions)	16,677	26,595	53,944	39.16	742.23	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	801	630	1,621	0.00	7.33	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	1,997	0	2,628	0.00	11.26	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet S-3 Part I Date/Time Prepared: 5/24/2013 9:28 am
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				39.16	760.82	27.00
28.00 Observation Bed Days		910	2,880			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00
Component	Full Time Equivalents	Discharges				
	Nonpaid Workers	Title V	Title VIII	Title XIX		Total All Patients
	11.00	12.00	13.00	14.00		15.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	2,813	4,081	8,849	1.00
2.00 HMO			237			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,813	4,081	8,849	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	61	53	129	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet S-3 Part II Date/Time Prepared: 5/24/2013 9:28 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	46,265,260	0	46,265,260	1,582,490.00	29.24	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		509,176	0	509,176	5,814.00	87.58	4.00
4.01	Physicians - Part A - Teaching		294,486	0	294,486	3,973.00	74.12	4.01
5.00	Physician-Part B		840,906	0	840,906	11,908.00	70.62	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	1,976,789	-1,013,165	963,624	42,088.00	22.90	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	677,055	0	677,055	23,415.00	28.92	9.00
10.00	Excluded area salaries (see instructions)		464,449	9,659	474,108	15,827.00	29.96	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		2,340,458	0	2,340,458	74,659.00	31.35	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		8,625,770	0	8,625,770	216,993.00	39.75	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		9,780,771	0	9,780,771			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		261,234	0	261,234			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		54,428	0	54,428			22.00
22.01	Physician Part A - Teaching		37,189	0	37,189			22.01
23.00	Physician Part B		111,477	0	111,477			23.00
24.00	Wage-related costs (RHC/FQHC)		249,117	0	249,117			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	6,689	0	6,689	80.00	83.61	26.00
27.00	Administrative & General	5.00	2,260,693	0	2,260,693	97,050.00	23.29	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,238,340	-9,659	1,228,681	40,415.00	30.40	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	971,646	0	971,646	77,995.00	12.46	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	949,408	-323,065	626,343	36,790.00	17.02	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	191,194	323,065	514,259	45,152.00	11.39	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,279,125	0	2,279,125	56,788.00	40.13	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,775,397	0	1,775,397	47,225.00	37.59	40.00

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HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2013 9:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	3.00	Adjusted Sal ari es (col . 2 ± col . 3)	4.00	Pai d Hours Related to Sal ari es in col . 4	5.00	Average Hourly Wage (col . 4 ÷ col . 5)	6.00
41.00	Medical Records & Medical Records Library	16.00	997,268	0	997,268	48,767.00	20.45	41.00		
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00		
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2013 9:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hours Rel ated to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	43,153,079	1,013,165	44,166,244	1,524,521.00	28.97	1.00
2.00	Excluded area salaries (see instructions)	1,141,504	9,659	1,151,163	39,242.00	29.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)	42,011,575	1,003,506	43,015,081	1,485,279.00	28.96	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,966,228	0	10,966,228	291,652.00	37.60	4.00
5.00	Subtotal wage-related costs (see inst.)	9,835,199	0	9,835,199	0.00	22.86	5.00
6.00	Total (sum of lines 3 thru 5)	62,813,002	1,003,506	63,816,508	1,776,931.00	35.91	6.00
7.00	Total overhead cost (see instructions)	10,669,760	-9,659	10,660,101	450,262.00	23.68	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2013 9:28 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,957,652	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	4,353,261	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	142,161	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	42,954	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	157,487	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	391,332	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,288,040	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	30,077	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	34,445	22.00
23.00	Tuition Reimbursement	96,808	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,494,217	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet S-3 Part V Date/Time Prepared: 5/24/2013 9:28 am
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		2,340,458	0 1.00
2.00	Hospital		2,340,458	0 2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-7
Date/Time Prepared:
5/24/2013 9:28 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	0	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	82	0	12.00
13.00		RUB	1,266	0	13.00
14.00		RUA	205	0	14.00
15.00		RVC	82	0	15.00
16.00		RVB	200	0	16.00
17.00		RVA	34	0	17.00
18.00		RHC	6	0	18.00
19.00		RHB	14	0	19.00
20.00		RHA	0	0	20.00
21.00		RMC	0	0	21.00
22.00		RMB	77	0	22.00
23.00		RMA	0	0	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	0	0	28.00
29.00		HE2	0	0	29.00
30.00		HE1	5	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	4	0	32.00
33.00		HC2	0	0	33.00
34.00		HC1	8	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	2	0	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	0	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	6	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	0	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	0	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	5	0	50.00
51.00		CB2	0	0	51.00
52.00		CB1	0	0	52.00
53.00		CA2	0	0	53.00
54.00		CA1	0	0	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-7

Date/Time Prepared:
5/24/2013 9:28 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	1	0	1	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,997	0	1,997	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		16974	16974	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		2,230,826			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/24/2013 9:28 am
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			1.00			
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.216503	1.00		
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		22,110,518	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		27,683,340	5.00		
6.00	Medicaid charges		177,607,783	6.00		
7.00	Medicaid cost (line 1 times line 6)		38,452,618	7.00		
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00		
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP		0	9.00		
10.00	Stand-alone SCHIP charges		0	10.00		
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00		
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00		
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00		
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00		
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00		
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00		
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00		
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00		
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00		
			Uninsured patients	Insured patients		
			1.00	2.00		
			Total (col. 1 + col. 2)	3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		3,605,902	52,101	3,658,003	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		780,689	11,280	791,969	21.00
22.00	Partial payment by patients approved for charity care		8,099	2,344	10,443	22.00
23.00	Cost of charity care (line 21 minus line 22)		772,590	8,936	781,526	23.00
			1.00			
24.00	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			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)				3,844,228	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				1,555,386	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)				2,288,842	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)				495,541	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				1,277,067	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				1,277,067	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,857,137	1,857,137	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,761,747	4,761,747	0	4,761,747	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	6,689	7,210,282	7,216,971	3,284,676	10,501,647	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,260,693	23,993,790	26,254,483	-196,978	26,057,505	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,238,340	3,863,374	5,101,714	-124,462	4,977,252	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	612,959	612,959	0	612,959	8.00
9.00	00900	HOUSEKEEPING	971,646	668,921	1,640,567	-69,248	1,571,319	9.00
10.00	01000	DIETARY	949,408	1,033,197	1,982,605	-849,805	1,132,800	10.00
11.00	01100	CAFETERIA	191,194	14,545	205,739	767,234	972,973	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,279,125	735,054	3,014,179	-160,671	2,853,508	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	328,614	328,614	-131,322	197,292	14.00
15.00	01500	PHARMACY	1,775,397	7,295,168	9,070,565	-7,317,783	1,752,782	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	997,268	541,029	1,538,297	-72,749	1,465,548	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	1,976,789	2,084,920	4,061,709	-1,136,020	2,925,689	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	1,013,165	1,013,165	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,604,479	5,156,001	18,760,480	-1,408,230	17,352,250	30.00
31.00	03100	INTENSIVE CARE UNIT	2,643,475	454,848	3,098,323	-321,052	2,777,271	31.00
41.00	04100	SUBPROVIDER - IIRF	458,981	54,579	513,560	-38,359	475,201	41.00
43.00	04300	NURSERY	367,480	137,098	504,578	-53,464	451,114	43.00
44.00	04400	SKILLED NURSING FACILITY	677,055	120,666	797,721	-96,942	700,779	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,447,516	5,439,649	7,887,165	-4,285,010	3,602,155	50.00
51.00	05100	RECOVERY ROOM	422,076	50,979	473,055	-44,187	428,868	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,123,257	564,288	2,687,545	-371,495	2,316,050	52.00
53.00	05300	ANESTHESIOLOGY	74,250	679,711	753,961	-205,332	548,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,413,321	1,254,074	3,667,395	-268,008	3,399,387	54.00
54.01	03190	OUTPATIENT ONCOLOGY	171,056	39,791	210,847	-34,013	176,834	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	94,909	130,732	225,641	-8,306	217,335	55.00
59.00	05900	CARDIAC CATHETERIZATION	290,107	623,194	913,301	-486,211	427,090	59.00
60.00	06000	LABORATORY	0	4,000,282	4,000,282	-2,557	3,997,725	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	471,844	471,844	-12,972	458,872	63.00
65.00	06500	RESPIRATORY THERAPY	808,171	221,585	1,029,756	-123,256	906,500	65.00
66.00	06600	PHYSICAL THERAPY	894,518	176,365	1,070,883	-69,186	1,001,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	507,696	41,377	549,073	-38,592	510,481	67.00
68.00	06800	SPEECH PATHOLOGY	98,403	7,528	105,931	-7,064	98,867	68.00
69.00	06900	ELECTROCARDIOLOGY	477,568	215,548	693,116	-45,425	647,691	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	95,262	271,522	366,784	-9,480	357,304	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	4,495,674	4,495,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,039,600	2,039,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,548,839	7,548,839	73.00
74.00	07400	RENAL DIALYSIS	307,492	135,781	443,273	-106,694	336,579	74.00
75.00	07500	ASC (NON-DISTINCT PART)	585,948	498,315	1,084,263	-395,080	689,183	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	0	1,800,359	1,800,359	-334	1,800,025	76.00
76.97	07697	CARDIAC REHABILITATION	86,384	18,615	104,999	-6,628	98,371	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	661,103	719,409	1,380,512	-73,987	1,306,525	90.00
91.00	09100	EMERGENCY	3,302,736	2,015,908	5,318,644	-695,421	4,623,223	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,785,920	1,785,920	-1,785,920	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	12,000	12,000	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,259,792	80,229,568	126,489,360	-33,918	126,455,442	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	24,724	24,724	0	24,724	193.00
194.00	07950	CONVENT	5,468	3,201	8,669	33,918	42,587	194.00
194.01	07951	OUTPATIENT PHARMACY	0	29	29	0	29	194.01

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012	Worksheet A Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
194.02	07952 FUND DEVELOPMENT	0	118	118	0	118
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0
200.00	TOTAL (SUM OF LINES 118-199)	46,265,260	80,257,640	126,522,900	0	126,522,900
Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation			
		6.00	7.00			
GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-119,568	1,737,569			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-675,419	4,086,328			2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0			3.00
4.00	00400 EMPLOYEE BENEFITS	298,728	10,800,375			4.00
5.00	00500 ADMIN STRATIVE & GENERAL	-2,989,361	23,068,144			5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700 OPERATION OF PLANT	-150,502	4,826,750			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	612,959			8.00
9.00	00900 HOUSEKEEPING	0	1,571,319			9.00
10.00	01000 DIETARY	0	1,132,800			10.00
11.00	01100 CAFETERIA	-437,903	535,070			11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0			12.00
13.00	01300 NURSING ADMINISTRATION	-16,734	2,836,774			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	913,407	1,110,699			14.00
15.00	01500 PHARMACY	0	1,752,782			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-2,001	1,463,547			16.00
17.00	01700 SOCIAL SERVICE	0	0			17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0			19.00
20.00	02000 NURSING SCHOOL	0	0			20.00
21.00	02100 I&R SRVCES-SALARY & FRINGES APPRVD	-3,099,284	-173,595			21.00
22.00	02200 I&R SRVCES-OTHER PRGM COSTS APPRVD	0	1,013,165			22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	17,352,250			30.00
31.00	03100 INTENSIVE CARE UNIT	-242,032	2,535,239			31.00
41.00	04100 SUBPROVIDER - IRF	-2,500	472,701			41.00
43.00	04300 NURSERY	-75,765	375,349			43.00
44.00	04400 SKILLED NURSING FACILITY	-6,000	694,779			44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	-50,000	3,552,155			50.00
51.00	05100 RECOVERY ROOM	0	428,868			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-555,699	1,760,351			52.00
53.00	05300 ANESTHESIOLOGY	-423,000	125,629			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-2,320	3,397,067			54.00
54.01	03190 OUTPATIENT ONCOLOGY	0	176,834			54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	217,335			55.00
59.00	05900 CARDIAC CATHETERIZATION	-300	426,790			59.00
60.00	06000 LABORATORY	189,983	4,187,708			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	458,872			63.00
65.00	06500 RESPIRATORY THERAPY	-5,625	900,875			65.00
66.00	06600 PHYSICAL THERAPY	0	1,001,697			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	510,481			67.00
68.00	06800 SPEECH PATHOLOGY	0	98,867			68.00
69.00	06900 ELECTROCARDIOLOGY	-67,150	580,541			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	-225,520	131,784			70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	4,495,674			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,039,600			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,548,839			73.00
74.00	07400 RENAL DIALYSIS	0	336,579			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	689,183			75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	-292,477	1,507,548			76.00
76.97	07697 CARDIAC REHABILITATION	-12,152	86,219			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0			76.98
76.99	07699 LI THOTRI PSY	0	0			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	-392,539	913,986			90.00
91.00	09100 EMERGENCY	-825,765	3,797,458			91.00
92.00	09200 OBSERVATION BEDS					92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0			94.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE	0	0			113.00
114.00	11400 UTILIZATION REVIEW-SNF	-12,000	0			114.00

C:\Client\Cient Folders\Presence Health\Cost Reports\St Mary & Elizabeth Med Ctr\St Mary & Elizabeth MCR 2012.mcrx

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	-9,279,498	117,175,944	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300 NONPAID WORKERS	0	24,724	193.00
194.00	07950 CONVENT	0	42,587	194.00
194.01	07951 OUTPATIENT PHARMACY	0	29	194.01
194.02	07952 FUND DEVELOPMENT	0	118	194.02
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	-9,279,498	117,243,402	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	3,284,676	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
TOTALS			0	3,284,676	
B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,548,839	1.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
TOTALS			0	7,548,839	
C - SUPPLIES					
1.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	4,495,674	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
TOTALS					
D - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,039,600	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
TOTALS					
E - CAFETERIA					
1.00	CAFETERIA	11.00	323,065	457,847	1.00
TOTALS					
F - DEFAULT					
1.00	I&R SRVCES-OTHER PRGM COSTS APPRVD	22.00	1,013,165	0	1.00
TOTALS					
G - CONVENT MAINT					
1.00	CONVENT	194.00	9,659	24,490	1.00
TOTALS					
I - BUILDING INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,217	1.00
TOTALS					
J - SNF UTILIZATION REVIEW					
1.00	UTILIZATION REVIEW-SNF	114.00	0	12,000	1.00
TOTALS					
K - MORTGAGE INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,785,920	1.00
TOTALS					
500.00	Grand Total: Increases		1,345,889	19,720,263	500.00

RECLASSIFICATIONS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-6
Date/Time Prepared:
5/24/2013 9:28 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	125,761	0		1.00
2.00	OPERATION OF PLANT	7.00	0	90,313	0		2.00
3.00	HOUSEKEEPING	9.00	0	69,248	0		3.00
4.00	DIETARY	10.00	0	68,893	0		4.00
5.00	CAFETERIA	11.00	0	13,678	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	160,671	0		6.00
7.00	PHARMACY	15.00	0	124,764	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	72,722	0		8.00
9.00	I&R SRVCES-SALARY & FRINGES	21.00	0	122,855	0		9.00
	APPRVD						
10.00	ADULTS & PEDIATRICS	30.00	0	998,961	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	176,921	0		11.00
12.00	SUBPROVIDER - IRF	41.00	0	33,621	0		12.00
13.00	NURSERY	43.00	0	26,992	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	49,399	0		14.00
15.00	OPERATING ROOM	50.00	0	177,670	0		15.00
16.00	RECOVERY ROOM	51.00	0	31,676	0		16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	0	139,177	0		17.00
18.00	ANESTHESIOLOGY	53.00	0	5,425	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	178,313	0		19.00
20.00	OUTPATIENT ONCOLOGY	54.01	0	12,716	0		20.00
21.00	RADIOLOGY-THERAPEUTIC	55.00	0	7,199	0		21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	20,411	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	61,064	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	65,140	0		24.00
25.00	OCCUPATIONAL THERAPY	67.00	0	37,092	0		25.00
26.00	SPEECH PATHOLOGY	68.00	0	7,064	0		26.00
27.00	ELECTROCARDIOLOGY	69.00	0	34,780	0		27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,221	0		28.00
29.00	RENAL DIALYSIS	74.00	0	23,047	0		29.00
30.00	ASC (NON-DISTINCT PART)	75.00	0	43,573	0		30.00
31.00	CARDIAC REHABILITATION	76.97	0	6,280	0		31.00
32.00	CLINIC	90.00	0	49,030	0		32.00
33.00	EMERGENCY	91.00	0	242,768	0		33.00
34.00	CONVENT	194.00	0	231	0		34.00
	TOTALS		0	3,284,676			
B - DRUGS							
1.00		0.00	0	0	0		1.00
3.00	PHARMACY	15.00	0	7,054,960	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	102,256	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	29,235	0		5.00
6.00	SUBPROVIDER - IRF	41.00	0	614	0		6.00
7.00	NURSERY	43.00	0	3,653	0		7.00
8.00	SKILLED NURSING FACILITY	44.00	0	6,113	0		8.00
9.00	OPERATING ROOM	50.00	0	56,676	0		9.00
10.00	RECOVERY ROOM	51.00	0	4,369	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	18,284	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	62,341	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,118	0		13.00
14.00	OUTPATIENT ONCOLOGY	54.01	0	9,113	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	35	0		15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	2,106	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	183	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	632	0		18.00
19.00	RENAL DIALYSIS	74.00	0	13,894	0		19.00
20.00	ASC (NON-DISTINCT PART)	75.00	0	21,288	0		20.00
21.00	CLINIC	90.00	0	8,053	0		21.00
22.00	EMERGENCY	91.00	0	144,916	0		22.00
	TOTALS		0	7,548,839			
C - SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	131,322	0		1.00
2.00	PHARMACY	15.00	0	138,059	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	27	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	307,013	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	112,868	0		5.00
6.00	SUBPROVIDER - IRF	41.00	0	4,124	0		6.00
7.00	NURSERY	43.00	0	22,819	0		7.00
8.00	SKILLED NURSING FACILITY	44.00	0	29,430	0		8.00
9.00	OPERATING ROOM	50.00	0	2,350,830	0		9.00
10.00	RECOVERY ROOM	51.00	0	8,142	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	214,034	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	136,568	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	78,372	0		13.00

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Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
14.00	OUTPATIENT ONCOLOGY	54.01	0	12,184	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,072	0		15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	139,561	0		16.00
17.00	LABORATORY	60.00	0	2,557	0		17.00
18.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	12,972	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	61,914	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	4,046	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	1,500	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	10,013	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,259	0		23.00
24.00	RENAL DIALYSIS	74.00	0	69,753	0		24.00
25.00	ASC (NON-DISTINCT PART)	75.00	0	327,101	0		25.00
26.00	MENTAL HEALTH OUTPATIENT	76.00	0	334	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	348	0		27.00
28.00	CLINIC	90.00	0	8,826	0		28.00
29.00	EMERGENCY	91.00	0	307,626	0		29.00
	TOTALS		0	4,495,674			
D - IMPLANTS							
1.00	INTENSIVE CARE UNIT	31.00	0	2,028	0		1.00
2.00	OPERATING ROOM	50.00	0	1,699,834	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	998	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,205	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	324,133	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	95	0		6.00
7.00	ASC (NON-DISTINCT PART)	75.00	0	3,118	0		7.00
8.00	CLINIC	90.00	0	8,078	0		8.00
9.00	EMERGENCY	91.00	0	111	0		9.00
	TOTALS		0	2,039,600			
E - CAFETERIA							
1.00	DIETARY	10.00	323,065	457,847	0		1.00
	TOTALS		323,065	457,847			
F - DEFAULT							
1.00	I&R SRVCES-SALARY & FRINGES	21.00	1,013,165	0	0		1.00
	APPRVD						
	TOTALS		1,013,165	0			
G - CONVENT MAINT							
1.00	OPERATION OF PLANT	7.00	9,659	24,490	0		1.00
	TOTALS		9,659	24,490			
I - BUILDING INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	71,217	12		1.00
	TOTALS		0	71,217			
J - SNF UTILIZATION REVIEW							
1.00	SKILLED NURSING FACILITY	44.00	0	12,000	0		1.00
	TOTALS		0	12,000			
K - MORTGAGE INTEREST							
1.00	INTEREST EXPENSE	113.00	0	1,785,920	11		1.00
	TOTALS		0	1,785,920			
500.00	Grand Total: Decreases		1,345,889	19,720,263			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2013 9:28 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,491,770	411,122	0	411,122	0 1.00
2.00	Land Improvements	758,289	2,611,432	0	2,611,432	0 2.00
3.00	Buildings and Fixtures	107,493,465	15,692,296	0	15,692,296	0 3.00
4.00	Building Improvements	0	0	0	0	0 4.00
5.00	Fixed Equipment	0	0	0	0	0 5.00
6.00	Movable Equipment	58,343,378	3,033,247	0	3,033,247	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	171,086,902	21,748,097	0	21,748,097	0 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	171,086,902	21,748,097	0	21,748,097	0 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,902,892	0			1.00
2.00	Land Improvements	3,369,721	0			2.00
3.00	Buildings and Fixtures	123,185,761	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	61,376,625	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	192,834,999	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	192,834,999	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,761,747	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	4,761,747	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,761,747				2.00
3.00	Total (sum of lines 1-2)	0	4,761,747				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	131,458,374	0	131,458,374	0.681714	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	61,376,625	0	61,376,625	0.318286	0	2.00
3.00	Total (sum of lines 1-2)	192,834,999	0	192,834,999	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	162,360	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,110,501	4,761,747	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,272,861	4,761,747	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,785,920	-210,711	0	0	1,737,569	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-1,785,920	0	0	0	4,086,328	2.00
3.00	Total (sum of lines 1-2)	0	-210,711	0	0	5,823,897	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst. A-7 Ref.			
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,785,920		CAP REL COSTS-MVBLE EQUIP	2.00		11	2.00
3.00 Investment income - other (chapter 2)		0			0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00		0	7.00
8.00 Television and radio service (chapter 21)		0			0.00		0	8.00
9.00 Parking lot (chapter 21)		0			0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-6,225,807					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	79,515					0	12.00
13.00 Laundry and linen service		0			0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-422,037		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employees and others		0			0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00		0	16.00
17.00 Sale of drugs to other than patients		0			0.00		0	17.00
18.00 Sale of medical records and abstracts		0			0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00		0	19.00
20.00 Vending machines	B	-15,866		CAFETERIA	11.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			ORESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			OPHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)	A	-12,000		UTILIZATION REVIEW-SNF	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-281,928		CAP REL COSTS-BLDG & FIXT	1.00		12	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0		CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0		NONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant		0			0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00			30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			OSPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00		0	32.00

Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet A-8 Date/Time Prepared: 5/24/2013 9:28 am
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
33.00 NON-OPERATING REV	B	-1,014	EMPLOYEE BENEFITS		4.00	0	33.00
35.00 OTHER OPERATING REV	B	-26,344	ADMINISTRATIVE & GENERAL		5.00	0	35.00
36.00 OTHER OPERATING REV	B	-150,502	OPERATION OF PLANT		7.00	0	36.00
38.00 OTHER OPERATING REV	B	-2,001	MEDICAL RECORDS & LIBRARY		16.00	0	38.00
39.00		0			0.00	0	39.00
40.00 OTHER OPERATING REV	B	-11,765	NURSERY		43.00	0	40.00
41.00 OTHER OPERATING REV	B	-880	RADIOLOGY-DIAGNOSTIC		54.00	0	41.00
42.00 OTHER OPERATING REV	B	-300	CARDIAC CATHETERIZATION		59.00	0	42.00
43.00 OTHER OPERATING REV	B	-29,530	LABORATORY		60.00	0	43.00
44.00		0			0.00	0	44.00
45.00 OTHER OPERATING REV	B	-292,477	MENTAL HEALTH OUTPATIENT		76.00	0	45.00
46.00 OTHER OPERATING REV	B	-2,027	CARDIAC REHABILITATION		76.97	0	46.00
47.00 OTHER OPERATING REV	B	-98,615	CLINIC		90.00	0	47.00
48.00		0			0.00	0	48.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,279,498					50.00

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

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-8-1

Date/Time Prepared:
5/24/2013 9:28 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS	HOME OFFICE	489,856	0
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,065,557	18,016,617
3.00	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	799,901	0
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,576,837	0
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,014,327	0
4.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	8,473,624	0
4.03	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	113,506	0
4.04	31.00	INTENSIVE CARE UNIT	HOME OFFICE	45,150	0
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,110,501	0
4.06	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	162,360	0
4.07	60.00	LABORATORY	LAB	4,200,500	3,955,987
5.00	0		0	22,052,119	21,972,604

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	100.00	RESURRECTION HEALTHCARE	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

(1) Use the following symbols to indicate 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.

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

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-8-1

Date/Time Prepared:
5/24/2013 9:28 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	489,856	0		1.00
2.00	-14,951,060	0		2.00
3.00	799,901	0		3.00
4.00	2,576,837	0		4.00
4.01	1,014,327	0		4.01
4.02	8,473,624	0		4.02
4.03	113,506	0		4.03
4.04	45,150	0		4.04
4.05	1,110,501	9		4.05
4.06	162,360	9		4.06
4.07	244,513	0		4.07
5.00	79,515			5.00

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO 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.

6.00	SOLE CORPORATE MEMBER		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate 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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/24/2013 9:28 am

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	81,005	74,755	6,250	177,200	50	1.00
2.00	13.00	106,016	0	106,016	177,200	1,048	2.00
3.00	21.00	3,786,950	3,099,284	687,666	177,200	8,689	3.00
4.00	0.00	0	0	0	0	0	4.00
5.00	31.00	287,182	287,182	0	0	0	5.00
6.00	41.00	2,500	2,500	0	0	0	6.00
7.00	43.00	64,000	64,000	0	0	0	7.00
8.00	44.00	6,000	6,000	0	0	0	8.00
9.00	50.00	50,000	50,000	0	0	0	9.00
10.00	52.00	555,699	555,699	0	0	0	10.00
11.00	53.00	423,000	423,000	0	0	0	11.00
12.00	54.00	1,440	1,440	0	0	0	12.00
14.00	60.00	25,000	25,000	0	0	0	14.00
15.00	65.00	5,625	5,625	0	0	0	15.00
16.00	69.00	67,150	67,150	0	0	0	16.00
17.00	70.00	225,520	225,520	0	0	0	17.00
18.00	76.97	10,125	10,125	0	0	0	18.00
19.00	90.00	293,924	293,924	0	0	0	19.00
20.00	91.00	825,765	825,765	0	0	0	20.00
21.00	4.00	190,114	190,114	0	0	0	21.00
200.00		7,007,015	6,207,083	799,932		9,787	200.00

Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	4,260	213	0	0	0	1.00
2.00	13.00	89,282	4,464	0	0	0	2.00
3.00	21.00	740,236	37,012	0	0	0	3.00
4.00	0.00	0	0	0	0	0	4.00
5.00	31.00	0	0	0	0	0	5.00
6.00	41.00	0	0	0	0	0	6.00
7.00	43.00	0	0	0	0	0	7.00
8.00	44.00	0	0	0	0	0	8.00
9.00	50.00	0	0	0	0	0	9.00
10.00	52.00	0	0	0	0	0	10.00
11.00	53.00	0	0	0	0	0	11.00
12.00	54.00	0	0	0	0	0	12.00
14.00	60.00	0	0	0	0	0	14.00
15.00	65.00	0	0	0	0	0	15.00
16.00	69.00	0	0	0	0	0	16.00
17.00	70.00	0	0	0	0	0	17.00
18.00	76.97	0	0	0	0	0	18.00
19.00	90.00	0	0	0	0	0	19.00
20.00	91.00	0	0	0	0	0	20.00
21.00	4.00	0	0	0	0	0	21.00
200.00		833,778	41,689	0	0	0	200.00

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	0	4,260	1,990	76,745	1.00
2.00	13.00	0	89,282	16,734	16,734	2.00
3.00	21.00	0	740,236	0	3,099,284	3.00
4.00	0.00	0	0	0	0	4.00
5.00	31.00	0	0	0	287,182	5.00
6.00	41.00	0	0	0	2,500	6.00
7.00	43.00	0	0	0	64,000	7.00
8.00	44.00	0	0	0	6,000	8.00
9.00	50.00	0	0	0	50,000	9.00
10.00	52.00	0	0	0	555,699	10.00
11.00	53.00	0	0	0	423,000	11.00
12.00	54.00	0	0	0	1,440	12.00
14.00	60.00	0	0	0	25,000	14.00
15.00	65.00	0	0	0	5,625	15.00
16.00	69.00	0	0	0	67,150	16.00
17.00	70.00	0	0	0	225,520	17.00
18.00	76.97	0	0	0	10,125	18.00
19.00	90.00	0	0	0	293,924	19.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/24/2013 9:28 am

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
20.00	91.00	EMERGENCY	0	0	0	825,765		20.00
21.00	4.00	EMPLOYEE BENEFITS	0	0	0	190,114		21.00
200.00			0	833,778	18,724	6,225,807		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	1,737,569	1,737,569				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	4,086,328		4,086,328			2.00
4.00 00400 EMPLOYEE BENEFITS	10,800,375	18,262	42,947	10,861,584		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	23,068,144	122,800	288,795	530,815	24,010,554	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	4,826,750	406,235	955,364	288,497	6,476,846	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	612,959	8,846	20,805	0	642,610	8.00
9.00 00900 HOUSEKEEPING	1,571,319	26,617	62,597	228,144	1,888,677	9.00
10.00 01000 DIETARY	1,132,800	52,826	124,234	147,067	1,456,927	10.00
11.00 01100 CAFETERIA	535,070	7,901	18,581	120,749	682,301	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATIONS	2,836,774	4,970	11,688	535,143	3,388,575	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	1,110,699	41,482	97,556	0	1,249,737	14.00
15.00 01500 PHARMACY	1,752,782	13,644	32,086	416,867	2,215,379	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,463,547	25,630	60,275	234,161	1,783,613	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100 I&R SRVCES-SALARY & FRINGES APPRVD	-173,595	6,012	14,139	226,261	72,817	21.00
22.00 02200 I&R SRVCES-OTHER PRGM COSTS APPRVD	1,013,165	6,240	14,674	237,893	1,271,972	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	17,352,250	447,035	1,051,310	3,194,336	22,044,931	30.00
31.00 03100 INTENSIVE CARE UNIT	2,535,239	21,496	50,553	620,693	3,227,981	31.00
41.00 04100 SUBPROVIDER - IIRF	472,701	17,438	41,010	107,770	638,919	41.00
43.00 04300 NURSERY	375,349	3,904	9,182	86,285	474,720	43.00
44.00 04400 SKILLED NURSING FACILITY	694,779	22,837	53,708	158,974	930,298	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3,552,155	110,106	258,943	574,682	4,495,886	50.00
51.00 05100 RECOVERY ROOM	428,868	7,701	18,111	99,104	553,784	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,760,351	51,485	121,080	498,545	2,431,461	52.00
53.00 05300 ANESTHESIOLOGY	125,629	1,082	2,545	17,434	146,690	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,397,067	51,064	120,089	566,653	4,134,873	54.00
54.01 03190 OUTPATIENT ONCOLOGY	176,834	0	0	40,164	216,998	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	217,335	2,716	6,389	22,285	248,725	55.00
59.00 05900 CARDIAC CATHETERIZATION	426,790	11,818	27,792	68,118	534,518	59.00
60.00 06000 LABORATORY	4,187,708	39,663	93,277	0	4,320,648	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	458,872	3,296	7,750	0	469,918	63.00
65.00 06500 RESPIRATORY THERAPY	900,875	2,380	5,596	189,760	1,098,611	65.00
66.00 06600 PHYSICAL THERAPY	1,001,697	16,234	38,178	210,035	1,266,144	66.00
67.00 06700 OCCUPATIONAL THERAPY	510,481	2,373	5,581	119,208	637,643	67.00
68.00 06800 SPEECH PATHOLOGY	98,867	844	1,986	23,105	124,802	68.00
69.00 06900 ELECTROCARDIOLOGY	580,541	17,750	41,743	112,134	752,168	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	131,784	0	0	22,368	154,152	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	4,495,674	0	0	0	4,495,674	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,039,600	0	0	0	2,039,600	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7,548,839	0	0	0	7,548,839	73.00
74.00 07400 RENAL DIALYSIS	336,579	1,895	4,457	72,200	415,131	74.00
75.00 07500 ASC (NON-DISTINCT PART)	689,183	0	0	137,582	826,765	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	1,507,548	25,417	59,775	0	1,592,740	76.00
76.97 07697 CARDIAC REHABILITATION	86,219	7,433	17,482	20,283	131,417	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	913,986	66,409	156,177	155,228	1,291,800	90.00
91.00 09100 EMERGENCY	3,797,458	61,999	145,807	775,489	4,780,753	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	117,175,944	1,735,840	4,082,262	10,858,032	117,166,597	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	24,724	0	0	0	24,724	193.00

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COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part I Date/Time Prepared: 5/24/2013 9:28 am
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.00	07950	CONVENT	42,587	0	0	3,552	46,139	194.00
194.01	07951	OUTPATIENT PHARMACY	29	1,152	2,709	0	3,890	194.01
194.02	07952	FUND DEVELOPMENT	118	577	1,357	0	2,052	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	117,243,402	1,737,569	4,086,328	10,861,584	117,243,402	202.00
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,010,554					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,668,002	0	8,144,848			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	165,493	0	60,535	868,638		8.00
9.00	00900	HOUSEKEEPING	486,397	0	182,139	48,477	2,605,690	9.00
10.00	01000	DIETARY	375,207	0	361,482	0	119,196	10.00
11.00	01100	CAFETERIA	175,715	0	54,065	0	17,828	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	872,670	0	34,007	0	11,214	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	321,849	0	283,857	58	93,600	14.00
15.00	01500	PHARMACY	570,533	0	93,361	0	30,785	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	459,339	0	175,381	0	57,831	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	18,753	0	41,140	0	13,566	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	327,575	0	42,696	0	14,079	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,677,317	0	3,058,981	283,631	1,008,681	30.00
31.00	03100	INTENSIVE CARE UNIT	831,312	0	147,094	63,490	48,503	31.00
41.00	04100	SUBPROVIDER - IRF	164,543	0	119,327	86,584	39,347	41.00
43.00	04300	NURSERY	122,256	0	26,716	22,425	8,809	43.00
44.00	04400	SKILLED NURSING FACILITY	239,582	0	156,273	27,423	51,530	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,157,839	0	753,441	73,380	248,442	50.00
51.00	05100	RECOVERY ROOM	142,618	0	52,696	15,267	17,376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	626,181	0	352,303	24,629	116,170	52.00
53.00	05300	ANESTHESIOLOGY	37,778	0	7,407	0	2,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,064,866	0	349,421	39,615	115,219	54.00
54.01	03190	OUTPATIENT ONCOLOGY	55,884	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	64,055	0	18,589	1,068	6,129	55.00
59.00	05900	CARDIAC CATHETERIZATION	137,656	0	80,867	2,880	26,665	59.00
60.00	06000	LABORATORY	1,112,709	0	271,407	0	89,495	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	121,019	0	22,551	0	7,436	63.00
65.00	06500	RESPIRATORY THERAPY	282,929	0	16,283	0	5,369	65.00
66.00	06600	PHYSICAL THERAPY	326,074	0	111,085	17,390	36,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,214	0	16,240	0	5,355	67.00
68.00	06800	SPEECH PATHOLOGY	32,141	0	5,778	0	1,905	68.00
69.00	06900	ELECTROCARDIOLOGY	193,708	0	121,460	4,900	40,050	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,699	0	0	283	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	1,157,784	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	525,264	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,944,075	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	106,910	0	12,969	3,233	4,276	74.00
75.00	07500	ASC (NON-DISTINCT PART)	212,919	0	0	0	0	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	410,183	0	173,925	0	57,351	76.00
76.97	07697	CARDIAC REHABILITATION	33,844	0	50,866	116	16,773	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	332,681	0	454,425	3,172	149,844	90.00
91.00	09100	EMERGENCY	1,231,202	0	424,251	149,267	139,894	91.00
92.00	09200	OBSERVATION BEDS						92.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,990,775	0	8,133,018	867,288	2,601,789	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	1,350	0	192.00
193.00	19300 NONPAID WORKERS	6,367	0	0	0	0	193.00
194.00	07950 CONVENT	11,882	0	0	0	0	194.00
194.01	07951 OUTPATIENT PHARMACY	1,002	0	7,882	0	2,599	194.01
194.02	07952 FUND DEVELOPMENT	528	0	3,948	0	1,302	194.02
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	24,010,554	0	8,144,848	868,638	2,605,690	202.00
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY	2,312,812					10.00
11.00	01100 CAFETERIA	0	929,909				11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300 NURSING ADMINISTRATION	0	52,128	0	4,358,594		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	1,949,101	14.00
15.00	01500 PHARMACY	0	40,607	0	186,818	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	22,810	0	192,918	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100 I&R SRVCES-SALARY & FRINGES APPRVD	0	22,040	0	0	0	21.00
22.00	02200 I&R SRVCES-OTHER PRGM COSTS APPRVD	0	23,173	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,890,613	311,164	0	1,884,066	547,591	30.00
31.00	03100 INTENSIVE CARE UNIT	196,454	60,462	0	265,877	73,421	31.00
41.00	04100 SUBPROVIDER - IIRF	64,425	10,498	0	60,288	17,073	41.00
43.00	04300 NURSERY	56,873	8,405	0	39,128	15,793	43.00
44.00	04400 SKILLED NURSING FACILITY	104,447	15,486	0	92,628	13,191	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	55,980	0	303,723	107,122	50.00
51.00	05100 RECOVERY ROOM	0	9,654	0	42,748	20,973	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	48,563	0	229,922	62,899	52.00
53.00	05300 ANESTHESIOLOGY	0	1,698	0	0	28,467	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	55,197	0	298,956	84,870	54.00
54.01	03190 OUTPATIENT ONCOLOGY	0	3,912	0	0	6	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	2,171	0	12,346	526	55.00
59.00	05900 CARDIAC CATHETERIZATION	0	6,635	0	23,273	33,928	59.00
60.00	06000 LABORATORY	0	0	0	0	213,251	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	22,574	63.00
65.00	06500 RESPIRATORY THERAPY	0	18,484	0	0	60,432	65.00
66.00	06600 PHYSICAL THERAPY	0	20,459	0	0	17,997	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	11,612	0	49,457	14,547	67.00
68.00	06800 SPEECH PATHOLOGY	0	2,251	0	0	2,859	68.00
69.00	06900 ELECTROCARDIOLOGY	0	10,923	0	68,857	43,521	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,179	0	0	727	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	105,551	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	33,187	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	302,854	73.00
74.00	07400 RENAL DIALYSIS	0	7,033	0	34,891	14,799	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	13,402	0	68,734	12,442	75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	0	0	0	0	28	76.00
76.97	07697 CARDIAC REHABILITATION	0	1,976	0	7,781	179	76.97

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	15,121	0	92,719	320	90.00
91.00	09100	EMERGENCY	0	75,540	0	403,464	97,973	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,312,812	929,563	0	4,358,594	1,949,101	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	346	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,312,812	929,909	0	4,358,594	1,949,101	202.00
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,137,483					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,691,892				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	881,276	2,200,494	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	118,196	228,653	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	27,485	74,984	0	0	0	41.00
43.00	04300	NURSERY	25,423	66,195	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	21,235	121,566	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	172,450	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	33,764	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	101,258	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	45,827	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,627	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	10	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	846	0	0	0	0	55.00
59.00	05900	CARDIAC CATHETERIZATION	54,618	0	0	0	0	59.00
60.00	06000	LABORATORY	343,300	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	36,340	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	97,286	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	28,972	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,418	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,603	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	70,062	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,170	0	0	0	0	70.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	169,920	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,426	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	487,548	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	23,824	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	20,029	0	0	0	0	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	45	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	288	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	515	0	0	0	0	90.00
91.00	09100	EMERGENCY	157,722	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,137,483	2,691,892	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,137,483	2,691,892	0	0	0	202.00
INTERNS & RESIDENTS								
Cost Center Description			SRVCES-SALARY & FRINGES	SRVCES-OTHER PRGM COSTS	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	168,316					21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	1,679,495				22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,319	542,003	0	40,385,067	-596,322	30.00
31.00	03100	INTENSIVE CARE UNIT	12,150	121,237	0	5,394,830	-133,387	31.00
41.00	04100	SUBPROVIDER - I&R	0	0	0	1,303,473	0	41.00
43.00	04300	NURSERY	8,934	89,145	0	964,822	-98,079	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,773,659	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,661	295,962	0	7,693,886	-325,623	50.00
51.00	05100	RECOVERY ROOM	0	0	0	888,880	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,075	60,619	0	4,060,080	-66,694	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	270,309	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	357	3,566	0	6,283,567	-3,923	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	276,810	0	54.01

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SRVCES-SALARY & FRINGES	SRVCES-OTHER PRGM COSTS				
	21.00	22.00				
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	354,455	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	901,040	0	59.00
60.00 06000 LABORATORY	0	0	0	6,350,810	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	679,838	0	63.00
65.00 06500 RESPIRATORY THERAPY	357	3,566	0	1,583,317	-3,923	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	1,824,750	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	922,486	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	174,339	0	68.00
69.00 06900 ELECTROCARDIOLOGY	6,790	67,750	0	1,380,189	-74,540	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	198,210	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	5,928,929	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,651,477	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	10,283,316	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	623,066	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	1,154,291	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0	0	2,234,272	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	243,240	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	41,096	410,068	0	2,791,761	-451,164	90.00
91.00 09100 EMERGENCY	8,577	85,579	0	7,554,222	-94,156	91.00
92.00 09200 OBSERVATION BEDS					0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
118.00	168,316	1,679,495	0	117,129,391	-1,847,811	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	1,350	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	31,091	0	193.00
194.00 07950 CONVENT	0	0	0	58,367	0	194.00
194.01 07951 OUTPATIENT PHARMACY	0	0	0	15,373	0	194.01
194.02 07952 FUND DEVELOPMENT	0	0	0	7,830	0	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00	0	0	0	0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	168,316	1,679,495	0	117,243,402	-1,847,811	202.00
Cost Center Description						
		Total				
		26.00				
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE						17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS						19.00
20.00 02000 NURSING SCHOOL						20.00
21.00 02100 I&R SRVCES-SALARY & FRINGES APPRVD						21.00
22.00 02200 I&R SRVCES-OTHER PRGM COSTS APPRVD						22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)						23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	39,788,745					30.00
31.00 03100 INTENSIVE CARE UNIT	5,261,443					31.00
41.00 04100 SUBPROVIDER - IIRF	1,303,473					41.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		Total	
		26.00	
43.00	04300 NURSERY	866,743	43.00
44.00	04400 SKILLED NURSING FACILITY	1,773,659	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	7,368,263	50.00
51.00	05100 RECOVERY ROOM	888,880	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,993,386	52.00
53.00	05300 ANESTHESIOLOGY	270,309	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,279,644	54.00
54.01	03190 OUTPATIENT ONCOLOGY	276,810	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	354,455	55.00
59.00	05900 CARDIAC CATHETERIZATION	901,040	59.00
60.00	06000 LABORATORY	6,350,810	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	679,838	63.00
65.00	06500 RESPIRATORY THERAPY	1,579,394	65.00
66.00	06600 PHYSICAL THERAPY	1,824,750	66.00
67.00	06700 OCCUPATIONAL THERAPY	922,486	67.00
68.00	06800 SPEECH PATHOLOGY	174,339	68.00
69.00	06900 ELECTROCARDIOLOGY	1,305,649	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	198,210	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	5,928,929	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,651,477	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,283,316	73.00
74.00	07400 RENAL DIALYSIS	623,066	74.00
75.00	07500 ASC (NON-DISTINCT PART)	1,154,291	75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	2,234,272	76.00
76.97	07697 CARDIAC REHABILITATION	243,240	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699 LI THOTRI PSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	2,340,597	90.00
91.00	09100 EMERGENCY	7,460,066	91.00
92.00	09200 OBSERVATION BEDS		92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0	94.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
114.00	11400 UTILIZATION REVIEW-SNF		114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	115,281,580	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,350	192.00
193.00	19300 NONPAID WORKERS	31,091	193.00
194.00	07950 CONVENT	58,367	194.00
194.01	07951 OUTPATIENT PHARMACY	15,373	194.01
194.02	07952 FUND DEVELOPMENT	7,830	194.02
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	194.03
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	115,395,591	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	18,262	42,947	61,209	61,209 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	122,800	288,795	411,595	2,991 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	0	406,235	955,364	1,361,599	1,626 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	8,846	20,805	29,651	0 8.00
9.00 00900	HOUSEKEEPING	0	26,617	62,597	89,214	1,285 9.00
10.00 01000	DIETARY	0	52,826	124,234	177,060	829 10.00
11.00 01100	CAFETERIA	0	7,901	18,581	26,482	680 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	4,970	11,688	16,658	3,015 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	41,482	97,556	139,038	0 14.00
15.00 01500	PHARMACY	0	13,644	32,086	45,730	2,349 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	25,630	60,275	85,905	1,319 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	6,012	14,139	20,151	1,275 21.00
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	6,240	14,674	20,914	1,340 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	447,035	1,051,310	1,498,345	18,009 30.00
31.00 03100	INTENSIVE CARE UNIT	0	21,496	50,553	72,049	3,497 31.00
41.00 04100	SUBPROVIDER - IRF	0	17,438	41,010	58,448	607 41.00
43.00 04300	NURSERY	0	3,904	9,182	13,086	486 43.00
44.00 04400	SKILLED NURSING FACILITY	0	22,837	53,708	76,545	896 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	110,106	258,943	369,049	3,238 50.00
51.00 05100	RECOVERY ROOM	0	7,701	18,111	25,812	558 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	51,485	121,080	172,565	2,809 52.00
53.00 05300	ANESTHESIOLOGY	0	1,082	2,545	3,627	98 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	51,064	120,089	171,153	3,193 54.00
54.01 03190	OUTPATIENT ONCOLOGY	0	0	0	0	226 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	2,716	6,389	9,105	126 55.00
59.00 05900	CARDIAC CATHETERIZATION	0	11,818	27,792	39,610	384 59.00
60.00 06000	LABORATORY	0	39,663	93,277	132,940	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	3,296	7,750	11,046	0 63.00
65.00 06500	RESPIRATORY THERAPY	0	2,380	5,596	7,976	1,069 65.00
66.00 06600	PHYSICAL THERAPY	0	16,234	38,178	54,412	1,183 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	2,373	5,581	7,954	672 67.00
68.00 06800	SPEECH PATHOLOGY	0	844	1,986	2,830	130 68.00
69.00 06900	ELECTROCARDIOLOGY	0	17,750	41,743	59,493	632 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	126 70.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	1,895	4,457	6,352	407 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	775 75.00
76.00 03550	MENTAL HEALTH OUTPATIENT	0	25,417	59,775	85,192	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	7,433	17,482	24,915	114 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	66,409	156,177	222,586	875 90.00
91.00 09100	EMERGENCY	0	61,999	145,807	207,806	4,370 91.00
92.00 09200	OBSERVATION BEDS	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0 114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,735,840	4,082,262	5,818,102	61,189 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	CONVENT	0	0	0	0	20 194.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
194.01 07951 OUTPATIENT PHARMACY	0	1,152	2,709	3,861	0	194.01
194.02 07952 FUND DEVELOPMENT	0	577	1,357	1,934	0	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,737,569	4,086,328	5,823,897	61,209	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	414,586				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	28,803	0	1,392,028		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,858	0	10,346	42,855	8.00
9.00	00900	HOUSEKEEPING	8,399	0	31,129	2,392	132,419
10.00	01000	DIETARY	6,479	0	61,781	0	6,057
11.00	01100	CAFETERIA	3,034	0	9,240	0	906
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	15,069	0	5,812	0	570
14.00	01400	CENTRAL SERVICES & SUPPLY	5,558	0	48,514	3	4,757
15.00	01500	PHARMACY	9,852	0	15,956	0	1,564
16.00	01600	MEDICAL RECORDS & LIBRARY	7,932	0	29,974	0	2,939
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	324	0	7,031	0	689
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	5,656	0	7,297	0	715
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	98,010	0	522,807	13,993	51,262
31.00	03100	INTENSIVE CARE UNIT	14,355	0	25,140	3,132	2,465
41.00	04100	SUBPROVIDER - IRF	2,841	0	20,394	4,272	2,000
43.00	04300	NURSERY	2,111	0	4,566	1,106	448
44.00	04400	SKILLED NURSING FACILITY	4,137	0	26,709	1,353	2,619
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,993	0	128,770	3,620	12,626
51.00	05100	RECOVERY ROOM	2,463	0	9,006	753	883
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,813	0	60,212	1,215	5,904
53.00	05300	ANESTHESIOLOGY	652	0	1,266	0	124
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,388	0	59,719	1,954	5,855
54.01	03190	OUTPATIENT ONCOLOGY	965	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	1,106	0	3,177	53	311
59.00	05900	CARDIAC CATHETERIZATION	2,377	0	13,821	142	1,355
60.00	06000	LABORATORY	19,214	0	46,386	0	4,548
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,090	0	3,854	0	378
65.00	06500	RESPIRATORY THERAPY	4,886	0	2,783	0	273
66.00	06600	PHYSICAL THERAPY	5,631	0	18,985	858	1,861
67.00	06700	OCCUPATIONAL THERAPY	2,836	0	2,776	0	272
68.00	06800	SPEECH PATHOLOGY	555	0	988	0	97
69.00	06900	ELECTROCARDIOLOGY	3,345	0	20,759	242	2,035
70.00	07000	ELECTROENCEPHALOGRAPHY	686	0	0	14	0
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	19,992	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,070	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	33,570	0	0	0	0
74.00	07400	RENAL DIALYSIS	1,846	0	2,216	159	217
75.00	07500	ASC (NON-DISTINCT PART)	3,677	0	0	0	0
76.00	03550	MENTAL HEALTH OUTPATIENT	7,083	0	29,725	0	2,915
76.97	07697	CARDIAC REHABILITATION	584	0	8,694	6	852
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,745	0	77,665	157	7,615
91.00	09100	EMERGENCY	21,260	0	72,508	7,364	7,109
92.00	09200	OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
118.00		SUBTOTALS (SUM OF LINES 1-117)	414,245	0	1,390,006	42,788	132,221
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	67	0
193.00	19300	NONPAID WORKERS	110	0	0	0	0
194.00	07950	CONVENT	205	0	0	0	0
194.01	07951	OUTPATIENT PHARMACY	17	0	1,347	0	132
194.02	07952	FUND DEVELOPMENT	9	0	675	0	66
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					

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ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140180			Period: From 07/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	414,586	0	1,392,028	42,855	132,419	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center	Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		10.00	11.00	12.00	13.00	14.00		
GENERAL SERVICE COST CENTERS								
1.00	00100							1.00
2.00	00200							2.00
4.00	00400							4.00
5.00	00500							5.00
6.00	00600							6.00
7.00	00700							7.00
8.00	00800							8.00
9.00	00900							9.00
10.00	01000	252,206						10.00
11.00	01100		40,342					11.00
12.00	01200			0				12.00
13.00	01300		2,261	0	43,385			13.00
14.00	01400			0	0	197,870		14.00
15.00	01500		1,761	0	1,860	0		15.00
16.00	01600		989	0	1,920	0		16.00
17.00	01700		0	0	0	0		17.00
19.00	01900		0	0	0	0		19.00
20.00	02000		0	0	0	0		20.00
21.00	02100		956	0	0	0		21.00
22.00	02200		1,005	0	0	0		22.00
23.00	02300		0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	206,166	13,505	0	18,754	55,659		30.00
31.00	03100	21,423	2,622	0	2,647	7,450		31.00
41.00	04100	7,025	455	0	600	1,732		41.00
43.00	04300	6,202	365	0	389	1,602		43.00
44.00	04400	11,390	672	0	922	1,338		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	2,428	0	3,023	10,870		50.00
51.00	05100	0	419	0	426	2,128		51.00
52.00	05200	0	2,106	0	2,289	6,382		52.00
53.00	05300	0	74	0	0	2,889		53.00
54.00	05400	0	2,394	0	2,976	8,612		54.00
54.01	03190	0	170	0	0	1	54.01	
55.00	05500	0	94	0	123	53	55.00	
59.00	05900	0	288	0	232	3,443	59.00	
60.00	06000	0	0	0	0	21,639	60.00	
62.30	06250	0	0	0	0	0	62.30	
63.00	06300	0	0	0	0	2,291	63.00	
65.00	06500	0	802	0	0	6,132	65.00	
66.00	06600	0	887	0	0	1,826	66.00	
67.00	06700	0	504	0	492	1,476	67.00	
68.00	06800	0	98	0	0	290	68.00	
69.00	06900	0	474	0	685	4,416	69.00	
70.00	07000	0	94	0	0	74	70.00	
71.00	07100	0	0	0	0	10,710	71.00	
72.00	07200	0	0	0	0	3,368	72.00	
73.00	07300	0	0	0	0	30,731	73.00	
74.00	07400	0	305	0	347	1,502	74.00	
75.00	07500	0	581	0	684	1,262	75.00	
76.00	03550	0	0	0	0	3	76.00	
76.97	07697	0	86	0	77	18	76.97	
76.98	07698	0	0	0	0	0	76.98	
76.99	07699	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	656	0	923	32		90.00
91.00	09100	0	3,276	0	4,016	9,941		91.00
92.00	09200							92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	0	0	0	0	0		94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300							113.00
114.00	11400							114.00
118.00		252,206	40,327	0	43,385	197,870		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0		190.00
192.00	19200	0	0	0	0	0		192.00
193.00	19300	0	0	0	0	0		193.00
194.00	07950	0	15	0	0	0		194.00
194.01	07951	0	0	0	0	0		194.01
194.02	07952	0	0	0	0	0		194.02
194.03	07953	0	0	0	0	0		194.03

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140180			Period: From 07/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		10.00	11.00	12.00	13.00	14.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	252,206	40,342	0	43,385	197,870		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am		
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL
		15.00	16.00	17.00	19.00	20.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	79,072			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	130,978		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,190	107,069	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,980	11,125	0	31.00
41.00	04100	SUBPROVIDER - IRF	693	3,648	0	41.00
43.00	04300	NURSERY	641	3,221	0	43.00
44.00	04400	SKILLED NURSING FACILITY	535	5,915	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,348	0	0	50.00
51.00	05100	RECOVERY ROOM	851	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,553	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,155	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,445	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	21	0	0	55.00
59.00	05900	CARDIAC CATHETERIZATION	1,377	0	0	59.00
60.00	06000	LABORATORY	8,656	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	916	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,453	0	0	65.00
66.00	06600	PHYSICAL THERAPY	730	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	590	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	116	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,766	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	4,284	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,347	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,292	0	0	73.00
74.00	07400	RENAL DIALYSIS	601	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	505	0	0	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	1	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13	0	0	90.00
91.00	09100	EMERGENCY	3,977	0	0	91.00
92.00	09200	OBSERVATION BEDS				92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	79,072	130,978	0	0
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	194.03

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ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140180			Period: From 07/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL		
		15.00	16.00	17.00	19.00	20.00		
200.00	Cross Foot Adjustments				0		0	200.00
201.00	Negative Cost Centers	0	0	0	0		0	201.00
202.00	TOTAL (sum lines 118-201)	79,072	130,978		0		0	202.00

ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SRVCES-SALARY & FRINGES	SRVCES-OTHER PRGM COSTS			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
6.00 00600 MAINTENANCE & REPAIRS					6.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000 NURSING SCHOOL					20.00
21.00 02100 I&R SRVCES-SALARY & FRINGES APPRVD	14,978				21.00
22.00 02200 I&R SRVCES-OTHER PRGM COSTS APPRVD		36,927			22.00
23.00 02300 PARAMED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS				2,625,769	0 30.00
31.00 03100 INTENSIVE CARE UNIT				168,885	0 31.00
41.00 04100 SUBPROVIDER - IRF				102,715	0 41.00
43.00 04300 NURSERY				34,223	0 43.00
44.00 04400 SKILLED NURSING FACILITY				133,031	0 44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM				557,965	0 50.00
51.00 05100 RECOVERY ROOM				43,299	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM				266,848	0 52.00
53.00 05300 ANESTHESIOLOGY				9,885	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC				277,689	0 54.00
54.01 03190 OUTPATIENT ONCOLOGY				1,362	0 54.01
55.00 05500 RADIOLOGY-THERAPEUTIC				14,169	0 55.00
59.00 05900 CARDIAC CATHETERIZATION				63,029	0 59.00
60.00 06000 LABORATORY				233,383	0 60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS				0	0 62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.				20,575	0 63.00
65.00 06500 RESPIRATORY THERAPY				26,374	0 65.00
66.00 06600 PHYSICAL THERAPY				86,373	0 66.00
67.00 06700 OCCUPATIONAL THERAPY				17,572	0 67.00
68.00 06800 SPEECH PATHOLOGY				5,104	0 68.00
69.00 06900 ELECTROCARDIOLOGY				93,847	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY				1,023	0 70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS				34,986	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT				13,785	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS				76,593	0 73.00
74.00 07400 RENAL DIALYSIS				13,952	0 74.00
75.00 07500 ASC (NON-DISTINCT PART)				7,484	0 75.00
76.00 03550 MENTAL HEALTH OUTPATIENT				124,919	0 76.00
76.97 07697 CARDIAC REHABILITATION				35,353	0 76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY				0	0 76.98
76.99 07699 LI THOTRI PSY				0	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC				316,267	0 90.00
91.00 09100 EMERGENCY				341,627	0 91.00
92.00 09200 OBSERVATION BEDS					0 92.00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS				0	0 94.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTILIZATION REVIEW-SNF					114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	0	5,748,086	0 118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0 190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES				67	0 192.00
193.00 19300 NONPAID WORKERS				110	0 193.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SRVCES-SALARY & FRINGES	SRVCES-OTHER PRGM COSTS				
			21.00	22.00				
194.00	07950	CONVENT				240	0	194.00
194.01	07951	OUTPATIENT PHARMACY				5,357	0	194.01
194.02	07952	FUND DEVELOPMENT				2,684	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE				0	0	194.03
200.00		Cross Foot Adjustments	14,978	36,927	0	51,905	0	200.00
201.00		Negative Cost Centers	15,448	0	0	15,448	0	201.00
202.00		TOTAL (sum lines 118-201)	30,426	36,927	0	5,823,897	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,625,769
31.00	03100	INTENSIVE CARE UNIT	168,885
41.00	04100	SUBPROVIDER - IRF	102,715
43.00	04300	NURSERY	34,223
44.00	04400	SKILLED NURSING FACILITY	133,031
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	557,965
51.00	05100	RECOVERY ROOM	43,299
52.00	05200	DELIVERY ROOM & LABOR ROOM	266,848
53.00	05300	ANESTHESIOLOGY	9,885
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,689
54.01	03190	OUTPATIENT ONCOLOGY	1,362
55.00	05500	RADIOLOGY-THERAPEUTIC	14,169
59.00	05900	CARDIAC CATHETERIZATION	63,029
60.00	06000	LABORATORY	233,383
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,575
65.00	06500	RESPIRATORY THERAPY	26,374
66.00	06600	PHYSICAL THERAPY	86,373
67.00	06700	OCCUPATIONAL THERAPY	17,572
68.00	06800	SPEECH PATHOLOGY	5,104
69.00	06900	ELECTROCARDIOLOGY	93,847
70.00	07000	ELECTROENCEPHALOGRAPHY	1,023
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	34,986
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,785
73.00	07300	DRUGS CHARGED TO PATIENTS	76,593
74.00	07400	RENAL DIALYSIS	13,952
75.00	07500	ASC (NON-DISTINCT PART)	7,484
76.00	03550	MENTAL HEALTH OUTPATIENT	124,919
76.97	07697	CARDIAC REHABILITATION	35,353
76.98	07698	HYPERBARIC OXYGEN THERAPY	0
76.99	07699	LITHOTRIpsy	0
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	316,267
91.00	09100	EMERGENCY	341,627
92.00	09200	OBSERVATION BEDS	
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	
114.00	11400	UTILIZATION REVIEW-SNF	
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,748,086
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	67
193.00	19300	NONPAID WORKERS	110
194.00	07950	CONVENT	240
194.01	07951	OUTPATIENT PHARMACY	5,357
194.02	07952	FUND DEVELOPMENT	2,684
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0
200.00		Cross Foot Adjustments	51,905
201.00		Negative Cost Centers	15,448

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ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:28 am
Cost Center Description		Total		
		26.00		
202.00	TOTAL (sum lines 118-201)	5,823,897		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	825,132				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		825,132			2.00
4.00 00400	EMPLOYEE BENEFITS	8,672	8,672	46,258,571		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	58,315	58,315	2,260,693	-24,010,554	93,232,848
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	192,912	192,912	1,228,681	0	6,476,846
8.00 00800	LAUNDRY & LINEN SERVICE	4,201	4,201	0	0	642,610
9.00 00900	HOUSEKEEPING	12,640	12,640	971,646	0	1,888,677
10.00 01000	DIETARY	25,086	25,086	626,343	0	1,456,927
11.00 01100	CAFETERIA	3,752	3,752	514,259	0	682,301
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	2,360	2,360	2,279,125	0	3,388,575
14.00 01400	CENTRAL SERVICES & SUPPLY	19,699	19,699	0	0	1,249,737
15.00 01500	PHARMACY	6,479	6,479	1,775,397	0	2,215,379
16.00 01600	MEDICAL RECORDS & LIBRARY	12,171	12,171	997,268	0	1,783,613
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD	2,855	2,855	963,624	0	72,817
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	2,963	2,963	1,013,165	0	1,271,972
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	212,286	212,286	13,604,479	0	22,044,931
31.00 03100	INTENSIVE CARE UNIT	10,208	10,208	2,643,475	0	3,227,981
41.00 04100	SUBPROVIDER - IRF	8,281	8,281	458,981	0	638,919
43.00 04300	NURSERY	1,854	1,854	367,480	0	474,720
44.00 04400	SKILLED NURSING FACILITY	10,845	10,845	677,055	0	930,298
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	52,287	52,287	2,447,516	0	4,495,886
51.00 05100	RECOVERY ROOM	3,657	3,657	422,076	0	553,784
52.00 05200	DELIVERY ROOM & LABOR ROOM	24,449	24,449	2,123,257	0	2,431,461
53.00 05300	ANESTHESIOLOGY	514	514	74,250	0	146,690
54.00 05400	RADIOLOGY-DIAGNOSTIC	24,249	24,249	2,413,321	0	4,134,873
54.01 03190	OUTPATIENT ONCOLOGY	0	0	171,056	0	216,998
55.00 05500	RADIOLOGY-THERAPEUTIC	1,290	1,290	94,909	0	248,725
59.00 05900	CARDIAC CATHETERIZATION	5,612	5,612	290,107	0	534,518
60.00 06000	LABORATORY	18,835	18,835	0	0	4,320,648
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,565	1,565	0	0	469,918
65.00 06500	RESPIRATORY THERAPY	1,130	1,130	808,171	0	1,098,611
66.00 06600	PHYSICAL THERAPY	7,709	7,709	894,518	0	1,266,144
67.00 06700	OCCUPATIONAL THERAPY	1,127	1,127	507,696	0	637,643
68.00 06800	SPEECH PATHOLOGY	401	401	98,403	0	124,802
69.00 06900	ELECTROCARDIOLOGY	8,429	8,429	477,568	0	752,168
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	95,262	0	154,152
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	4,495,674
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,039,600
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,548,839
74.00 07400	RENAL DIALYSIS	900	900	307,492	0	415,131
75.00 07500	ASC (NON-DISTINCT PART)	0	0	585,948	0	826,765
76.00 03550	MENTAL HEALTH OUTPATIENT	12,070	12,070	0	0	1,592,740
76.97 07697	CARDIAC REHABILITATION	3,530	3,530	86,384	0	131,417
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	31,536	31,536	661,103	0	1,291,800
91.00 09100	EMERGENCY	29,442	29,442	3,302,736	0	4,780,753
92.00 09200	OBSERVATION BEDS					92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	824,311	824,311	46,243,444	-24,010,554	93,156,043
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	24,724
194.00 07950	CONVENT	0	0	15,127	0	46,139

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
194.01 07951 OUTPATIENT PHARMACY	547	547	0	0	3,890	194.01
194.02 07952 FUND DEVELOPMENT	274	274	0	0	2,052	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,737,569	4,086,328	10,861,584		24,010,554	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	2.105807	4.952332	0.234802		0.257533	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			61,209		414,586	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001323		0.004447	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet B-1	
Date/Time Prepared: 5/24/2013 9:28 am							
Cost Center	Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700		565,233				7.00
8.00	00800		4,201	1,202,368			8.00
9.00	00900		12,640	67,102	548,392		9.00
10.00	01000		25,086		25,086	58,193	10.00
11.00	01100		3,752		3,752		11.00
12.00	01200		0		0		12.00
13.00	01300		2,360		2,360		13.00
14.00	01400		19,699	80	19,699		14.00
15.00	01500		6,479		6,479		15.00
16.00	01600		12,171		12,171		16.00
17.00	01700		0		0		17.00
19.00	01900		0		0		19.00
20.00	02000		0		0		20.00
21.00	02100		2,855		2,855		21.00
22.00	02200		2,963		2,963		22.00
23.00	02300		0		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000		212,286	392,602	212,286	47,570	30.00
31.00	03100		10,208	87,883	10,208	4,943	31.00
41.00	04100		8,281	119,850	8,281	1,621	41.00
43.00	04300		1,854	31,041	1,854	1,431	43.00
44.00	04400		10,845	37,959	10,845	2,628	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000		52,287	101,572	52,287		50.00
51.00	05100		3,657	21,132	3,657		51.00
52.00	05200		24,449	34,092	24,449		52.00
53.00	05300		514	0	514		53.00
54.00	05400		24,249	54,835	24,249		54.00
54.01	03190		0	0	0		54.01
55.00	05500		1,290	1,478	1,290		55.00
59.00	05900		5,612	3,987	5,612		59.00
60.00	06000		18,835	0	18,835		60.00
62.30	06250		0	0	0		62.30
63.00	06300		1,565	0	1,565		63.00
65.00	06500		1,130	0	1,130		65.00
66.00	06600		7,709	24,071	7,709		66.00
67.00	06700		1,127	0	1,127		67.00
68.00	06800		401	0	401		68.00
69.00	06900		8,429	6,782	8,429		69.00
70.00	07000		0	392	0		70.00
71.00	07100		0	0	0		71.00
72.00	07200		0	0	0		72.00
73.00	07300		0	0	0		73.00
74.00	07400		900	4,475	900		74.00
75.00	07500		0	0	0		75.00
76.00	03550		12,070	0	12,070		76.00
76.97	07697		3,530	160	3,530		76.97
76.98	07698		0	0	0		76.98
76.99	07699		0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000		31,536	4,391	31,536		90.00
91.00	09100		29,442	206,615	29,442		91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400		0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00			564,412	1,200,499	547,571	58,193	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000		0	0	0	0	190.00
192.00	19200		0	1,869	0	0	192.00
193.00	19300		0	0	0	0	193.00
194.00	07950		0	0	0	0	194.00
194.01	07951		547	0	547	0	194.01
194.02	07952		274	0	274	0	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	8,144,848	868,638	2,605,690	2,312,812	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	14.409718	0.722439	4.751510	39.743818	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	1,392,028	42,855	132,419	252,206	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	2.462751	0.035642	0.241468	4.333958	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet B-1 Date/Time Prepared: 5/24/2013 9:28 am			
Cost Center	Description	CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (INPATIENT REVENUE)	PHARMACY (INPATIENT REVENUE)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	40,656,949					11.00
12.00	01200		0				12.00
13.00	01300	2,279,125		1,101,792			13.00
14.00	01400				329,612,458		14.00
15.00	01500	1,775,397		47,225		329,612,458	15.00
16.00	01600	997,268		48,767			16.00
17.00	01700						17.00
19.00	01900						19.00
20.00	02000						20.00
21.00	02100	963,624					21.00
22.00	02200	1,013,165					22.00
23.00	02300						23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,604,479	0	476,266	92,590,994	92,590,994	30.00
31.00	03100	2,643,475	0	67,210	12,416,881	12,416,881	31.00
41.00	04100	458,981	0	15,240	2,887,395	2,887,395	41.00
43.00	04300	367,480	0	9,891	2,670,812	2,670,812	43.00
44.00	04400	677,055	0	23,415	2,230,826	2,230,826	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,447,516	0	76,777	18,116,403	18,116,403	50.00
51.00	05100	422,076	0	10,806	3,546,997	3,546,997	51.00
52.00	05200	2,123,257	0	58,121	10,637,465	10,637,465	52.00
53.00	05300	74,250	0	0	4,814,310	4,814,310	53.00
54.00	05400	2,413,321	0	75,572	14,353,057	14,353,057	54.00
54.01	03190	171,056	0	0	1,000	1,000	54.01
55.00	05500	94,909	0	3,121	88,886	88,886	55.00
59.00	05900	290,107	0	5,883	5,737,799	5,737,799	59.00
60.00	06000		0		36,064,732	36,064,732	60.00
62.30	06250		0		0	0	62.30
63.00	06300		0		3,817,623	3,817,623	63.00
65.00	06500	808,171	0	0	10,220,141	10,220,141	65.00
66.00	06600	894,518	0	0	3,043,622	3,043,622	66.00
67.00	06700	507,696	0	12,502	2,460,182	2,460,182	67.00
68.00	06800	98,403	0	0	483,583	483,583	68.00
69.00	06900	477,568	0	17,406	7,360,204	7,360,204	69.00
70.00	07000	95,262	0	0	122,873	122,873	70.00
71.00	07100		0		17,850,589	17,850,589	71.00
72.00	07200		0		5,612,592	5,612,592	72.00
73.00	07300		0		51,218,392	51,218,392	73.00
74.00	07400	307,492	0	8,820	2,502,779	2,502,779	74.00
75.00	07500	585,948	0	17,375	2,104,154	2,104,154	75.00
76.00	03550		0		4,696	4,696	76.00
76.97	07697	86,384	0	1,967	30,210	30,210	76.97
76.98	07698		0		0	0	76.98
76.99	07699		0		0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	661,103	0	23,438	54,102	54,102	90.00
91.00	09100	3,302,736	0	101,990	16,569,159	16,569,159	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		40,641,822	0	1,101,792	329,612,458	329,612,458	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	15,127	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (INPATIENT REVENUE)	PHARMACY (INPATIENT REVENUE)	
		11.00	12.00	13.00	14.00	15.00	
194.02	07952 FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	929,909	0	4,358,594	1,949,101	3,137,483	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.022872	0.000000	3.955914	0.005913	0.009519	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	40,342	0	43,385	197,870	79,072	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000992	0.000000	0.039377	0.000600	0.000240	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (INPATIENT REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (PATIENT DAYS)	INTERNS & RESIDENTS	SRVCES-SALARY & FRINGES (PATIENT DAYS)	
	16.00	17.00	19.00	20.00	21.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00 00400 EMPLOYEE BENEFITS							4.00
5.00 00500 ADMINISTRATIVE & GENERAL							5.00
6.00 00600 MAINTENANCE & REPAIRS							6.00
7.00 00700 OPERATION OF PLANT							7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8.00
9.00 00900 HOUSEKEEPING							9.00
10.00 01000 DIETARY							10.00
11.00 01100 CAFETERIA							11.00
12.00 01200 MAINTENANCE OF PERSONNEL							12.00
13.00 01300 NURSING ADMINISTRATION							13.00
14.00 01400 CENTRAL SERVICES & SUPPLY							14.00
15.00 01500 PHARMACY							15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	58,193						16.00
17.00 01700 SOCIAL SERVICE	0	0					17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0				19.00
20.00 02000 NURSING SCHOOL	0	0		0			20.00
21.00 02100 I&R SRVCES-SALARY & FRINGES APPRVD	0	0			471		21.00
22.00 02200 I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0					22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	47,570	0			152		30.00
31.00 03100 INTENSIVE CARE UNIT	4,943	0			34		31.00
41.00 04100 SUBPROVIDER - IRF	1,621	0			0		41.00
43.00 04300 NURSERY	1,431	0			25		43.00
44.00 04400 SKILLED NURSING FACILITY	2,628	0			0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	83		50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	17		52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	1		54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0		55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0		59.00
60.00 06000 LABORATORY	0	0	0	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	1		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	19		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0		75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0	0	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	115		90.00
91.00 09100 EMERGENCY	0	0	0	0	24		91.00
92.00 09200 OBSERVATION BEDS							92.00
OTHER REIMBURSABLE COST CENTERS							
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0		94.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE							113.00
114.00 11400 UTILIZATION REVIEW-SNF							114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	58,193	0	0	0	471		118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0		192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0		193.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (INPATIENT REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (PATIENT DAYS)	INTERNS & RESIDENTS	SRVCES-SALARY & FRINGES (PATIENT DAYS)	
			16.00	17.00	19.00	20.00	21.00		
194.00	07950	CONVENT	0	0	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers							201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,691,892	0	0	0	168,316		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.258004	0.000000	0.000000	0.000000	357.358811		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	130,978	0	0	0	30,426		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.250752	0.000000	0.000000	0.000000	31.800425		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SRVCES-OTHER PRGM COSTS (PATIENT DAYS)		
	22.00		
GENERAL SERVICE COST CENTERS			
1.00 00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400 EMPLOYEE BENEFITS			4.00
5.00 00500 ADMINISTRATIVE & GENERAL			5.00
6.00 00600 MAINTENANCE & REPAIRS			6.00
7.00 00700 OPERATION OF PLANT			7.00
8.00 00800 LAUNDRY & LINEN SERVICE			8.00
9.00 00900 HOUSEKEEPING			9.00
10.00 01000 DIETARY			10.00
11.00 01100 CAFETERIA			11.00
12.00 01200 MAINTENANCE OF PERSONNEL			12.00
13.00 01300 NURSING ADMINISTRATION			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY			14.00
15.00 01500 PHARMACY			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY			16.00
17.00 01700 SOCIAL SERVICE			17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS			19.00
20.00 02000 NURSING SCHOOL			20.00
21.00 02100 I&R SRVCES-SALARY & FRINGES APPRVD			21.00
22.00 02200 I&R SRVCES-OTHER PRGM COSTS APPRVD	471		22.00
23.00 02300 PARAMED PRGM- (SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 03000 ADULTS & PEDIATRICS	152	0	30.00
31.00 03100 INTENSIVE CARE UNIT	34	0	31.00
41.00 04100 SUBPROVIDER - I&R	0	0	41.00
43.00 04300 NURSERY	25	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	83	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	17	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	1	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	19	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	115	0	90.00
91.00 09100 EMERGENCY	24	0	91.00
92.00 09200 OBSERVATION BEDS			92.00
OTHER REIMBURSABLE COST CENTERS			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	94.00
SPECIAL PURPOSE COST CENTERS			
113.00 11300 INTEREST EXPENSE			113.00
114.00 11400 UTILIZATION REVIEW-SNF			114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	471	0
NONREIMBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	193.00
194.00 07950 CONVENT	0	0	194.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description	INTERNS & RESIDENTS	PARAMETERED PRGM (ASSIGNED TIME)	
	SRVCS-OTHER PRGM COSTS (PATIENT DAYS)		
	22.00		
194.01 07951 OUTPATIENT PHARMACY	0	0	194.01
194.02 07952 FUND DEVELOPMENT	0	0	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	194.03
200.00 Cross Foot Adjustments			200.00
201.00 Negative Cost Centers			201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,679,495	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	3,565.806794	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	36,927	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	78.401274	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet C Part I Date/Time Prepared: 5/24/2013 9:28 am		
			Title XVII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	Total Costs	Inpatient			
	1.00	2.00	3.00	4.00	5.00	6.00			
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	39,788,745		39,788,745	0	39,788,745	91,657,270	30.00
31.00	03100	INTENSIVE CARE UNIT	5,261,443		5,261,443	0	5,261,443	12,416,881	31.00
41.00	04100	SUBPROVIDER - IRF	1,303,473		1,303,473	0	1,303,473	2,887,395	41.00
43.00	04300	NURSERY	866,743		866,743	0	866,743	2,670,812	43.00
44.00	04400	SKILLED NURSING FACILITY	1,773,659		1,773,659	0	1,773,659	2,230,826	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,368,263		7,368,263	0	7,368,263	18,116,403	50.00
51.00	05100	RECOVERY ROOM	888,880		888,880	0	888,880	3,546,997	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,993,386		3,993,386	0	3,993,386	10,637,465	52.00
53.00	05300	ANESTHESIOLOGY	270,309		270,309	0	270,309	4,814,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,279,644		6,279,644	0	6,279,644	14,353,057	54.00
54.01	03190	OUTPATIENT ONCOLOGY	276,810		276,810	0	276,810	1,000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	354,455		354,455	0	354,455	88,886	55.00
59.00	05900	CARDIAC CATHETERIZATION	901,040		901,040	0	901,040	5,737,799	59.00
60.00	06000	LABORATORY	6,350,810		6,350,810	0	6,350,810	36,064,732	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0	62.30
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	679,838		679,838	0	679,838	3,817,623	63.00
65.00	06500	RESPIRATORY THERAPY	1,579,394	0	1,579,394	0	1,579,394	10,220,141	65.00
66.00	06600	PHYSICAL THERAPY	1,824,750	0	1,824,750	0	1,824,750	3,043,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	922,486	0	922,486	0	922,486	2,460,182	67.00
68.00	06800	SPEECH PATHOLOGY	174,339	0	174,339	0	174,339	483,583	68.00
69.00	06900	ELECTROCARDIOLOGY	1,305,649		1,305,649	0	1,305,649	7,360,204	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	198,210		198,210	0	198,210	122,873	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,928,929		5,928,929	0	5,928,929	17,850,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,651,477		2,651,477	0	2,651,477	5,612,592	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,283,316		10,283,316	0	10,283,316	51,218,392	73.00
74.00	07400	RENAL DIALYSIS	623,066		623,066	0	623,066	2,502,779	74.00
75.00	07500	ASC (NON-DISTINCT PART)	1,154,291		1,154,291	0	1,154,291	2,104,154	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	2,234,272		2,234,272	0	2,234,272	4,696	76.00
76.97	07697	CARDIAC REHABILITATION	243,240		243,240	0	243,240	30,210	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,340,597		2,340,597	0	2,340,597	54,102	90.00
91.00	09100	EMERGENCY	7,460,066		7,460,066	0	7,460,066	16,569,159	91.00
92.00	09200	OBSERVATION BEDS	2,271,398		2,271,398	0	2,271,398	933,724	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	117,552,978	0	117,552,978	0	117,552,978	329,612,458	200.00
201.00		Less Observation Beds	2,271,398		2,271,398		2,271,398		201.00
202.00		Total (see instructions)	115,281,580	0	115,281,580	0	115,281,580	329,612,458	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
		Outpatient	Total (col. 6 + col. 7)						
		7.00	8.00						
		9.00	10.00	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		91,657,270					30.00
31.00	03100	INTENSIVE CARE UNIT		12,416,881					31.00
41.00	04100	SUBPROVIDER - IRF		2,887,395					41.00
43.00	04300	NURSERY		2,670,812					43.00
44.00	04400	SKILLED NURSING FACILITY		2,230,826					44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	17,199,207	35,315,610	0.208640	0.000000	0.208640		50.00
51.00	05100	RECOVERY ROOM	3,643,151	7,190,148	0.123625	0.000000	0.123625		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	532,485	11,169,950	0.357512	0.000000	0.357512		52.00
53.00	05300	ANESTHESIOLOGY	4,122,177	8,936,487	0.030248	0.000000	0.030248		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,083,818	52,436,875	0.119756	0.000000	0.119756		54.00
54.01	03190	OUTPATIENT ONCOLOGY	2,069,929	2,070,929	0.133665	0.000000	0.133665		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,719,982	2,808,868	0.126191	0.000000	0.126191		55.00
59.00	05900	CARDIAC CATHETERIZATION	3,328,603	9,066,402	0.099382	0.000000	0.099382		59.00
60.00	06000	LABORATORY	21,598,136	57,662,868	0.110137	0.000000	0.110137		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	319,309	4,136,932	0.164334	0.000000	0.164334		63.00
65.00	06500	RESPIRATORY THERAPY	1,105,545	11,325,686	0.139452	0.000000	0.139452		65.00
66.00	06600	PHYSICAL THERAPY	2,430,988	5,474,610	0.333311	0.000000	0.333311		66.00
67.00	06700	OCCUPATIONAL THERAPY	362,713	2,822,895	0.326787	0.000000	0.326787		67.00
68.00	06800	SPEECH PATHOLOGY	62,071	545,654	0.319505	0.000000	0.319505		68.00
69.00	06900	ELECTROCARDIOLOGY	8,375,847	15,736,051	0.082972	0.000000	0.082972		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	759,772	882,645	0.224564	0.000000	0.224564		70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	4,631,983	22,482,572	0.263712	0.000000	0.263712		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,429,529	8,042,121	0.329699	0.000000	0.329699		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,249,528	80,467,920	0.127794	0.000000	0.127794		73.00
74.00	07400	RENAL DIALYSIS	184,660	2,687,439	0.231844	0.000000	0.231844		74.00
75.00	07500	ASC (NON-DISTINCT PART)	8,160,908	10,265,062	0.112449	0.000000	0.112449		75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	3,038,367	3,043,063	0.734218	0.000000	0.734218		76.00
76.97	07697	CARDIAC REHABILITATION	120,449	150,659	1.614507	0.000000	1.614507		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0.000000		76.98
76.99	07699	LITHOTRIpsy	0	0	0.000000	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,734,818	3,788,920	0.617748	0.000000	0.617748		90.00
91.00	09100	EMERGENCY	39,869,576	56,438,735	0.132180	0.000000	0.132180		91.00
92.00	09200	OBSERVATION BEDS	4,725,459	5,659,183	0.401365	0.000000	0.401365		92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0.000000		94.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	202,859,010	532,471,468					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	202,859,010	532,471,468					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/24/2013 9:28 am

		Title XIX			Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	39,788,745		39,788,745	0	0	91,657,270	30.00
31.00	03100	INTENSIVE CARE UNIT	5,261,443		5,261,443	0	0	12,416,881	31.00
41.00	04100	SUBPROVIDER - IRF	1,303,473		1,303,473	0	0	2,887,395	41.00
43.00	04300	NURSERY	866,743		866,743	0	0	2,670,812	43.00
44.00	04400	SKILLED NURSING FACILITY	1,773,659		1,773,659	0	0	2,230,826	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,368,263		7,368,263	0	0	18,116,403	50.00
51.00	05100	RECOVERY ROOM	888,880		888,880	0	0	3,546,997	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,993,386		3,993,386	0	0	10,637,465	52.00
53.00	05300	ANESTHESIOLOGY	270,309		270,309	0	0	4,814,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,279,644		6,279,644	0	0	14,353,057	54.00
54.01	03190	OUTPATIENT ONCOLOGY	276,810		276,810	0	0	1,000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	354,455		354,455	0	0	88,886	55.00
59.00	05900	CARDIAC CATHETERIZATION	901,040		901,040	0	0	5,737,799	59.00
60.00	06000	LABORATORY	6,350,810		6,350,810	0	0	36,064,732	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0	62.30
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	679,838		679,838	0	0	3,817,623	63.00
65.00	06500	RESPIRATORY THERAPY	1,579,394	0	1,579,394	0	0	10,220,141	65.00
66.00	06600	PHYSICAL THERAPY	1,824,750	0	1,824,750	0	0	3,043,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	922,486	0	922,486	0	0	2,460,182	67.00
68.00	06800	SPEECH PATHOLOGY	174,339	0	174,339	0	0	483,583	68.00
69.00	06900	ELECTROCARDIOLOGY	1,305,649		1,305,649	0	0	7,360,204	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	198,210		198,210	0	0	122,873	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,928,929		5,928,929	0	0	17,850,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,651,477		2,651,477	0	0	5,612,592	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,283,316		10,283,316	0	0	51,218,392	73.00
74.00	07400	RENAL DIALYSIS	623,066		623,066	0	0	2,502,779	74.00
75.00	07500	ASC (NON-DISTINCT PART)	1,154,291		1,154,291	0	0	2,104,154	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	2,234,272		2,234,272	0	0	4,696	76.00
76.97	07697	CARDIAC REHABILITATION	243,240		243,240	0	0	30,210	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,340,597		2,340,597	0	0	54,102	90.00
91.00	09100	EMERGENCY	7,460,066		7,460,066	0	0	16,569,159	91.00
92.00	09200	OBSERVATION BEDS	2,271,398		2,271,398	0	0	933,724	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	117,552,978	0	117,552,978	0	0	329,612,458	200.00
201.00		Less Observation Beds	2,271,398		2,271,398		0		201.00
202.00		Total (see instructions)	115,281,580	0	115,281,580	0	0	329,612,458	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/24/2013 9:28 am
				Title XIX	Hospital	Cost
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
	Outpatient	Total (col. 6 + col. 7)				
	7.00	8.00				
		9.00	10.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,657,270			30.00
31.00	03100	INTENSIVE CARE UNIT	12,416,881			31.00
41.00	04100	SUBPROVIDER - IRF	2,887,395			41.00
43.00	04300	NURSERY	2,670,812			43.00
44.00	04400	SKILLED NURSING FACILITY	2,230,826			44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,199,207	0.208640	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,643,151	0.123625	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	532,485	0.357512	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,122,177	0.030248	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,083,818	0.119756	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	2,069,929	0.133665	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,719,982	0.126191	0.000000	55.00
59.00	05900	CARDIAC CATHETERIZATION	3,328,603	0.099382	0.000000	59.00
60.00	06000	LABORATORY	21,598,136	0.110137	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	319,309	0.164334	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,105,545	0.139452	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,430,988	0.333311	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,713	0.326787	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	62,071	0.319505	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,375,847	0.082972	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	759,772	0.224564	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	4,631,983	0.263712	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,429,529	0.329699	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,249,528	0.127794	0.000000	73.00
74.00	07400	RENAL DIALYSIS	184,660	0.231844	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	8,160,908	0.112449	0.000000	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	3,038,367	0.734218	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	120,449	1.614507	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,734,818	0.617748	0.000000	90.00
91.00	09100	EMERGENCY	39,869,576	0.132180	0.000000	91.00
92.00	09200	OBSERVATION BEDS	4,725,459	0.401365	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0.000000	0.000000	94.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
200.00		Subtotal (see instructions)	202,859,010	532,471,468		200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	202,859,010	532,471,468		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,625,769	0	2,625,769	50,450	52.05	30.00
31.00	INTENSIVE CARE UNIT	168,885		168,885	4,943	34.17	31.00
41.00	SUBPROVIDER - IRF	102,715	0	102,715	1,621	63.37	41.00
43.00	NURSERY	34,223		34,223	1,431	23.92	43.00
44.00	SKILLED NURSING FACILITY	133,031		133,031	2,628	50.62	44.00
200.00	Total (Lines 30-199)	3,064,623		3,064,623	61,073		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	15,178	790,015				
31.00	INTENSIVE CARE UNIT	1,499	51,221				
41.00	SUBPROVIDER - IRF	801	50,759				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	1,997	101,088				
200.00	Total (Lines 30-199)	19,475	993,083				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/24/2013 9:28 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	557,965	35,315,610	0.015799	7,274,739	114,934	50.00
51.00	05100 RECOVERY ROOM	43,299	7,190,148	0.006022	1,342,875	8,087	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	266,848	11,169,950	0.023890	22,946	548	52.00
53.00	05300 ANESTHESIOLOGY	9,885	8,936,487	0.001106	1,725,979	1,909	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	277,689	52,436,875	0.005296	6,725,274	35,617	54.00
54.01	03190 OUTPATIENT ONCOLOGY	1,362	2,070,929	0.000658	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	14,169	2,808,868	0.005044	26,731	135	55.00
59.00	05900 CARDIAC CATHETERIZATION	63,029	9,066,402	0.006952	2,353,293	16,360	59.00
60.00	06000 LABORATORY	233,383	57,662,868	0.004047	14,432,573	58,409	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	20,575	4,136,932	0.004973	1,536,722	7,642	63.00
65.00	06500 RESPIRATORY THERAPY	26,374	11,325,686	0.002329	4,365,546	10,167	65.00
66.00	06600 PHYSICAL THERAPY	86,373	5,474,610	0.015777	506,029	7,984	66.00
67.00	06700 OCCUPATIONAL THERAPY	17,572	2,822,895	0.006225	227,436	1,416	67.00
68.00	06800 SPEECH PATHOLOGY	5,104	545,654	0.009354	204,807	1,916	68.00
69.00	06900 ELECTROCARDIOLOGY	93,847	15,736,051	0.005964	3,708,303	22,116	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,023	882,645	0.001159	56,753	66	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	34,986	22,482,572	0.001556	5,981,334	9,307	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	13,785	8,042,121	0.001714	2,695,913	4,621	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	76,593	80,467,920	0.000952	20,854,078	19,853	73.00
74.00	07400 RENAL DIALYSIS	13,952	2,687,439	0.005192	1,308,929	6,796	74.00
75.00	07500 ASC (NON-DISTINCT PART)	7,484	10,265,062	0.000729	944,243	688	75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	124,919	3,043,063	0.041050	1,154	47	76.00
76.97	07697 CARDIAC REHABILITATION	35,353	150,659	0.234656	11,210	2,630	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	316,267	3,788,920	0.083472	22,352	1,866	90.00
91.00	09100 EMERGENCY	341,627	56,438,735	0.006053	6,072,096	36,754	91.00
92.00	09200 OBSERVATION BEDS	149,896	5,659,183	0.026487	419,582	11,113	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00	Total (lines 50-199)	2,833,359	420,608,284		82,820,897	380,981	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/24/2013 9:28 am	
Title XVIII			Hospital		PPS			
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)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	50,450	0.00	15,178	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,943	0.00	1,499	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	1,621	0.00	801	0	0	41.00
43.00	04300	NURSERY	1,431	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,628	0.00	1,997	0	0	44.00
200.00		Total (lines 30-199)	61,073		19,475	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		Title XVIII				Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:28 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	35,315,610	0.000000	0.000000	7,274,739	50.00
51.00	05100 RECOVERY ROOM	0	7,190,148	0.000000	0.000000	1,342,875	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	11,169,950	0.000000	0.000000	22,946	52.00
53.00	05300 ANESTHESIOLOGY	0	8,936,487	0.000000	0.000000	1,725,979	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	52,436,875	0.000000	0.000000	6,725,274	54.00
54.01	03190 OUTPATIENT ONCOLOGY	0	2,070,929	0.000000	0.000000	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	2,808,868	0.000000	0.000000	26,731	55.00
59.00	05900 CARDIAC CATHETERIZATION	0	9,066,402	0.000000	0.000000	2,353,293	59.00
60.00	06000 LABORATORY	0	57,662,868	0.000000	0.000000	14,432,573	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	4,136,932	0.000000	0.000000	1,536,722	63.00
65.00	06500 RESPIRATORY THERAPY	0	11,325,686	0.000000	0.000000	4,365,546	65.00
66.00	06600 PHYSICAL THERAPY	0	5,474,610	0.000000	0.000000	506,029	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,822,895	0.000000	0.000000	227,436	67.00
68.00	06800 SPEECH PATHOLOGY	0	545,654	0.000000	0.000000	204,807	68.00
69.00	06900 ELECTROCARDIOLOGY	0	15,736,051	0.000000	0.000000	3,708,303	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	882,645	0.000000	0.000000	56,753	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	22,482,572	0.000000	0.000000	5,981,334	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	8,042,121	0.000000	0.000000	2,695,913	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	80,467,920	0.000000	0.000000	20,854,078	73.00
74.00	07400 RENAL DIALYSIS	0	2,687,439	0.000000	0.000000	1,308,929	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	10,265,062	0.000000	0.000000	944,243	75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	0	3,043,063	0.000000	0.000000	1,154	76.00
76.97	07697 CARDIAC REHABILITATION	0	150,659	0.000000	0.000000	11,210	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	3,788,920	0.000000	0.000000	22,352	90.00
91.00	09100 EMERGENCY	0	56,438,735	0.000000	0.000000	6,072,096	91.00
92.00	09200 OBSERVATION BEDS	0	5,659,183	0.000000	0.000000	419,582	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00	Total (lines 50-199)	0	420,608,284			82,820,897	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:28 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	4,130,407	0	50.00
51.00	05100 RECOVERY ROOM	0	760,646	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,801	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,035,767	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,337,653	0	54.00
54.01	03190 OUTPATIENT ONCOLOGY	0	929,041	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	1,055,635	0	55.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,422,610	0	59.00
60.00	06000 LABORATORY	0	1,073,043	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	26,605	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	179,376	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,738,288	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	69,304	0	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	1,042,139	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,180,953	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13,243,196	0	73.00
74.00	07400 RENAL DIALYSIS	0	85,302	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	2,806,572	0	75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	0	839,482	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	43,510	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	583,058	0	90.00
91.00	09100 EMERGENCY	0	5,011,429	0	91.00
92.00	09200 OBSERVATION BEDS	0	1,636,013	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	0	48,233,830	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.208640	4,130,407	0	0	861,768	50.00	
51.00 05100 RECOVERY ROOM	0.123625	760,646	0	0	94,035	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.357512	3,801	0	0	1,359	52.00	
53.00 05300 ANESTHESIOLOGY	0.030248	1,035,767	0	0	31,330	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.119756	8,337,653	0	0	998,484	54.00	
54.01 03190 OUTPATIENT ONCOLOGY	0.133665	929,041	0	0	124,180	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.126191	1,055,635	0	0	133,212	55.00	
59.00 05900 CARDIAC CATHETERIZATION	0.099382	1,422,610	0	0	141,382	59.00	
60.00 06000 LABORATORY	0.110137	1,073,043	0	0	118,182	60.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.164334	26,605	0	0	4,372	63.00	
65.00 06500 RESPIRATORY THERAPY	0.139452	179,376	0	0	25,014	65.00	
66.00 06600 PHYSICAL THERAPY	0.333311	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.326787	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0.319505	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.082972	2,738,288	0	0	227,201	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.224564	69,304	0	0	15,563	70.00	
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.263712	1,042,139	0	0	274,825	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.329699	1,180,953	0	0	389,359	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.127794	13,243,196	0	387,932	1,692,401	73.00	
74.00 07400 RENAL DIALYSIS	0.231844	85,302	0	0	19,777	74.00	
75.00 07500 ASC (NON-DISTINCT PART)	0.112449	2,806,572	0	0	315,596	75.00	
76.00 03550 MENTAL HEALTH OUTPATIENT	0.734218	839,482	0	0	616,363	76.00	
76.97 07697 CARDIAC REHABILITATION	1.614507	43,510	0	0	70,247	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.617748	583,058	0	0	360,183	90.00	
91.00 09100 EMERGENCY	0.132180	5,011,429	0	0	662,411	91.00	
92.00 09200 OBSERVATION BEDS	0.401365	1,636,013	0	0	656,638	92.00	
OTHER REIMBURSABLE COST CENTERS							
94.00 09400 HOME PROGRAM DIALYSIS	0.000000		0	0		94.00	
200.00		Subtotal (see instructions)	48,233,830	0	387,932	7,833,882	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00		Net Charges (line 200 +/- line 201)	48,233,830	0	387,932	7,833,882	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:28 am
		Title XVII I	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	49,575		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
200.00 Subtotal (see instructions)	0	49,575		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	49,575		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140180 Component CCN: 14T180		Period: From 07/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/24/2013 9:28 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	557,965	35,315,610	0.015799	13,041	206	50.00
51.00	05100 RECOVERY ROOM	43,299	7,190,148	0.006022	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	266,848	11,169,950	0.023890	0	0	52.00
53.00	05300 ANESTHESIOLOGY	9,885	8,936,487	0.001106	3,435	4	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	277,689	52,436,875	0.005296	31,665	168	54.00
54.01	03190 OUTPATIENT ONCOLOGY	1,362	2,070,929	0.000658	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	14,169	2,808,868	0.005044	0	0	55.00
59.00	05900 CARDIAC CATHETERIZATION	63,029	9,066,402	0.006952	0	0	59.00
60.00	06000 LABORATORY	233,383	57,662,868	0.004047	224,332	908	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	20,575	4,136,932	0.004973	7,819	39	63.00
65.00	06500 RESPIRATORY THERAPY	26,374	11,325,686	0.002329	59,820	139	65.00
66.00	06600 PHYSICAL THERAPY	86,373	5,474,610	0.015777	481,927	7,603	66.00
67.00	06700 OCCUPATIONAL THERAPY	17,572	2,822,895	0.006225	461,266	2,871	67.00
68.00	06800 SPEECH PATHOLOGY	5,104	545,654	0.009354	43,839	410	68.00
69.00	06900 ELECTROCARDIOLOGY	93,847	15,736,051	0.005964	17,460	104	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,023	882,645	0.001159	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	34,986	22,482,572	0.001556	132,171	206	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	13,785	8,042,121	0.001714	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	76,593	80,467,920	0.000952	499,766	476	73.00
74.00	07400 RENAL DIALYSIS	13,952	2,687,439	0.005192	75,690	393	74.00
75.00	07500 ASC (NON-DISTINCT PART)	7,484	10,265,062	0.000729	0	0	75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	124,919	3,043,063	0.041050	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	35,353	150,659	0.234656	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	316,267	3,788,920	0.083472	0	0	90.00
91.00	09100 EMERGENCY	341,627	56,438,735	0.006053	0	0	91.00
92.00	09200 OBSERVATION BEDS	0	5,659,183	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00	Total (Lines 50-199)	2,683,463	420,608,284		2,052,231	13,527	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140180 Component CCN: 14T180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:28 am
Title XVIII		Subprovider - IRF	PPS

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)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140180 Component CCN: 14T180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:28 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	35,315,610	0.000000	0.000000	13,041 50.00
51.00 05100 RECOVERY ROOM	0	7,190,148	0.000000	0.000000	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	11,169,950	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	8,936,487	0.000000	0.000000	3,435 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	52,436,875	0.000000	0.000000	31,665 54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	2,070,929	0.000000	0.000000	0 54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	2,808,868	0.000000	0.000000	0 55.00
59.00 05900 CARDIAC CATHETERIZATION	0	9,066,402	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	57,662,868	0.000000	0.000000	224,332 60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0 62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	4,136,932	0.000000	0.000000	7,819 63.00
65.00 06500 RESPIRATORY THERAPY	0	11,325,686	0.000000	0.000000	59,820 65.00
66.00 06600 PHYSICAL THERAPY	0	5,474,610	0.000000	0.000000	481,927 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,822,895	0.000000	0.000000	461,266 67.00
68.00 06800 SPEECH PATHOLOGY	0	545,654	0.000000	0.000000	43,839 68.00
69.00 06900 ELECTROCARDIOLOGY	0	15,736,051	0.000000	0.000000	17,460 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	882,645	0.000000	0.000000	0 70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	22,482,572	0.000000	0.000000	132,171 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	8,042,121	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	80,467,920	0.000000	0.000000	499,766 73.00
74.00 07400 RENAL DIALYSIS	0	2,687,439	0.000000	0.000000	75,690 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	10,265,062	0.000000	0.000000	0 75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	3,043,063	0.000000	0.000000	0 76.00
76.97 07697 CARDIAC REHABILITATION	0	150,659	0.000000	0.000000	0 76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0 76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	3,788,920	0.000000	0.000000	0 90.00
91.00 09100 EMERGENCY	0	56,438,735	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS	0	5,659,183	0.000000	0.000000	0 92.00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0 94.00
200.00 Total (Lines 50-199)	0	420,608,284			2,052,231 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140180 Component CCN: 14T180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:28 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	9,063	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	544	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	254	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	322	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,935	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00 Total (lines 50-199)	0	21,118	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140180 Component CCN: 14T180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:28 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00		5.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.208640	0	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	0.123625	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.357512	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0.030248	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.119756	9,063	0	0	1,085	54.00	
54.01 03190 OUTPATIENT ONCOLOGY	0.133665	0	0	0	0	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.126191	0	0	0	0	55.00	
59.00 05900 CARDIAC CATHETERIZATION	0.099382	0	0	0	0	59.00	
60.00 06000 LABORATORY	0.110137	544	0	0	60	60.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.164334	254	0	0	42	63.00	
65.00 06500 RESPIRATORY THERAPY	0.139452	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0.333311	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.326787	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0.319505	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.082972	322	0	0	27	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.224564	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.263712	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.329699	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.127794	10,935	0	1,930	1,397	73.00	
74.00 07400 RENAL DIALYSIS	0.231844	0	0	0	0	74.00	
75.00 07500 ASC (NON-DISTINCT PART)	0.112449	0	0	0	0	75.00	
76.00 03550 MENTAL HEALTH OUTPATIENT	0.734218	0	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	1.614507	0	0	0	0	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.617748	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0.132180	0	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS	0.401365	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
94.00 09400 HOME PROGRAM DIALYSIS	0.000000		0			94.00	
200.00	Subtotal (see instructions)		21,118	0	1,930	2,611	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		21,118	0	1,930	2,611	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140180 Component CCN: 14T180	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:28 am
	Title XVII I	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	247	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	94.00
200.00	Subtotal (see instructions)	0	247
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	247

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140180 Component CCN: 145541	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:28 am
Title XVIII		Skilled Nursing Facility	PPS

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)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140180 Component CCN: 145541	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:28 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	35,315,610	0.000000	0.000000	5,509	50.00
51.00 05100 RECOVERY ROOM	0	7,190,148	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	11,169,950	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	8,936,487	0.000000	0.000000	1,181	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	52,436,875	0.000000	0.000000	66,176	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	2,070,929	0.000000	0.000000	730	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	2,808,868	0.000000	0.000000	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0	9,066,402	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	57,662,868	0.000000	0.000000	551,198	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	4,136,932	0.000000	0.000000	31,102	63.00
65.00 06500 RESPIRATORY THERAPY	0	11,325,686	0.000000	0.000000	428,208	65.00
66.00 06600 PHYSICAL THERAPY	0	5,474,610	0.000000	0.000000	883,007	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,822,895	0.000000	0.000000	890,509	67.00
68.00 06800 SPEECH PATHOLOGY	0	545,654	0.000000	0.000000	7,700	68.00
69.00 06900 ELECTROCARDIOLOGY	0	15,736,051	0.000000	0.000000	9,835	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	882,645	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	22,482,572	0.000000	0.000000	812,989	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	8,042,121	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	80,467,920	0.000000	0.000000	1,542,365	73.00
74.00 07400 RENAL DIALYSIS	0	2,687,439	0.000000	0.000000	138,240	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	10,265,062	0.000000	0.000000	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	3,043,063	0.000000	0.000000	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	150,659	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	3,788,920	0.000000	0.000000	10,842	90.00
91.00 09100 EMERGENCY	0	56,438,735	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS	0	5,659,183	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00 Total (Lines 50-199)	0	420,608,284			5,379,591	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140180 Component CCN: 145541	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:28 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00 Total (Lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140180 Component CCN: 145541	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:28 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.208640	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.123625	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.357512	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.030248	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.119756	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0.133665	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.126191	0	0	0	0	55.00
59.00 05900 CARDIAC CATHETERIZATION	0.099382	0	0	0	0	59.00
60.00 06000 LABORATORY	0.110137	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.164334	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.139452	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.333311	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.326787	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.319505	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.082972	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.224564	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.263712	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.329699	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.127794	0	0	1,391	0	73.00
74.00 07400 RENAL DIALYSIS	0.231844	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.112449	0	0	0	0	75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0.734218	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	1.614507	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.617748	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.132180	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS	0.401365	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00	Subtotal (see instructions)	0	0	1,391	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	1,391	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140180 Component CCN: 145541	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:28 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	178		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03550 MENTAL HEALTH OUTPATIENT	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
200.00	Subtotal (see instructions)	0	178	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	178	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/24/2013 9:28 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		50,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		50,450	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		47,570	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		15,178	9.00
10.00	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)		0	10.00
11.00	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)		0	11.00
12.00	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		0	12.00
13.00	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)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		39,788,745	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		39,788,745	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		97,130,798	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		97,130,798	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.409641	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,041.85	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		39,788,745	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		788.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,970,585	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		11,970,585	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/24/2013 9:28 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,261,443	4,943	1,064.42	1,499	1,595,566	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					12,411,232	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,977,383	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					841,236	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					380,981	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,222,217	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,755,166	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,880	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					788.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,271,398	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center Description		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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,625,769	39,788,745	0.065993	2,271,398	149,896	90.00
91.00	Nursing School cost	0	39,788,745	0.000000	2,271,398	0	91.00
92.00	Allied health cost	0	39,788,745	0.000000	2,271,398	0	92.00
93.00	All other Medical Education	0	39,788,745	0.000000	2,271,398	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14T180		Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,621	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,621	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		801	9.00
10.00	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)		0	10.00
11.00	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)		0	11.00
12.00	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		0	12.00
13.00	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)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,303,473	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,303,473	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,887,395	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,887,395	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.451436	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,781.24	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,303,473	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		804.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		644,100	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		644,100	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 14T180				Date/Time Prepared: 5/24/2013 9:28 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					484,045	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,128,145	49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50,759	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					13,527	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					64,286	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					1,063,859	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180 Component CCN: 14T180		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:28 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	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)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	102,715	1,303,473	0.078801	0	0	90.00
91.00	Nursing School cost	0	1,303,473	0.000000	0	0	91.00
92.00	Allied health cost	0	1,303,473	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,303,473	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 145541		Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,628	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,628	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,628	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,997	9.00
10.00	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)		0	10.00
11.00	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)		0	11.00
12.00	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		0	12.00
13.00	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)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,773,659	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,773,659	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,230,826	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,230,826	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.795068	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		848.87	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,773,659	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180 Component CCN: 145541		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:28 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					1,773,659	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					674.91	71.00
72.00	Program routine service cost (line 9 x line 71)					1,347,795	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					1,347,795	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					1,347,795	83.00
84.00	Program inpatient ancillary services (see instructions)					1,173,587	84.00
85.00	Utilization review - physician compensation (see instructions)					6,000	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					2,527,382	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180 Component CCN: 145541		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:28 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	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)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/24/2013 9:28 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		50,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		50,450	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		47,570	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		22,508	9.00
10.00	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)		0	10.00
11.00	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)		0	11.00
12.00	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		0	12.00
13.00	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)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,431	15.00
16.00	Nursery days (title V or XIX only)		1,100	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		39,788,745	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		39,788,745	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		97,130,798	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		97,130,798	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.409641	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,041.85	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		39,788,745	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		788.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,751,609	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		17,751,609	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/24/2013 9:28 am		
Cost Center Description			Title XIX	Hospital	Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	866,743	1,431	605.69	1,100	666,259	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,261,443	4,943	1,064.42	2,987	3,179,423	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					21,597,291	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,880	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					788.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,271,398	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center Description		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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14T180		Date/Time Prepared: 5/24/2013 9:28 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,621	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,621	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		630	9.00
10.00	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)		0	10.00
11.00	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)		0	11.00
12.00	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		0	12.00
13.00	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)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,431	15.00
16.00	Nursery days (title V or XIX only)		1,100	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,303,473	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,303,473	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,887,395	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,887,395	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.451436	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,781.24	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,303,473	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		804.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		506,596	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		506,596	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 14T180				Date/Time Prepared: 5/24/2013 9:28 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					506,596	49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140180 Component CCN: 14T180		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:28 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	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)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/24/2013 9:28 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		30,931,611	30.00
31.00	03100	INTENSIVE CARE UNIT		5,734,985	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.208640	7,274,739	50.00
51.00	05100	RECOVERY ROOM	0.123625	1,342,875	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.357512	22,946	52.00
53.00	05300	ANESTHESIOLOGY	0.030248	1,725,979	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119756	6,725,274	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.133665	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.126191	26,731	55.00
59.00	05900	CARDIAC CATHETERIZATION	0.099382	2,353,293	59.00
60.00	06000	LABORATORY	0.110137	14,432,573	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.164334	1,536,722	63.00
65.00	06500	RESPIRATORY THERAPY	0.139452	4,365,546	65.00
66.00	06600	PHYSICAL THERAPY	0.333311	506,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.326787	227,436	67.00
68.00	06800	SPEECH PATHOLOGY	0.319505	204,807	68.00
69.00	06900	ELECTROCARDIOLOGY	0.082972	3,708,303	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.224564	56,753	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.263712	5,981,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.329699	2,695,913	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.127794	20,854,078	73.00
74.00	07400	RENAL DIALYSIS	0.231844	1,308,929	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.112449	944,243	75.00
76.00	03550	MENTAL HEALTH OUTPATIENT	0.734218	1,154	76.00
76.97	07697	CARDIAC REHABILITATION	1.614507	11,210	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.617748	22,352	90.00
91.00	09100	EMERGENCY	0.132180	6,072,096	91.00
92.00	09200	OBSERVATION BEDS	0.401365	419,582	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		82,820,897	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		82,820,897	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet D-3
		Component CCN: 14T180		Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		1,438,041	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.208640	13,041	50.00
51.00	05100 RECOVERY ROOM	0.123625	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.357512	0	52.00
53.00	05300 ANESTHESIOLOGY	0.030248	3,435	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119756	31,665	54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.133665	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.126191	0	55.00
59.00	05900 CARDIAC CATHETERIZATION	0.099382	0	59.00
60.00	06000 LABORATORY	0.110137	224,332	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.164334	7,819	63.00
65.00	06500 RESPIRATORY THERAPY	0.139452	59,820	65.00
66.00	06600 PHYSICAL THERAPY	0.333311	481,927	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.326787	461,266	67.00
68.00	06800 SPEECH PATHOLOGY	0.319505	43,839	68.00
69.00	06900 ELECTROCARDIOLOGY	0.082972	17,460	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.224564	0	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.263712	132,171	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.329699	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.127794	499,766	73.00
74.00	07400 RENAL DIALYSIS	0.231844	75,690	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.112449	0	75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	0.734218	0	76.00
76.97	07697 CARDIAC REHABILITATION	1.614507	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.617748	0	90.00
91.00	09100 EMERGENCY	0.132180	0	91.00
92.00	09200 OBSERVATION BEDS	0.401365	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00	Total (sum of lines 50-94 and 96-98)		2,052,231	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		2,052,231	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140180 Component CCN: 145541	Period: From 07/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.208640	5,509	1,149 50.00
51.00	05100 RECOVERY ROOM	0.123625	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.357512	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.030248	1,181	36 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119756	66,176	7,925 54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.133665	730	98 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.126191	0	0 55.00
59.00	05900 CARDIAC CATHETERIZATION	0.099382	0	0 59.00
60.00	06000 LABORATORY	0.110137	551,198	60,707 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.164334	31,102	5,111 63.00
65.00	06500 RESPIRATORY THERAPY	0.139452	428,208	59,714 65.00
66.00	06600 PHYSICAL THERAPY	0.333311	883,007	294,316 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.326787	890,509	291,007 67.00
68.00	06800 SPEECH PATHOLOGY	0.319505	7,700	2,460 68.00
69.00	06900 ELECTROCARDIOLOGY	0.082972	9,835	816 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.224564	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.263712	812,989	214,395 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.329699	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.127794	1,542,365	197,105 73.00
74.00	07400 RENAL DIALYSIS	0.231844	138,240	32,050 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.112449	0	0 75.00
76.00	03550 MENTAL HEALTH OUTPATIENT	0.734218	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	1.614507	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.617748	10,842	6,698 90.00
91.00	09100 EMERGENCY	0.132180	0	0 91.00
92.00	09200 OBSERVATION BEDS	0.401365	0	0 92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0 94.00
200.00	Total (sum of lines 50-94 and 96-98)		5,379,591	1,173,587 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		5,379,591	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/24/2013 9:28 am
		Title XVII I	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		21,263,148	1.00
2.00	Outlier payments for discharges. (see instructions)		529,126	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		1,823,884	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		436.35	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		40.45	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		4.28	8.00
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.		0.00	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)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		44.73	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		43.14	10.00
11.00	FTE count for residents in dental and podiatric programs.		3.00	11.00
12.00	Current year allowable FTE (see instructions)		46.14	12.00
13.00	Total allowable FTE count for the prior year.		35.81	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		35.54	14.00
15.00	Sum of lines 12 through 14 divided by 3.		39.16	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		39.16	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.089744	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.082890	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.082890	21.00
22.00	IME payment adjustment (see instructions)		1,021,578	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		1,021,578	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		19.61	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		51.52	31.00
32.00	Sum of lines 30 and 31		71.13	32.00
33.00	Allowable disproportionate share percentage (see instructions)		47.90	33.00
34.00	Disproportionate share adjustment (see instructions)		10,185,048	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		32,998,900	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		32,998,900	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		2,044,430	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		604,775	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/24/2013 9:28 am
		Title XVII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			35,648,105 59.00
60.00	Primary payer payments			0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			35,648,105 61.00
62.00	Deductibles billed to program beneficiaries			1,920,116 62.00
63.00	Coinurance billed to program beneficiaries			391,306 63.00
64.00	Allowable bad debts (see instructions)			1,519,939 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			1,063,957 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			763,330 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			34,400,640 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			15,752 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-80,003 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			34,336,389 71.00
72.00	Interim payments			34,100,610 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			235,779 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			71,381 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 9:28 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		49,575	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,833,882	2.00
3.00	PPS payments		7,919,994	3.00
4.00	Outlier payment (see instructions)		62,474	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		49,575	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		387,932	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		387,932	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	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)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		387,932	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		338,357	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		49,575	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		7,982,468	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,796,478	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		6,235,565	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		161,486	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		6,397,051	30.00
31.00	Primary payer payments		260	31.00
32.00	Subtotal (line 30 minus line 31)		6,396,791	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		690,481	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		483,337	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		427,597	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		6,880,128	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		6,880,128	40.00
41.00	Interim payments		6,625,281	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		254,847	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180 Component CCN: 14T180	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		247	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,611	2.00
3.00	PPS payments		1,304	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		247	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,930	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,930	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,930	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,683	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		247	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		1,304	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		273	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		1,278	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,278	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,278	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		1,278	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		1,278	40.00
41.00	Interim payments		1,095	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		183	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180 Component CCN: 145541	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		178	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		178	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,391	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,391	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	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)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,391	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,213	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		178	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		178	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		178	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		178	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		178	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		178	40.00
41.00	Interim payments		195	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-17	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		34,280,076		6,732,615	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	10/04/2012	179,466	10/04/2012	107,334	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-179,466		-107,334	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		34,100,610		6,625,281	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		235,779		254,847	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		34,336,389		6,880,128	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140180
Component CCN: 14T180

Period:
From 07/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,286,940		1,095	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	10/04/2012	11,152		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		11,152		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,298,092		1,095	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		26,160		183	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,324,252		1,278	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140180
Component CCN: 145541

Period:
From 07/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2013 9:28 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,053,321		195	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,053,321		195	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		6,000		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		17	6.02
7.00	Total Medicare program liability (see instructions)		1,059,321		178	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180 Component CCN: 14T180	Period: From 07/01/2012 To 12/31/2012	Worksheet E-3 Part III Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,105,695 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.1382 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			217,643 3.00
4.00	Outlier Payments			14,497 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			8.809783 10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1)\}$.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			1,337,835 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,337,835 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,337,835 19.00
20.00	Deductibles			10,404 20.00
21.00	Subtotal (line 19 minus line 20)			1,327,431 21.00
22.00	Coinurance			11,271 22.00
23.00	Subtotal (line 21 minus line 22)			1,316,160 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			11,560 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			8,092 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,560 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,324,252 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,324,252 32.00
33.00	Interim payments			1,298,092 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			26,160 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			24,497 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			14,497 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180 Component CCN: 145541	Period: From 07/01/2012 To 12/31/2012	Worksheet E-3 Part VI Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,081,210	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,081,210	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		27,889	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		6,000	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		1,059,321	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		1,059,321	15.00
16.00	Interim payments		1,053,321	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		6,000	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2013 9:28 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		21,597,291		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		21,597,291	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		21,597,291	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		21,597,291	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		21,597,291	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140180 Component CCN: 14T180	Period: From 07/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2013 9:28 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital /SNF/NF services	506,596		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	506,596	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	506,596	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	506,596	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	506,596	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet E-4 Date/Time Prepared: 5/24/2013 9:28 am	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			41.12	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			-2.82	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			3.80	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			47.74	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			35.00	6.00
7.00	Enter the lesser of line 5 or line 6			35.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	41.26	1.33	42.59	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	41.26	1.33	42.59	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	41.26	1.33		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	34.81	1.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	34.54	1.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	36.87	1.11		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	36.87	1.11		17.00
18.00	Per resident amount	58,504.76	58,504.76		18.00
19.00	Approved amount for resident costs	2,157,071	64,940	2,222,011	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			2,222,011	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days	17,478	1,386		26.00
27.00	Total Inpatient Days (see instructions)	54,134	54,134		27.00
28.00	Ratio of inpatient days to total inpatient days	0.322865	0.025603		28.00
29.00	Program direct GME amount	717,410	56,890		29.00
30.00	Reduction for direct GME payments for Medicare managed care		8,039		30.00
31.00	Net Program direct GME amount			766,261	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet E-4 Date/Time Prepared: 5/24/2013 9:28 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		2,687,439	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		29,534,533	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		29,534,533	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		7,886,493	42.00
43.00	Primary payer payments (see instructions)		260	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		7,886,233	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		37,420,766	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.789255	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.210745	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		766,261	48.00
49.00	Part A Medicare GME payment (line 46 x 48)(Title XVIII only)(see instructions)		604,775	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		161,486	50.00

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

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet G

Date/Time Prepared:
5/24/2013 9:28 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	22,000	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	86,512,206	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-54,633,206	0	0	0	6.00
7.00	Inventory	3,866,672	0	0	0	7.00
8.00	Prepaid expenses	118,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	101,015,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	136,900,672	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,902,892	0	0	0	12.00
13.00	Land improvements	3,369,721	0	0	0	13.00
14.00	Accumulated depreciation	-729,466	0	0	0	14.00
15.00	Buildings	123,185,761	0	0	0	15.00
16.00	Accumulated depreciation	-66,623,495	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	61,376,625	0	0	0	23.00
24.00	Accumulated depreciation	-48,438,224	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	77,043,814	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	82,014,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,074,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	86,088,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	300,032,486	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,571,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	11,309,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,880,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	14,000,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	29,596,491	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,596,491	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	62,476,491	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	237,555,995	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	237,555,995	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	300,032,486	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet G-1

Date/Time Prepared:
5/24/2013 9:28 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		222,664,973		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		22,869,023				2.00
3.00	Total (sum of line 1 and line 2)		245,533,996		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		245,533,996		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	TRANSFER TO AFFILIATE	7,978,001		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		7,978,001		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		237,555,995		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00	TRANSFER TO AFFILIATE		0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2013 9:28 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	97,130,798		97,130,798	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,887,395		2,887,395	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,230,826		2,230,826	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	102,249,019		102,249,019	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,466,801		12,466,801	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	12,466,801		12,466,801	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	114,715,820		114,715,820	17.00
18.00	Ancillary services	202,860,982	154,641,871	357,502,853	18.00
19.00	Outpatient services	16,631,943	43,620,850	60,252,793	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	334,208,745	198,262,721	532,471,466	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		126,522,900		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	RECONCILIATION	33			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		33		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		126,522,867		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140180

Period:
From 07/01/2012
To 12/31/2012

Worksheet G-3

Date/Time Prepared:
5/24/2013 9:28 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	532,471,466	1.00
2.00	Less contractual allowances and discounts on patients' accounts	390,236,143	2.00
3.00	Net patient revenues (line 1 minus line 2)	142,235,323	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	126,522,867	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,712,456	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,620,104	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	REVENUE FROM OTHER SERVICES	4,509,162	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	27,301	24.01
25.00	Total other income (sum of lines 6-24)	7,156,567	25.00
26.00	Total (line 5 plus line 25)	22,869,023	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	22,869,023	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet I-5 Date/Time Prepared: 5/24/2013 9:28 am
				1.00
1.00	Total expenses related to care of program beneficiaries (see instructions)		0	1.00
2.00	Total payment (from Worksheet I-4, column 6, line 11)		0	2.00
3.00	Deductibles billed to Medicare (Part B) patients		0	3.00
4.00	Coinsurance billed to Medicare (Part B) patients		0	4.00
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries		0	5.00
6.00				6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)		0	8.00
9.00	Program payment (line 2 less line 3, times 80 percent)		0	9.00
10.00	Unrecovered from Medicare (Part B) patients (Line 1 minus the sum of lines 8 and 9. If negative, enter zero and do not complete line 11.)		0	10.00
11.00	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)		0	11.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140180	Period: From 07/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/24/2013 9:28 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,705,368	1.00
2.00	Capital DRG outlier payments		7,538	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		285.40	3.00
4.00	Number of interns & residents (see instructions)		39.16	4.00
5.00	Indirect medical education percentage (see instructions)		3.95	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		67,362	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		19.61	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		51.52	8.00
9.00	Sum of lines 7 and 8		71.13	9.00
10.00	Allowable disproportionate share percentage (see instructions)		15.49	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		264,162	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		2,044,430	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	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)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

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